Idaho

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/19/2015 10.50.49 AM)

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	2016
End Year	2017

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	Richard
Last Name	Armstrong
Agency Name	Idaho Department of Health and Welfare
Mailing Address	450 West State Street
City	Boise
Zip Code	83720-0036
Telephone	208-334-5500
Fax	208-334-6558
Email Address	OsbornJ@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	Richard
Last Name	Armstrong
Agency Name	Idaho Department of Health and Welfare
Mailing Address	450 West State Street

City	Boise
Zip Code	83720-0036
Telephone	208-334-5500
Fax	208-334-6558
Email Address	OsbornJ@dhw.idaho.gov

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

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Terry
Last Name	Pappin
Telephone	208-334-6452
Fax	208-334-5998
Email Address	pappint@dhw.idaho.gov

Footnotes:

Anne Bloxham is the lead for the Mental Health portion of this application. Her phone number is 208-5527. Her email address is BloxhamA@dhw.idaho.gov. Terry Pappin is the lead for the Substance Abuse Prevention and Treatment portions of this application

State Information

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

Fiscal Year 2016

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

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

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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Richard M. Armstrong

Signature of CEO or Designee[1]: _____

Title: Director, 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.

Footnotes:

State Information

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

Fiscal Year 2016

U.S. Department of Health and Human Services
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Title XIX, Part B, Subpart II of the Public Health Service Act		
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Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
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Signature of CEO or Designee[1]: _____

Title: Director, Department of Health and Welfare

Date Signed: _____

mm/dd/yyyy

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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	Richard Armstrong
Title	Director
Organization	Department of Health and Welfare

Signature: _____ Date: _____

Footnotes:

Planning Steps

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

Narrative Question:

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

Footnotes:

II: Planning Steps

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

Identification of Data Sources Used to Identify Needs and Gaps in Prevention Services

The Office of Drug Policy gathers and reports data from several sources, both administrative and self-reported, to identify needs and gaps in prevention services. The primary source of substance abuse consumption and consequences data is used to continuously update the State of Idaho Substance Abuse Prevention Needs Assessment, which is a report that encompasses all indicators of substance abuse as identified by the State Epidemiological Outcomes Workgroup (SEOW). The SEOW, which is composed of many research professionals from multiple state agencies, developed a four step process to identify all relevant substance abuse indicators for alcohol, prescription drugs, tobacco, marijuana, and other drugs in the state. The Needs Assessment contains mostly information at the state-level, but some county level information is also available in the report.

Agencies that provide data to be used in the State of Idaho Substance Abuse Prevention Needs Assessment include: U.S. Census Bureau; Bureau of Labor Statistics; Idaho State Liquor Division; Bureau of Vital Records and Health Statistics; and, Idaho Department of Transportation. Additionally, other data sources contributing to identifying needs in Idaho regarding substance abuse prevention include the Idaho Youth Risk Behavior Survey (YRBS), Idaho Behavioral Risk Factor Surveillance System (BRFSS), Incidence Based Reporting System, National Survey on Drug Use and Health (NSDUH), and Treatment Episodes Data Set (TEDS).

As previously mentioned, the (SEOW) is composed of state agency staff with research expertise interested in substance abuse prevention. The mission of the SEOW is to promote the strategic use and dissemination of data for informing and guiding Idaho's substance abuse prevention and behavioral health promotion policy and program development, decision-making, resource allocation and capacity building. With regards to prevention, the SEOW operates as an ad hoc research resource for policy decision makers, and facilitates statewide partnerships. Additionally the group maintains a web dissemination resource.

The PATR website at http://patr.idaho.gov/ states that "The Idaho Prevention and Treatment Research (PATR) Workgroup exists to develop a system of substance abuse related data collection, analysis and reporting that reflects substance abuse consumption and consequences throughout Idaho." This public site is accessible to all Idaho stakeholders and reflects 15 prevention risk factors, reported for each of Idaho's 44 counties resulting in a single source for 4,620 data points. Collected at the county level, the PATR website is a resource for state organizations, community members, prevention providers, researchers and coalitions needing data to develop substance abuse (including underage drinking) or other plans for their specific needs. Data is graphed by county on this site and reflects domains related to school (i.e., incidents of bullying, suspensions, truancies), individual (i.e., adolescent pregnancy, juvenile arrests for alcohol related charges and juvenile arrests for drug related charges), family (i.e., child abuse and neglect, heavy drinking, illicit drug use), and community (i.e., adult arrests for alcohol related charges, adult arrests for drug related charges, free or reduced school lunch eligibility (K-12), impaired driving crashes, per capita sales of distilled spirits, unemployment rate). The PATR website uses data

provided by the Idaho State Liquor Division, the Idaho State Police and the Idaho Departments of Education, Transportation and Idaho Department of Health and Welfare. Currently, the SEOW is taking steps to update the site to make it more useful for policy makers, substance abuse prevention providers, coalitions, and others.

Unmet Service Needs and Critical Gaps

ODP has identified the following areas of unmet service needs and critical gaps:

Data Collection Gaps: Identified data gaps relevant to ODP's prevention program planning efforts include **limited regional and county level data and limited sub-population level data.** Although the YRBS is successfully administered every other year, it has been challenging to implement any additional surveys to garner information relevant to substance abuse prevention (e.g., perception of harm, parental disapproval for substance use, etc.). Additionally, the data from the YRBS is only generalizable to the state, which does not provide local level data to substance abuse prevention providers and coalitions.

To address this deficit, ODP is working with the Idaho State Department of Education to increase student survey participation. In 2014, the two agencies partnered with the Idaho Department of Health and Welfare to administer the Idaho Youth Prevention Survey (IYPS). Despite some successes, the participation rates were not high enough to provide county level data. Currently, the state is determining how to best move forward with this survey in order to achieve higher participation rates while minimizing the burden of survey administration on educators.

Idaho's identified sub-populations of interest are: American Indians/Alaska Natives; Hispanics/Latinos; Veterans; youth; and, individuals identifying as lesbian, gay, bisexual, or transgendered (LGBT). The two greatest issues with sub-population data are: 1) small sample sizes; and, 2) a lack of collection.

First, because of the combination of Idaho's relatively small population and limited surveillance infrastructure, obtaining sub-population data is a challenge for the State. Due to the lack of sampling, it is often difficult to obtain reliable and valid data without aggregating data, making it difficult to view change over time.

Second, some data are simply not collected. For example, out of all the subpopulations, the greatest breadth of data we have are for youth, yet even still, there is some information that would be valuable to prevention efforts that are not currently being collected at the statewide level (e.g., perceptions, availability, etc.). Although consequence data (i.e., arrests and mortality) are categorized by race and ethnicity, this information cannot be analyzed by veteran status or sexual orientation. Because of this, it is typically the case that only consumption data is available for veterans and LGBT populations. Additionally, there is no statewide survey that collects consumption data for LGBT youth, and the BRFSS just recently began collecting such data.

Despite limited data collection capacity, the SEOW's monthly meetings provide a forum for the exploration of issues related to data collection and analysis relevant to prevention planning efforts. One goal of the SEOW is to establish standardized data collection procedures across state agencies, and build the capacity to obtain relevant data for substance abuse prevention and treatment professionals.

System Gaps: ODP continues to focus on the development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practices. ODP contracts with KIT Solutions (KITS), LLC to provide a web-based Data Collection, Reporting and Evaluation System for substance abuse prevention programs. The KITS system was implemented in April 2014. Training of ODP staff and prevention providers was conducted throughout SFY2014. The KITS format follows the Strategic Prevention Framework model, and allows providers to enter Needs Assessment, Capacity, Planning, Implementation, and Evaluation data related to prevention programs and activities delivered. Additionally, the system is used to collect data on participant demographics, attendance, pre/post test scores, providers/staff and staff training, and service costs. Required block grant and NOMS data is also recorded in the data management system. There are currently forty eight (48) providers using the KITS data management system to track SABG funded community substance abuse prevention services. This system can be viewed at: https://idprev.kithost.net/idprevent2014/.

Identified system gaps include the recent transition to the KITS system which includes ongoing improvements to data collection processes and addressing deficits in system functions. To date, substance abuse prevention providers and coalitions have received minimal training and support in using the new data collection system, resulting in the potential for inaccuracies in the data. Efforts to improve available technical assistance for providers are underway.

Service Gaps: ODP has prioritized the development of a workforce development plan to address identified service gaps related to the prevention workforce. Several efforts have been initiated to improve training and technical assistance available. After analyzing data from a survey of current prevention providers, ODP identified that there was a large need for program specific training for instructors. Of the 32 respondents, over 21% reported that they had never received program specific training for the program they were currently instructing. Although ODP is attempting to meet the need by arranging for these trainings, there is still room to improve.

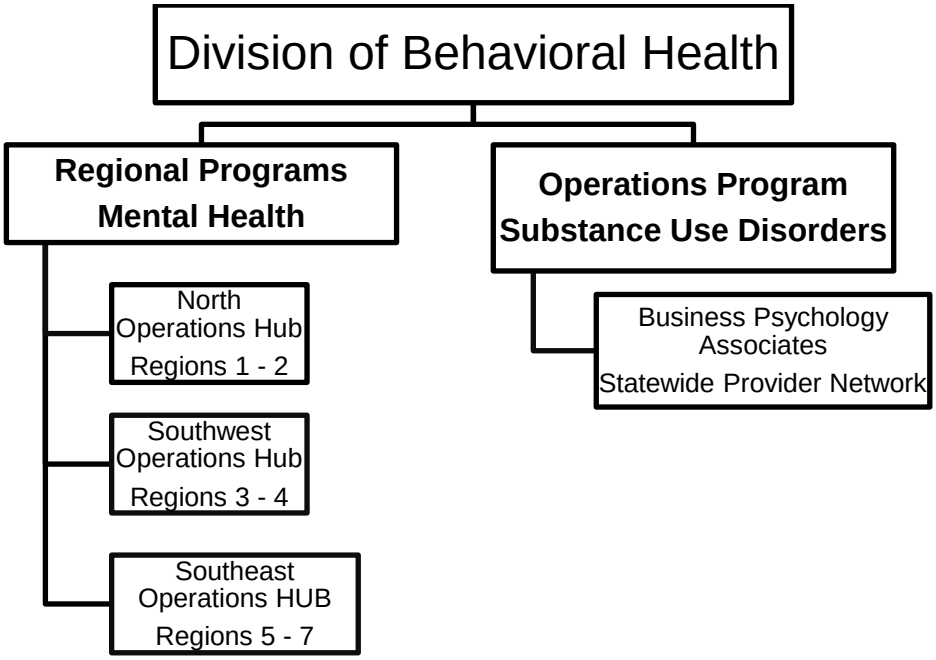
ODP is partnering with the Center for Application of Prevention Technologies (CAPT) and Community Anti-Drug Coalitions of America (CADCA) to develop training opportunities designed to increase the number of Certified Prevention Specialists (CPS). Idaho currently has a total of 3 CPS registered by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC). A recent assessment of prevention providers across the state indicated a large range of both experience and expertise. Efforts to standardize provider training and improve system quality are in process.

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

Idaho Response:

This response only covers substance use disorders treatment and mental health services. The Office of Drug Policy will be providing a prevention-related response to this section. The Division of Behavioral Health, located within the Idaho Department of Health and Welfare is responsible for delivery of mental health and substance use disorders services to all adults and children/adolescents who meet diagnostic and financial criteria. 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. This mission drives everything the Division does.

The Division of Behavioral Health employs two separate systems in the delivery of mental health and substance use disorder systems. For both systems, individuals must been diagnostic and financial needs criteria to qualify for state-funded services. Individuals with Medicaid are served under a separate system. The Division does cover the the cost for Medicaid-covered clients to receive services not allowable under the Idaho Medicaid plan. Both systems are community-based and focus on using local resources. The chart below depicts the Division of Behavioral Health's substance use disorders and mental health treatment services system.



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

Division mental health services are primarily delivered in the Department of Health and Welfare's regional offices located throughout Idaho. A map of the regions follows this paragraph. Each region has a separate team for adult services and for children's services. This ensures that both adults and children receive both care appropriate for their diagnosis and developmental stage. While the description of the system does not differentiate between child and adult clients, the knowledge and experience of the staff delivering services and the services delivered are specific to the population served. 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. Individuals needing hospital care are served through three mechanisms.

The Division includes two state hospitals which serve individuals with mental health or co-occurring diagnoses. One facility is located in north Idaho and the other in southeastern Idaho. The hospital in southeast Idaho has the capacity to serve children and adolescents as well as adults. Individuals needing a higher level of hospital services that are available in the Division's facilities receive services in primary care hospitals until such time as they are sufficiently stable to discharge to a lower level of care. For individuals needing specialty services or residential care, the Division contracts with non-government providers to deliver the needed services. The Division also contracts with consumer and family advocacy organizations and, in FFY 2014-15, with a hospital located in Region V, to deliver early intervention services. For the FFY 16 grant

period, Idaho will be using the early intervention funding to support outpatient activities in Region VII.

The Division of Behavioral Health's substance use disorders services are delivered by community based providers who are managed by an intermediary. The provider network is composed of private agencies from throughout the state. The Division contracts with Business Psychology Associates (BPA) to manage this system. This system facilitates immediate access to care locally thereby reducing barriers for treatment clients. All individuals, regardless of race, language, ethnicity, sexual preference, religion, age and gender have equal access to care. By using a local provider network system, the Division of Behavioral Health is able to meet the needs of specific populations within an area. Likewise, the providers are knowledgeable about resources within their area and are able to capitalize on local resources to support recovery for all clients receiving Division-funded care.

Individuals enter the Division's Substance Use Disorders service system by calling a 1-800 number. During this call, the individual is screened for clinical and financial eligibility, age, priority population. Once an individual is determined to qualify for state-funded services and a level care is is established, BPA works with them to select a provider from their statewide network.

The network includes agencies who deliver adolescent and children's care. Individuals under the age of 18 are referred to these agencies only. At these sites all services are tailored for the age group and the only time an adolescent or child will be in a group with adults is during family sessions. Every care is taken to ensure the safety of adolescents and children in the substance use disorders system. Information about the providers within the BPA treatment services network and the type of clients they serve is located online at http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/tabid/382/Default.aspx. .

The community-based provider conducts a comprehensive assessment using the Global Appraisal of Individual Needs (GAIN) tool to evaluate the client's need for services in five axes - clinical disorders, personality disorders, general medical conditions, psychosocial and environmental problems and clinical functioning. The provider, using this information, partners with the client to establish a treatment plan. Services are delivered based on the treatment plan, which is updated as needed. Typical treatment plans include clinical services, case management and recovery support services. Discharge planning begins with the development of the treatment plan and evolves as the client completes their treatment goals.

Priority access to assessment and treatment services is always provided to pregnant women and IV Drug Users. BPA is responsible for ensuring these women are admitted to treatment within forty-eight hours of the screening and IV drug users must be admitted within fourteen days. These requirements remain fixed throughout the term of the contract. If unable to comply with these requirements, BPA must notify the Department immediately and initiate interim services. Idaho has been able to meet this requirement for the past 10 years.

Specialized services for pregnant women and women with dependent children are also under the purview of the BPA contract. BPA has a specialty network with providers located around the state that focus on the specific needs of women and their dependent children. At a minimum this

care includes, comprehensive assessment for the woman and her dependent children, intensive case management, referral to ancillary services including medical care for the women and their children, gender-specific services for the women and developmental programs for the children.

Idaho is predominantly populated by individuals of Euro-American descent. The vast majority of clients seeking treatment are likewise of Euro-American ancestry. Below are two charts that demonstrate the populations of Idaho and the individuals receiving substance use disorders services.

Race	State Population	Treatment Clients
White	93.7%	94.6%
Black	1.5%	0.8%
Asian	1.4%	0.3%
Native American	1.7%	0.0%
2 or More Races	2.2%	2.5%

Ethnicity	State Population	Treatment Clients
Not Hispanic	89.4%	88.2%
Hispanic	10.6%	11.8%

These charts document that the Division of Behavioral Health is serving the populations of Idaho. The only population significantly underserved is is Asians. In Idaho, this population consistently is under-represented in negative behaviors such as crime, school drop-out and alcohol and drug use.

Behavioral Health Prevention, Early Identification, Treatment and Recovery Support Systems

The Division of Behavioral Health's "Transformation Legislation" was approved by the 2014 Idaho Legislature. The resulting Regional Behavioral Health Services Act is intended to transform Idaho's mental health and substance use services into an Integrated Behavioral Health System of Care. The Statute includes requirements to integrate mental health and substance use treatment through the creation of a governor appointed State Behavioral Health Planning Council (Planning Council) and Regional Behavioral Health Boards (Regional Boards), designated the Department of Health and Welfare as the State behavioral health authority and defines the priory populations to be served by the state operated regional behavioral health centers.

The Planning Council is tasked with monitoring and evaluating the statewide behavioral health system of care and the laws that govern that system and is responsible for establishing readiness and performance criteria for the Regional Boards as well as monitoring the readiness of the Regional Boards to provide local support services within their regions of the state. The Planning Council is charged with working with the Regional Boards in monitoring and evaluating the effectiveness of the state behavioral health service delivery system.

Regional Boards have the responsibility to work with local communities to recommend behavioral health services, identify service gaps and promote plans for improvement through communication with the

Council and the Department. Regional Boards may facilitate community-based recovery support services by partnering with entities such as Public Heath Districts, form a private nonprofit organization or remain as an advisory only entity. Once the infrastructure is established the Regional Board my contract to organize and deliver locally driven Recovery Support Services (e.g., community education, housing assistance, employment, transportation, prevention) further enhancing the local behavioral health service delivery system allowing individuals with behavioral health diagnoses greater opportunities to live in their community of choice and avoid hospitalization.

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

Public Behavioral Health System Organization at the State, Intermediate and Local Levels

The Idaho Department of Health and Welfare (IDHW) operates within the Executive Branch of Idaho state government. IDHW is composed of the Divisions of Public Health, Behavioral Health, Family and Community Services, Welfare, Medicaid, Information Technology, and Operational Services.

The Department of Health and Welfare is designated by statute (Idaho Code Section 39 Chapter 31) as the State Behavioral Health Authority. These responsibilities are carried out by the Department's Division of Behavioral Health. The Division of Behavioral Health's Central Office includes a Policy Unit, a Quality Improvement Unit, an Operations Unit and the WITS Unit. The Central Office component of the Division of Behavioral Health provides system coordination and leadership, policy and standards development, rule promulgation and interpretation, technical assistance, training, consultation, funding application and regulation, needs assessment and evaluation resources, minors' access to tobacco prevention, contract management, quality improvement and quality assurance monitoring, and support for the statewide WITS electronic health record.

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

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

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

1. Emergency psychiatric services (I.C. 39-2128
2. Court ordered clients (I.C. 39-20511a, 6-2416, 21-519b)

3. Voluntary clients without benefits (I.C. 39-3128)

Treatment services include crisis response, assessment and a range of mental health services available to eligible adults with serious mental illness, children with serious emotional disorders and their families. Idaho's two (2) state psychiatric hospitals, State Hospital North and State Hospital South, are also under the jurisdiction of the DBH Administrator. State Hospital North serves adults only, while State Hospital South serves both adults and adolescents.

The SSA oversees treatment and recovery services for adolescents, adults, pregnant women and women with dependent children who are below 100% of the federal poverty rate and who are diagnosed as substance dependent with at least an outpatient need according to the ASAM (PPC 2R, Level 1). Treatment referral sources include child protection, education agencies, probation and parole, youth-serving organizations, faith-based groups, judges and Drug Courts. Treatment services available to a client are based on the individual's need. Services available are assessment using the Global Appraisal of Individual Needs (GAIN), individual and group counseling, recovery support activities, case management, transportation, detoxification and education in the outpatient, residential and half-way house settings. The Division utilizes a contractor, Business Psychology Associates (BPA) to manage the treatment and recovery service delivery through a network of Department approved treatment providers. The contractor is responsible to provide care management utilization review. Care Management responsibilities include 1) use of a statewide 1-800 number for eligibility screenings, 2) making an initial ASAM PPC-2R level of care determination and 3) prior authorizing units of service. As of SFY 2014, substance abuse prevention services are assigned to the Office of Drug Policy (ODP) within the Governor's office.

The Division of Behavioral Health continues to make significant efforts to integrate Idaho's mental health and substance use disorders (SUD) service systems into a unified behavioral health system of care. Recognizing the benefit and necessity of uniform requirements for behavioral health programs, DBH has made the decision to propose changes to IDAPA rules that will establish a process and requirements for community mental health and SUD agencies to obtain State approval as a behavioral health program.

Local SMHA service delivery is based on seven geographical Department of Health and Welfare service regions. Publicly funded adult mental health (AMH) and Children's Mental Health (CMH) services are provided through Regional DBH center sites, with one Regional Program Manager responsible to oversee service delivery and quality for both programs. Psychiatric services may be supplemented through tele-health video conferencing to rural and frontier locations. The high definition video conference system is also used for statewide meetings, including meetings of the State Planning Council on Mental Health.

Priority local services for AMH and CMH are directed to crisis and court-ordered clients, with voluntary clients served as there is room in the system. Efforts are made to refer Medicaid eligible clients to Medicaid eligible private provider resources. Idaho subscribes to an integrated service delivery system. Service components include mental health, social services, education, health, vocational services and corrections. Recognizing that services are provided by multiple public and private agencies, the Division continues to seek cooperative agreements with other departments and providers.

Highlights of the AMH service array include medication management, Assertive Community Treatment (ACT), co-occurring integrated disorders treatment, crisis response, collaboration with vocational rehabilitation and strong collaboration with mental health courts. Recovery and resilience are modeled

through inclusion of Certified Peer Specialists on regional ACT teams and use of Certified Peer Specialists as outreach providers through the Projects for Assistance in Transition from Homelessness (PATH) program. The AMH programs and the courts coordinate treatment plans and service delivery with mental health court referred clients, with most eligible clients provided individual and group services by regional ACT teams.

The AMH program provides services to adults diagnosed with a serious mental illness who are homeless or at risk of becoming homeless. The SFY 2014 Projects for Assistance in Transition from Homelessness (PATH) grant funds included the allocation of a small amount for each regional CMHC to help with housing costs (i.e., one time rental assistance or security deposits); with the majority of funds allocated to a contract with the Office of Consumer and Family Affairs (OCAFA). The OCAFA contract allows for two part time PATH Certified Peer Specialists to be assigned to each of the seven regional DBH service sites. The PATH Certified Peer Specialists strive to conduct up to 75% of their time in face to face outreach to those in their region who have a mental health diagnosis and who are literally homeless. PATH Certified Peer Specialist have received training in evidence based practices related to Supported Housing, Supported Employment and SSI/SSDI Outreach and Recovery (SOAR), and Mental Health First Aid.. PATH peer specialists also assist in Point in Time (PIT) homelessness activities in all regions.

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. However growth exceeded the supply with IHFA accepting limited referrals in SFY2014.

Special projects serving adults diagnosed with serious mental illness and/or substance use disorder diagnoses include the Wood Project and the Allumbaugh House detoxification center. Both projects were initially supported through legislatively allocated funds to identify unmet local needs and develop a plan to address those needs. The Bonneville County's Substance Abuse/Mental Health Treatment Program (i.e., the Wood Project) provides mental health and substance abuse assessments, drug testing and treatment to male and female offenders who are likely to be sentenced to correctional facilities. The Allumbaugh House opened May 2010 in Boise and is operated through a contract with Terry Reilly Health services. This facility offers treatment services that include crisis mental health, medically monitored chemical detoxification and sobering stations. Sobering station referrals are accepted from health care providers and local law enforcement. The Legislative operating allocation for this facility in SFY 2015 is $867,400.

The Division of Behavioral Health oversees two SAMHSA grant projects with a recovery focus. The Idaho Home Outreach Program for Empowerment (ID-HOPE) grant was a five year award, beginning in 2010 and ending in 2015. ID-HOPE is designed to implement transformative changes in mental health services delivery through the use of an adapted Critical Time Intervention (CTI) team, with a goal of preventing or reducing state and community psychiatric hospital admissions. The CTI team provides 9 months of linkage/coordination/advocacy case management and practical and emotional support in an effort to build a strong foundation for community recovery. The ID-HOPE team is composed of staff members with a bachelor's degree and Certified Peer Specialists. Specialty team members have responsibilities in supported housing, supported employment and short-term crisis stabilization.

Idaho has utilized the Recovery Infrastructure Training for Empowerment Transformation Transfer Initiative (RITE-TTI) grant awarded through the National Association of Mental Health Program Directors (NASMHPD) to develop and enhance recovery coaching. The initial RITE-TTI project was utilized to provide training to build an integrated infrastructure for behavioral health recovery (mental health and substance use) through training of Recovery Coaches with a substance use focus. More than 290 Recovery Coaches have been trained statewide. Participants included substance use peers, regional board members and Community Resource Development Specialists. The DBH has collaborated with the Idaho Board of Alcohol/Drug Counselors Certification (IBADCC) to create a recovery coach certification process which has been implemented. Requirements are posted on the IBADCC website: http://www.ibadcc.org . Idaho has been awarded RITE-TTI-4 grant which will be utilized to develop peer specialty endorsements for a crisis endorsement, a criminal justice endorsement and a co-occurring endorsement.

The CMH system's comprehensive system of care includes assessment, case management, family support (e.g., family preservation, counseling, transportation, parent skills training and education, flexible funding and peer support) and family respite. The Division contracts with a private provider to provide statewide family and youth education and support groups, a statewide respite information and referral center, and to recruit and train respite care providers. The CMH program also provides foster care, crisis response, outpatient services, residential and hospitalization. State Hospital South's 16-bed Adolescent Unit provides inpatient stabilization and treatment, with average lengths of stay of 45 to 90 days. Longer term treatment may be provided by foster parents and residential facilities. Some unique aspects of the CMH program that are not available in the community or through existing benefit packages include provision of the evidence based Parenting with Love and Limits (PLL) intensive outpatient program, wraparound and clinical case management. Few services are available to parents with mental illness who have dependent children. Youth 15 years and under are required to have parental consent for services, while those 16 and older can access treatment services without parental consent. Services for children and youth who are diagnosed with SED and a substance use disorder (SUD) are delivered by two different Division of Behavioral Health programs. The CMH comprehensive assessment includes assessment of substance use and service recommendations. The majority of CMH services (mental health and substance abuse) are delivered by private providers. For children and youth diagnosed with SED and a developmental disability, services are coordinated through the Department's Division of Behavioral Health and Division of Family and Community Services.

The CMH Division of Behavioral Health program works closely with the Department of Health and Welfare's Child Welfare Program and with the Department of Education. A memorandum between CMH and Child Welfare describes how services will be coordinated for shared clients. The Department's Service Integration program facilitates family efforts to navigate the range of Department programs and services. The Service Integration program works with Idaho's Health Information and Referral Center, or the 211-Idaho CareLine. The CareLine provides referral information (including housing and other resources) through the statewide 211 number. The Bannock Youth Foundation (Pocatello) and Hays Shelter Home (Boise) provide federal grant funded crisis and emergency shelter to runaway and homeless youth; these programs coordinate mental health care needs with CMH. The Division's CMH program and the Department of Education collaborate with local school districts to to implement intensive community and school based programs. All 114 independent Idaho local school districts respond to the Individuals with Disabilities Education Act (IDEA) for eligible children. IDEA services include child find/referral, evaluation/eligibility, individualized education plans (IEP), related services, least restrictive

environments, review and re-evaluation, transition requirements and consideration of behavior management needs.

The Division works collaboratively with juvenile corrections programs in several ways. The Division allocates $327,000 to the Department of Juvenile Corrections to fund the placement of licensed Clinicians in each juvenile detention centers to assist with evaluations, service referrals and crisis counseling. The Juvenile Justice/Children's Mental Health (JJCMH) collaborative workgroup focuses on resolving obstacles to serving youth with SED who are involved with the juvenile justice system. This group sponsored implementation of Youth Mental Health Court. The Youth Mental Health Court uses the wraparound service model to facilitate treatment planning and coordination. The SUD prevention staff also participates on the juvenile corrections sponsored Enforcing Underage Drinking Laws workgroup. This partnership enables Idaho to reduce duplication and increase effectiveness in service delivery to this population.

The Division of Medicaid within the Department of Health and Welfare provides comprehensive medical coverage in accordance with Titles XIX and XXI of the Social Security Act and state statute. Medicaid participants have access to covered benefits through three benefit plans that align with health needs. The Medicaid benefits plans, including the Medicaid Basic Plan Benefits, the Medicaid Enhanced Plan Benefits and the Medicare/Medicaid Coordinated Plan Benefits were effective as of July 1, 2006. Blue Cross of Idaho, under contract with Idaho Medicaid has administered the True Blue Special Needs Plan since 2006. Behavioral Health Services are excluded from the Medicaid Basic Plan Benefits except for diagnostic and evaluation services to determine eligibility for these services. These services continue to be covered under the Medicaid Enhanced Plan Benefits. The services available in the Medicaid Enhanced Plan include the full range of services covered by the Idaho Medicaid program including outpatient services and case management. 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.

Several strategies were implemented in an effort to control rising Medicaid behavioral health service costs. Prior to SFY 2014, Medicaid had implemented managed care programs for dental care and transportation. During SFY 2014 Medicaid implemented behavioral health managed care and continued work moving forward on managed care for participants eligible for both Medicaid and Medicare. The True Blue Special Needs Plan expanded in 2014 to incorporate additional benefits including Aged and Disabled Waiver services, developmental disability targeted service coordination, community –based rehabilitation services, personal care services, nursing home care and services for people individuals residing in intensive care facilities for the intellectually disabled. The Medicaid Management Information System (MMIS) was implemented in May 2010 to address data needs related to claims processing, provider enrollment, eligibility, benefit maintenance and prior authorization of services and pharmaceuticals.

Per Legislation and relevant Idaho Code changes Medicaid was directed to develop plans for managed care models of service delivery. 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 provides Quality Assurance review of the Optum contract.

The Division of Behavioral Health is able to extend services through an assortment of federal SAMHSA grants. The SUD program's Access to Recovery (ATR) grant serves military (includes veterans, military reserves and Idaho National Guard), adolescents re-entering the community from state and county institutions (e.g., juvenile detention, state run correctional, hospitals) and adult supervised misdemeanants. Services include intensive SUD outpatient, safe and sober housing for adults and adolescents, case management, drug testing, transportation, child care, and life skills education. The Projects for Assistance in Transition from Homelessness (PATH) grant allows for outreach to adults with serious mental illness who are homeless. The federally funded (Center for Mental Health Services) Idaho Home Outreach Program for Empowerment (ID-HOPE) transformation grant supports provision of evidence based Critical Time Intervention (CTI) services in Region 4. Idaho's prevention data capacity has been significantly increased by the State Epidemiological Outcomes Workgroup (SEOW) grant, which funded the Division's development of the Idaho Prevention and Treatment Research website (www.patr.idaho.gov). This website provides county level risk-factor data to enable community coalitions and other interested individuals and groups to easily access substance abuse-related data.

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

In SFY 2014 the Idaho Legislature approved funding for one Behavioral Health Crisis Center which was established in Idaho Falls in Eastern Idaho. Funding was approved in SFY2015 for a second Behavioral Crisis Center to be located in North Idaho. Behavioral Health Crisis Centers are designed to be short term community resources that fill the gap for individuals experiencing a crisis that may otherwise end up in jail or the emergency room. The crisis center serves as a link to the existing behavioral health services available in the community. Locations are selected on several factors including community readiness, project proposal, community involvement, and legislative support.

The Division of Behavioral Health collaborates with the Social Security Administration to encourage collaborative efforts to educate Idaho providers about their system and to train them in SSI/SSDI Outreach, Access and Recovery (SOAR). SOAR is a program designed to increase access to SSI/SSDI for eligible adults who are experiencing or at risk of homelessness ad have a mental illness, medical impairment, and/or a co-occurring substance use disorder. This training helps providers to facilitate more effective completion of eligible client SSI/SSDI benefit applications. The Division of Behavioral Health includes two staff trained in the SOAR benefits skills. These SOAR trainers began providing SOAR training to Idaho behavioral health providers in March 2011. 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.

The Division of Behavioral Health is dedicated to the pursuit of a behavioral health service system that is focused on a philosophy of recovery and resilience. As of February 2013, Certified Peer Specialists were working on teams providing mental health services related to Assertive Community Treatment (ACT), Projects for Assistance in Transition from Homelessness (PATH), and Critical Time Intervention (ID-HOPE). The Division of Behavioral Health directly hired half-time peers for ACT teams in each of seven regions. State hospitals also have half-time peers that are supervised through a contract with Mountain States Group. The Division is also in the process of developing a Peer Support Specialist certification,

developed Peer Support Specialist standards and a state job classification description. The Division has also implemented a website dedicated to providing peer specialist training, certification and endorsement information.

Parenting with Love and Limits (PLL) is an evidence based treatment model implemented in the DBH children's mental health program for adolescents, aged 10-17, with emotional and behavioral problems. The PLL model combines parenting management group therapy, family therapy, and wound work into one system of care to quickly engage parent and the children. The PLL model is grounded in structural and strategic family therapy. It is a brief therapy model, which much emphasis being placed on engaging families quickly and giving them concrete tools and skills to create a new structure a within the family system to help create lasting change. Approximately 1,100 families have been served statewide through the PLL program since 2008. Families are referred through a variety avenues including through the CMH program, youth involved in the juvenile justice system, by juvenile probation officers or through a court ordered 20-511A treatment plan.

The Idaho Youth Treatment Program (IYTP) provides treatment to transitional aged youth, ages 18-25, using the Adolescent Community Reinforcement Approach (A-CRA) evidence based practice. Services were provided in Regions 2 and 4 during the first year of the grant and were expanded in 2015 to include Region 3. Two more regions will be added each year in 2016 and 2017. A-CRA is Idaho's first evidence based behavioral health service specifically targeted to the transitional aged youth.

The Division has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation. This Agreement supports the placement of a vocational rehabilitation (VR) counselor at each of the regional CMHC sites. The VR counselor is responsible to attend at least one weekly ACT team meeting. Often, the VR counselor attends more than one weekly ACT meeting and may also attend weekly mental health court meetings that relate to shared clients. The contract was amended to change the definition of eligible participant to individuals with SMI as the contract previously limited eligible participants to individuals with SPMI. This change allows for greater access to IDVR services.

The Division participated in community networking meetings sponsored by the courts for the purpose of creating a veteran's court in SFY 2011. These meetings included representation from the courts, behavioral health treatment providers, the veteran's administration, law enforcement and other stakeholders. As of SFY 2013, there were veteran's courts operating in Ada, Canyon and Bannock and New Perce counties.

The Veteran's networking committee meets at least quarterly to identify treatment needs and resources for military populations. Representation includes the Idaho National Guard, the Division of Behavioral Health, the Veteran's Administration, the courts, behavioral health providers that contract with the Idaho National Guard and other stakeholders.

The Division meets regularly with the Department of Juvenile Corrections sponsored Enforcing Underage Drinking Laws workgroup to facilitate coordination of substance abuse prevention activities. Representation on this workgroup includes Departments of Education and Transportation, the Liquor Division, the Idaho State Police, the Idaho College/Universities Coalition and Idaho Prosecuting Attorneys Association. This workgroup addresses issues identified by member agencies and seeks to use research based strategies to address youth access, desire and opportunities to drink alcohol. Workgroup efforts have been instrumental in targeting parents to work with their children and adolescents to reduce underage drinking. A primary prevention services funded by the SSA are delivered by community-based organizations or community coalitions. These groups receive small amounts of funding from the SSA which enables them to deliver substance abuse prevention services as a part of other activities provided. This integration of services makes prevention resources available to a broad range of populations within Idaho.

How Systems Address Needs of Diverse Racial, Ethnic and Sexual Gender Minorities and Often Underserved Youth

The 2014 Census Bureau estimates 93.7% of Idaho citizens self-identify as white; 83% as White/not Hispanic; .8% Black, 1.7% American or Alaska Native; 1.4% Asian; .2% native Hawaiian/Pacific Islander and 11.8% Hispanic/Latino origin. Regions 3 and 4 contain the largest concentrations of individuals with Hispanic heritage, with up to 15% of the population.

Cultural issues are addressed through learning applications available to all staff on the Department of Health and Welfare's Knowledge Learning Center (KLC) website, but this does not address specifics related to Native American Tribes. A curriculum specific to Gay, Lesbian, Transgender, Bisexual or Questioning (GLTBQ) populations was developed and included in the KLC in SFY 2012. The Idaho Minor in Prevention Curriculum includes attention to culture, age and gender. Literacy is addressed during service delivery, and materials may be read to the individual if they are unable to read. Regional service information and treatment materials are available in English and Spanish in Behavioral Health offices, and other languages can be addressed through translator resources. The annual Idaho Conference on Alcohol Drug Dependency (ICADD) offers a session on elements of culture.

With respect to GLTBQ 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 GLTBQ issues and services.

Idaho's six federally recognized tribes are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. The Division of Behavioral Health's Substance Use Disorder provider network includes the tribally owned Benewah Medical and Wellness Center in northern Idaho (Plummer). Interaction with the Division on SUD treatment services is limited to the facility renewal process. The Division continues to contract with Benchmark Research Safety to provide funds to tribal organizations, school districts on tribal lands or other entities serving tribal populations. Historically three Idaho Tribes (i.e., Shoshone Bannock, Nez Perce and Kootenai) have applied for substance abuse prevention programs. In SFY 2014, prevention responsibilities and funds were allocated to the Office of Drug Policy (ODP) in the Governor's office. In SFY 2016-2017, the ODP will be responsible to contract for substance abuse prevention programs.

The Idaho Tobacco Project which is dedicated to preventing minors' access to tobacco has met with the Shoshone Bannock and the Nez Perce Tribes to provide retailer education resources.

The Division of Behavioral Health efforts are ongoing in engaging Tribal leaders. The regional behavioral health center staff actively engage in coordination with tribal representatives. Regions 3 and 4 regularly communicate and coordinate services with the Duck Valley Reservation and are planning on providing an 8 hour CIT training as requested by the Tribe. This training will include collaboration with the BH Tribal Coordinator, law enforcement and paramedics. The Department of Health and Welfare has a designated Tribal liaison. The Division of Medicaid has quarterly meetings with Tribal representatives. The Division of Behavioral Health has also attended these meetings on an as needed basis. The Division values the development of opportunities to collaborate with Tribal leaders formally identified a representative to serve as an active liaison to leaders of Idaho tribes. This liaison will work with the Department of Health and Welfare's Tribal Relations Manager to build relationships with Tribal

leaders from each Tribe, and to invite ongoing input into behavioral health planning and service implementation.

Planning Steps

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

Narrative Question:

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

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

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

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

Through the Healthy People Initiative[18] 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.

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

Footnotes:

II: Planning Steps

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

Identification of Data Sources Used to Identify Needs and Gaps in Prevention Services

The Office of Drug Policy gathers and reports data from several sources, both administrative and self-reported, to identify needs and gaps in prevention services. The primary source of substance abuse consumption and consequences data is used to continuously update the State of Idaho Substance Abuse Prevention Needs Assessment, which is a report that encompasses all indicators of substance abuse as identified by the State Epidemiological Outcomes Workgroup (SEOW). The SEOW, which is composed of many research professionals from multiple state agencies, developed a four step process to identify all relevant substance abuse indicators for alcohol, prescription drugs, tobacco, marijuana, and other drugs in the state. The Needs Assessment contains mostly information at the state-level, but some county level information is also available in the report.

Agencies that provide data to be used in the State of Idaho Substance Abuse Prevention Needs Assessment include: U.S. Census Bureau; Bureau of Labor Statistics; Idaho State Liquor Division; Bureau of Vital Records and Health Statistics; and, Idaho Department of Transportation. Additionally, other data sources contributing to identifying needs in Idaho regarding substance abuse prevention include the Idaho Youth Risk Behavior Survey (YRBS), Idaho Behavioral Risk Factor Surveillance System (BRFSS), Incidence Based Reporting System, National Survey on Drug Use and Health (NSDUH), and Treatment Episodes Data Set (TEDS).

As previously mentioned, the (SEOW) is composed of state agency staff with research expertise interested in substance abuse prevention. The mission of the SEOW is to promote the strategic use and dissemination of data for informing and guiding Idaho's substance abuse prevention and behavioral health promotion policy and program development, decision-making, resource allocation and capacity building. With regards to prevention, the SEOW operates as an ad hoc research resource for policy decision makers, and facilitates statewide partnerships. Additionally the group maintains a web dissemination resource.

The PATR website at http://patr.idaho.gov/ states that "The Idaho Prevention and Treatment Research (PATR) Workgroup exists to develop a system of substance abuse related data collection, analysis and reporting that reflects substance abuse consumption and consequences throughout Idaho." This public site is accessible to all Idaho stakeholders and reflects 15 prevention risk factors, reported for each of Idaho's 44 counties resulting in a single source for 4,620 data points. Collected at the county level, the PATR website is a resource for state organizations, community members, prevention providers, researchers and coalitions needing data to develop substance abuse (including underage drinking) or other plans for their specific needs. Data is graphed by county on this site and reflects domains related to school (i.e., incidents of bullying, suspensions, truancies), individual (i.e., adolescent pregnancy, juvenile arrests for alcohol related charges and juvenile arrests for drug related charges), family (i.e., child abuse and neglect, heavy drinking, illicit drug use), and community (i.e., adult arrests for alcohol related charges, adult arrests for drug related charges, free or reduced school lunch eligibility (K-12), impaired driving crashes, per capita sales of distilled spirits, unemployment rate). The PATR website uses data

provided by the Idaho State Liquor Division, the Idaho State Police and the Idaho Departments of Education, Transportation and Idaho Department of Health and Welfare. Currently, the SEOW is taking steps to update the site to make it more useful for policy makers, substance abuse prevention providers, coalitions, and others.

Unmet Service Needs and Critical Gaps

ODP has identified the following areas of unmet service needs and critical gaps:

Data Collection Gaps: Identified data gaps relevant to ODP's prevention program planning efforts include **limited regional and county level data and limited sub-population level data.** Although the YRBS is successfully administered every other year, it has been challenging to implement any additional surveys to garner information relevant to substance abuse prevention (e.g., perception of harm, parental disapproval for substance use, etc.). Additionally, the data from the YRBS is only generalizable to the state, which does not provide local level data to substance abuse prevention providers and coalitions.

To address this deficit, ODP is working with the Idaho State Department of Education to increase student survey participation. In 2014, the two agencies partnered with the Idaho Department of Health and Welfare to administer the Idaho Youth Prevention Survey (IYPS). Despite some successes, the participation rates were not high enough to provide county level data. Currently, the state is determining how to best move forward with this survey in order to achieve higher participation rates while minimizing the burden of survey administration on educators.

Idaho's identified sub-populations of interest are: American Indians/Alaska Natives; Hispanics/Latinos; Veterans; youth; and, individuals identifying as lesbian, gay, bisexual, or transgendered (LGBT). The two greatest issues with sub-population data are: 1) small sample sizes; and, 2) a lack of collection.

First, because of the combination of Idaho's relatively small population and limited surveillance infrastructure, obtaining sub-population data is a challenge for the State. Due to the lack of sampling, it is often difficult to obtain reliable and valid data without aggregating data, making it difficult to view change over time.

Second, some data are simply not collected. For example, out of all the subpopulations, the greatest breadth of data we have are for youth, yet even still, there is some information that would be valuable to prevention efforts that are not currently being collected at the statewide level (e.g., perceptions, availability, etc.). Although consequence data (i.e., arrests and mortality) are categorized by race and ethnicity, this information cannot be analyzed by veteran status or sexual orientation. Because of this, it is typically the case that only consumption data is available for veterans and LGBT populations. Additionally, there is no statewide survey that collects consumption data for LGBT youth, and the BRFSS just recently began collecting such data.

Despite limited data collection capacity, the SEOW's monthly meetings provide a forum for the exploration of issues related to data collection and analysis relevant to prevention planning efforts. One goal of the SEOW is to establish standardized data collection procedures across state agencies, and build the capacity to obtain relevant data for substance abuse prevention and treatment professionals.

System Gaps: ODP continues to focus on the development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practices. ODP contracts with KIT Solutions (KITS), LLC to provide a web-based Data Collection, Reporting and Evaluation System for substance abuse prevention programs. The KITS system was implemented in April 2014. Training of ODP staff and prevention providers was conducted throughout SFY2014. The KITS format follows the Strategic Prevention Framework model, and allows providers to enter Needs Assessment, Capacity, Planning, Implementation, and Evaluation data related to prevention programs and activities delivered. Additionally, the system is used to collect data on participant demographics, attendance, pre/post test scores, providers/staff and staff training, and service costs. Required block grant and NOMS data is also recorded in the data management system. There are currently forty eight (48) providers using the KITS data management system to track SABG funded community substance abuse prevention services. This system can be viewed at: https://idprev.kithost.net/idprevent2014/.

Identified system gaps include the recent transition to the KITS system which includes ongoing improvements to data collection processes and addressing deficits in system functions. To date, substance abuse prevention providers and coalitions have received minimal training and support in using the new data collection system, resulting in the potential for inaccuracies in the data. Efforts to improve available technical assistance for providers are underway.

Service Gaps: ODP has prioritized the development of a workforce development plan to address identified service gaps related to the prevention workforce. Several efforts have been initiated to improve training and technical assistance available. After analyzing data from a survey of current prevention providers, ODP identified that there was a large need for program specific training for instructors. Of the 32 respondents, over 21% reported that they had never received program specific training for the program they were currently instructing. Although ODP is attempting to meet the need by arranging for these trainings, there is still room to improve.

ODP is partnering with the Center for Application of Prevention Technologies (CAPT) and Community Anti-Drug Coalitions of America (CADCA) to develop training opportunities designed to increase the number of Certified Prevention Specialists (CPS). Idaho currently has a total of 3 CPS registered by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC). A recent assessment of prevention providers across the state indicated a large range of both experience and expertise. Efforts to standardize provider training and improve system quality are in process.

Regional Behavioral Health Board

Gaps and Needs Analysis

2015

Please provide a brief description for each of the columns listed. Include additional information as needed.

Identified Regional Service Needs and Gaps *Relating to Prevention, Treatment and Rehabilitation Services*	**Short Falls and Challenges**	**Project Proposals and Progress** *Including those related to Family Support Services and Recovery Support Services*	**Improvement and Strategy Measures**
MH/SUD Crisis Services Detox Regions – 1,2,3,4,5,7	• Lack of crisis services with health care status and 24 hour availability • Lack of general and intensive outpatient providers in rural areas • Lack of capacity for local ERs to identify/manage/address/ acute crisis needs • Lack of SUD prevention, early intervention services and residential options • Lack of case management services • Better crisis response plan • High demand on crisis center and additional centers are needed • Increased need for diversion	• Continue to survey steak-holds to prioritize needs • Research results submitted to legislature • All Substance Abuse Providers need to be certified to treat dual diagnosis • Adults: Community Recovery Centers to assist those in recovery • Improve communication about hospital actions that limit bed availability and result in diversion to other hospitals out of region • Engage the new BHC Director in community planning • Explore options for sub-acute detoxification services	• CDA selected as site of crisis center 23 hour voluntary holds • Collect data from primary and secondary consumers on perception of their needs for services • Latah County NAMI assisting with WSU data collections for Region 2 • Searching for funding that incorporates individuals with dual diagnosis legislature need to pass/approve Medicaid Expansion/Restructuring • Youth: Data/outcomes from Shelter Care, Prevention data/outcomes from schools,

	programs • Need to de-criminalize substance use disorders • Additional resources for community supervision • Lack of local detox facilities	• Increase number of beds available for adults and youth • Alternative resources for the waiting period until a bed becomes available • Create transportation options to transport to nearest available bed or crisis center • Have a crisis center open and running 24/7 in all Regions • Community support and awareness • Utilization of existing buildings to house the facility • Further support for community recovery centers • Provide for additional probation officer s based on per capita populations • Establish subsidized respite care program • Provide training for first responders on mentally ill children and their families	decrease in youth hospitalizations and referrals to juvenile probation • Adults: decrease in Probation and Parole, incarceration, hospitalization, client holds, and increase in case management. • Address psychiatric beds at the quarterly PCH (protective custody hold) Meetings. • Create a list of what is currently available with a payment source and seek funding opportunities • Create a list of what is being used now for detox • Enhance communications between provider and law enforcement to create a more efficient process • Increase awareness and promote the need for a Crisis Center
Access to Psychiatric Services for both Adults and Children Regions 1,2,4,5,7	• Funding for Tel-Health/ Insurance and the structure is inadequate • Best use of existing TH facilities • PCP not willing to prescribe psychotropic RX • Lack of Psychiatric Providers who can subscribe • Limited staff at BHC on weekends. • Lack of dependable access to	• Increased uses of Psych NP • Continue use of tele-health in outlying areas and provide state-subsidies for professionals willing to work in outlying areas. Load re-payment options and identify a facility/site to house the equipment • Psychiatric Mid-level providers • Use of existing facilities and	• ACA increased access • Advocate for local tele-health services and change IDAPA SUD regulations to allow clinical supervision via Tele-health • Partner with North-West Children's Home for psychiatric services • Acquire data on frequency of use of ERs for Behavioral

	psychiatric beds • Lack of understanding around medical necessity determination for CBRS • Mental health services for families in rural areas • Inability to access reimbursement for prevention or treatment • SOAR needs faster accessibility to Medicaid approval • Lack of available child psychiatrists • No short-term acute services for youth • Expand services for infant & toddlers • Psych-education for agencies, school personnel, & juvenile justice system on Trauma-Informed Care • Post adoption services for children with SED • Use of evidence-based practices for children & for parent education • Better pay for psychiatrists • School loan repayment for physicians • Increase Medicaid payments	building that are not currently being used to house Community Recovery Center, Centers for Community Health, and as satellite sites for providers • Provider Trainings – Demonstration of medical necessity for care to include CBRS • Support Medicaid expansion or Health Plan Idaho. • Increase SOAR trained professionals in the area. Decrease time frame for those in need to access services. • Children's Mental Health Planning Council • Psychiatric Mid-level Providers • Children's mental health first responder training	Health Services • Research and seek out funding sources and programs that support tele-health initiatives such as – The Healhtcare Connection 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 businesses about the positive effects that enhanced access to behavioral health has on communities • Reopen regional satellite office. • Collect data on psychiatrist's salaries • Publicize the loan repayment program
Financial help with Medications for both Children and Adults Regions 1,5	• Person to apply for aid from drug companies • Complicated paperwork requiring assistance to prepare • Demand exceeds availability	• Use a 340 B drug program for the community • Increase access to med-management to reduce avoidable readmissions • Enhance communication with	• Create awareness and provide accurate information about what med-management is • Engage and include community providers in the

		care-givers across the continuum of care • Improve the perception of "Med. Management" and why it is a necessary component of care	conversations addressing this need • Increase access to medications by addressing cost and affordability
Sustainable Housing for the Homeless and Transitional Populations **Regions 1,2,3,4,5,7**	• Community acceptance, stigma • Limited funding for housing • Lack of Safe and Sober Housing for males/females For both Adults and Juveniles • Lack of shelter, transitional, residential or supportive care facilities insufficient for the demand and need	• Apply for ID Housing monies • Housing for felons • PATH therapeutic foster care • Address housing policies that • Establish an Emancipation Home type of program • Develop temporary residential housing and treatment for youth with mental illness who are unable to remain in homes • Well-managed, clean transitional housing units • Housing opportunities that "screen in" individuals rather than "screen out" individuals • Engage more housing providers in case management of existing/potential residents, connect to Community Recovery Centers and peer/Recovery supports • Address policy of requiring 24 hours homelessness for those leaving institutions (jail, hospital) before eligible for shelter • Develop additional partnerships and linkages to increase housing options	• Develop sustainable housing for men, women, youth; group homes or secure homes • Explore grant opportunities for housing • Create Housing committee on Regional Boards • Partner with local colleges to research grants and work on data collection • Decrease risk of homelessness to this vulnerable population • Have a housing representative educate the RBHB regarding statistics and housing options for the behavioral health population. • Engage our community members while educating about the social and fiscal benefits of crisis/transitional housing • Capture sources of funding for first-month rent and deposits • Research functioning housing models in other regions/ states and address hurdles

			encountered during state-up • Research and collaborate regarding the opportunity to renovate and use existing vacant dwellings/structures.
Respite/Therapeutic Foster Care for both Children and Adults Regions 1,2,4 CMH Day	• Funding to provide training • Lack of available affordable respite care • Funding for services • Licensure for Day Treatment • Increase number of therapeutic foster homes	• Train volunteer families to accept referrals on temp basis • PATH therapeutic foster care • Youth: Shelter Care, a form of short-term intervention, residential respite care	
Suds/MH Parent Education, Training and Services for both Children and Adults to include Intervention & Prevention **Regions 1,3,4,5**	• Family education needed • Community education, survey of what is needed in specific communities • Parenting classes are available – need to help insure people know it is available • Community Acceptance; stigma • Individual SD Resistance • Funding from MH and SUD groups and connecting of current available resources • Idaho does not have DEC Alliance protocol in place; need system in place to identify kids at risk.	• Expansion of behavioral health youth mentoring program, connecting provides with needs in the community • Develop a resource for employers that addresses common questions in an effort to support success for both parties • Expand Mental Health First Aid training • Normalize the concept of attending parenting classes in effort to boost attendance and provide valuable tools for families • More afterschool programs with the assistance of applications for the State Dept. of Education 21st Century Grant, • Increase school participation in Prevention Block Grant	• Use resources of advocacy groups to start: NAMI, IFFCMH • Data/outcomes of referrals through judicial system, adult/juvenile probation and hospitalization. • Public education about behavioral health and community wellness issues • Seek funding sources for promotion and delivery of educational material • Collaborate with OPTUM to promote and expand the Mental health First Aid Trainings to a broader audience • Work towards evaluating why parenting classes have low attendance and consider re-evaluating • QPR Training

		funding, • Engage Mayor's Youth Advisory Councils to promote healthy youth involvement, • Engage BHB to assist in the writing of grant funding opportunities • Address needs of children in dangerous drug environments • Formation of community-based partnerships with agencies across multiple disciplines • Support state services and local communities to develop efficient/effective strategies/for avocation of victims • Implement more prevention programs within schools.	• Overall reduction of recidivism, incarceration, and hospitalization by changing environmental strategies • Identify drug endangered children the dangers they face. • Offer ongoing education, support and linking services
Transportation for MH/SUD Clients **Regions 1,2,3,4,5,**	• Currently no transportation in rural areas • Limited City Link bus routes • Taxi services are unaware of available funding to transport individuals with SUD • Limited access to transportation to access needed appointments and employment	• Establish a state supported bus pass program for MH/SUD individuals to attend treatment, medical, probation and other related appointments • Combine and coordinate individual vehicle fleets from multiple organizations/agencies/provides to offer efficient public transport from a single transit organization/central dispatch • Consider the use of existing transportation sources to provide services to	• Improve access to car/services/supports and decrease no show rates • Investigate rural transportation models that have proved successful in areas with similar geographic/populations make up • Seek expanding the use of Section 5311 funds to communities with populations less than 50,000 • Telehealth reduces need for transportation services • Need for continued reform of

		rural/frontier areas	shackling policy • Explore use of Virtual Behavioral Health Care to meet local mental health needs
Education for Law Enforcement and First Responders about MH and SUD issues **Regions 4,5**	• Increase funding for CIT Training • Time for officers to attend training • Resistance by LE Administration • 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	• More CIT training • Propose the idea of shorter mini-training sessions to reach locations that are unable to attend the week-long training in one block
Specialty Court Client Issues – including youth Mental Health Court **Regions 1,2,3**	• Case Management services are underutilized and in high need. • Housing is an issue • Funding, lack of grant writing experience (opportunities exist), engaging judicial involvement	• Offer housing and case management • Engage BHB to assist in the writing of grant funding opportunities, engage judicial system and juvenile probation. • Review models in other regions with date review.	• Data/outcomes of referrals through judicial system, juvenile probation, and hospitalization. • Need for approval by Idaho Drug and MH Coordinating Committee Funding
Access to Services without criminal involvement **Regions 3,4**	• Funding, a successful model(school disciplinary hearings), parental/caregiver involvement • Schools in more rural areas do not have the resources to provide services needed for children/families with mental illness • Lack of training and resource to hire within. These services are currently contracted out which limits response and resources	• Research funding sources such as the Juvenile Justice Commission, develop a model for schools/communities to refer at-risk youth, engage parents/caregivers in family supports (family therapy/groups) • Work with DHW for crisis services (law enforcement, schools, parents, caregivers). • Engage in community training such as trauma informed care,	• Decrease in referrals to juvenile probation, outcomes/data from successful model implementation and crisis calls deferred, and increase in parental/caregiver involvement in family supports • Adult Corrections accessing funds through Justice Reinvestment Act • Identify specific need for

	for the school • Minimal Trauma informed care and strengthening families training opportunities • Support for children of incarcerated parents • Limit incarceration terms, reassess risk levels • Increase services for this population • Difficulty in obtaining services under children's mental health unless involved in the system.	suicide prevention, at-risk youth behavioral education. • Establish and/or support these training opportunities • Establish a state-wide system, at the court level, to identify children of parents being incarcerated; provide professional to engage them in prevention interventions immediately. • Establish diversion programs in lieu of incarceration. • Develop Grant writing partnerships	recovery in each region • Legislature need to pass/approve Medicaid Expansion/Restructuring
Optum Idaho SUD Referrals Regions 1,2,3,4,5	• Lack of SUD diagnosis and internal referral processes • Policy barriers to qualify care and accessibility: H0001 code attached facility instead of license • No reimbursement from contractors for paperwork required from providers • Currently no path in place within contractors referral system to refer clients to a SUD Provider when a need is identified • Issues with Co-Occurring referrals • Establish a culture of collaboration with Medicaid provider and contractor. Increase oversight of Medicaid contractor, increase	• Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidenced based practices, appropriate referral of co-occurring clients. • Better communication between Medicaid/Behavioral Health division lines • Policy changes that allow for assessments to be conducted based on licenses not facility approval • Better oversight by Medicaid contractor to identify clients with SUD needs and conversely push toward drug Dependent Epidemiology (DDE) programs for all SUD providers	• Increase diagnosis and treatment of SUD and co-occurring • Request enhanced data reports and measures to ensure providers operate within scope of practice • Improved service provision and patient outcomes. Maintain capacity (provider networks). • Reimbursement rates are below average • Collaborate with Optum for Fall/Winter PCP/Provider Collaboration Education

	communication across lines.	• Incorporation of American Society of Addiction Medicine (ASAM) in Medicaid paperwork allowances in the billing matrix to bill for communication. • Develop system to track co-occurring client referrals • Increase SUD Provider network • Service Provider Contractors should reflect sub-categories being treated	
Interpreters/translators **Regions 3,4,5**	• Lack of training and availability of service	• Increase training • Increase access to care • Improve quality of care and outcomes	• Increase the number of available providers • Promote and educate regarding the need for this type of service in the regions • Seek funding sources that aim to address this need by promoting training, certification, and community education
Systems Issues **Region 4**	• Policy and legislation requirements are often redundant and in conflict with current licensing standards • Need for better communication and consistency across division lines • Need for better communication with contract managers • Need to create funding stream for gaps in care • Offender re-entry • Patients released for IDOC/SHS	• Establish and communicate measureable goals for state mental health/SUD system, in a fashion that incorporates input from all levels • Establish working relationship with licensing boards so that policy and legislation are written with current licensing standards in mind. • Division lines (Behavioral Health and Medicaid) collaborate, measure goals/	•

	• Medicaid expansion populations • Legislative support of program needs	outcomes of both populations concurrently, drill down with contract managers and into provider network. • Support of legislation related to proposed mental and behavioral health services and programs.	
Data Collection and Data Sharing Issues: **Region 7**	• There is a need for a database that would allow multiple agencies to share information on persons with mental illness in order to provide better response and ongoing care.	• Identify core performance indicators and collection points. • Determine a mechanism to be able to appropriately share critical information across those systems with a need to know (database)	• Continue to collaborate with OPTUM/Medicaid for data sharing • Compile a data request list to submit to Optum.
Primary Care **Regions 1,2,7**	• Ongoing funding for Federally Qualified Health Centers • Move towards holistic model • Often times clients are in need of medical, psychiatric, dental and vision services – but don't have access if they do not have insurance or benefits • Urgent care centers are not connected to the mental health system (but treat many individuals for mental health issues) • Lacking for clients not on Medicare, Medicaid or Private Insurance • Idaho needs to make use of Medicaid realignment funds • Clinics treating the uninsured	• Lack of medical insurance • Develop better linkages between mental health and primary medical care including physical health , dental care and vision care • Explore access barriers • Assist with necessary application for various medical assistance benefits • Expand community collaboration	• Collaborate with the 211 care line to ensure it accurately covers resources available in each of the regions • Create a cover letter to distribute to primary care providers throughout the region with information on how to access the newly updated 211 care line • ACA • SHIP Program • Legislature need to pass/approve Medicaid Expansion/Restructuring

	need increased funding and resources		
Peer Support and Recovery: Coaches **Region 7**	• Region would benefit from a broader availability of peer support and recovery coaches. All agencies need to have access to peer support and recovery coaches • Need to expand use of Peer support and Recovery coaches in the community to probation and parole	• Expand the availability and use of peer support and recovery coaches	• Develop a Community recovery Center • Provide more opportunities for peer Support/Recovery coach training in the region • Connect and collaborate with Optum's peer and family support • Create and maintain a current list of all recovery coaches and peer support specialists in the region
Accomplishments and Progress	**Accomplishments and Progress**	**Accomplishments and Progress**	**Accomplishments and Progress**
• Kootenai Co had two orgs present to BHB about group homes • Legislation passed ID House/Senate HB 264 • Legislation passed to offer loan repayment to Psych MDs to work at State Hospitals • Children's Mental Health Planning Council • Children's mental health first responder training • Developed Iris House/transitional housing with 1 crisis bed • Parenting with Love and Limits/Logic available • NAMI Family to Family	• Abbaddy House in Cottonwood • Transitional Housing Funds from IDOC • Shelter Plus Care is available • NAMI Family to Family • FFCMH Building Stronger Families; online courses, seminars • CMH ACE training in April 2015 • QPR Suicide Prevention Training • ACE (Adverse Childhood Experience) workshop April 30th, 2015 • April 10 Presentation Building a Trauma Informed Care Community at Kroc • 2014 Legislation approved loan repayment for physicians at state hospitals	• SHIP Program to focus on Patient Centered Medical Home • CIT Training for First Responders • Progress: Have requested data and measures to ensure SUD referrals • ACA increased access to needed care • CDA selected as site of crisis center 23 hours voluntary holds • Provided 5 scholarships to ICADD for providers • QPR Training in Silver Valley	• IFFCMH Building Stronger Families; online courses, seminars • CMH ACE training in April • QPR Suicide Prevention Training • CIT trainings, youth mentoring programs • Providing training (eating disorders, PLL Parent Support Groups • BH meeting with housing authorities to provide on-site BH referrals

• Region 3 was a pilot for Vallivue and Nampa School Districts that utilized funding to deter youth from the criminal justice system. Potential to follow that pilot model/outcomes. CIT Trainings within the schools, youth mentoring program • Progress/Youth: Working with Juvenile Probation to develop Shelter Care Model, increase transportation services to needed behavioral health services, increase individual/family group therapy, add full ACT options with Optum • Progress/Adult: Increase transportation services to needed behavioral health services, increase individual/family group therapy, youth mentoring programs • Shackling legislation passed in 2014 Session • Prescription drop-off boxes in the communities • Drug courts • FQHC's (Federally Qualified Health Centers) established in Idaho.	• State Healthcare Innovation Plan funded by Feds and awarded to DHW • Idaho Health Insurance Exchange • BH provided training to medical staff, schools and law enforcement • Region 2 Developed of Respite Care Training Curriculum • Adult Mental Health provide Designated Examiner Training for Psychologists • Improved relationships with Tribal representatives • Mental Health First Aid Training • Recovery Center in Latah County • Establishment of Children's Mental Health subcommittees • Children's Mental Health Council provided information, training for schools and public established support groups • ATR4 – allows for homeless SUD (substance use disorder) population to access needed services.		

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.
Page 46 of the Application Guidance
Narrative Question: This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must 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 serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse 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 behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Identification of Data Sources Used to Identify Needs and Gaps

The U.S. Census Bureau (2014)estimates that Idaho's population is 1,634,464, with a 2013 estimate of 93.7% white persons; .8% black; 1.7% American Indian/Alaska Native; .2% Native Hawaiian or Pacific Islander; 2.2% reporting two or more races; 11.8% Hispanic and 83.1% white, not Hispanic. The United States Census Bureau estimated the Idaho has 19 residents per square mile, compared to a national average of 87.4 per square mile. Idaho has eighteen rural counties (less than 100 persons per square mile), twenty-two frontier counties (i.e., less than seven per square mile) and three urban counties. (More than 100 persons per square mile) Idaho ranks 13th in area size of the fifty states, with 82,643 square miles and diverse areas that include wilderness, mountains, deserts, farmland and canyons. The Idaho Department of Labor's jobless report indicated a 4.6 unemployment rate in December 2014, with an estimated 2014 average unemployment rate of 4.8 percent.

Idaho's behavioral health unmet service needs and critical gaps are based on data from multiple sources, including input from the State Behavioral Health Planning Council. These numbers represent Idaho's best estimate to date of incidence, treated prevalence, and quantitative targets. This information represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. These numbers represent publicly provided and/or funded (including Medicaid) mental health services rendered by the public sector. Some individuals received services from both public mental health system and private sector providers during FY2014. As of July 1, 2011, numbers served for adult mental health and children's mental health were captured in the Division's Web Infrastructure for Treatment Services

(WITS) system. All SUD network providers were required to input data into WITS as of October 1, 2013. The Crisis Center began using WITS as of December 1, 2014.

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

The WITS system was implemented 10/1/09 for collection of Adult Mental Health (AMH) data for public services provided through regional mental health center (RMHC) sites and 10/1/2013 for all SUD Network providers. Implemented in SFY 2009, the VistA data infrastructure system is used by State Hospital South (SHS) and State Hospital North (SHN). The Division of Behavioral Health (DBH) has an Interagency Agreement with the Idaho Division of Vocational Rehabilitation (IDVR), and IDVR provides monthly reports on employment services provided to shared clients. Employment data is extracted from WITS for federal reporting on the National Outcome Measures (NOMS). The Office of Consumer Affairs (OCAFA) provides monthly reports of services for Consumer and Family Advocacy/Education, Peer Specialist Certification and Programs for Assistance in Transition from Homelessness (PATH) outreach, engagement and case management activities provided by PATH peer specialists. Children's mental health data is collected and extracted from WITS. Consumer survey information is based on annual and end of service MHSIP and YSS-F survey requests. Regional computer kiosks provided easier access for service recipients to complete these surveys. Medicaid data must be requested. Medicaid's contract with the data management vendor, Molina, began in May 2010. This system handles Medicaid service and billing data.

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

The SUD treatment data is used to create a number of standard reports that are utilized for State planning and assessment. Standard reports include State Utilization Management and Grant Data; Level of Care Capacity and Census Management; Budget Tracker; Treatment Completion Data; Length of Stay Report; County/Regional Utilization Report; Pregnant Women With Children (PWWC) Chart Audit Results and Client, Provider & Stakeholder Satisfaction reports. Each of the seven regions in Idaho has a Regional Behavioral Health Board that provides an annual report and updated information to help determine regional and local treatment needs, emerging trends, gaps in service and the need for programs and services in regions throughout the State. During SFY 2016-2017, the Department plans to continue use of the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), YRBS,

BRFSS, substance use disorder treatment data and information from regional behavioral health boards to assess SUD treatment needs in Idaho.

Idaho implemented the full WITS system for the SUD Treatment Services Delivery System in October 2013. This allows contracted network treatment providers to use WITS to assess clients, manage treatment, bill for services and collect outcome measurement data in real-time. All contracted network providers are required to utilize WITS as their electronic health record and to track and submit claims for payment of state funded community substance abuse services. The managed care service contractor maintains the adjudication process in WITS and providers are paid based upon the submitted and accepted claims in WITS. Additionally, the Department's contract with Chestnut Health Systems allows for the Global Appraisal of Individual Needs (GAIN) SS to be used for all client screenings and the GAIN-I for all clinical assessments.

The Idaho State Epidemiological Outcomes Workgroup (SEOW) is composed of state agency staff and community stakeholders (Idaho Prevention Fellow, researchers) with an interest in the substance abuse prevention system. In regards to prevention, the SEOW operates as an ad hoc research resource for policy decision makers. Additionally the group maintains a web dissemination resource for more general data related questions.

On the State level, the SEOW is identified as the Idaho Prevention and Treatment Research (PATR) work group. The PATR website at http://patr.idaho.gov/ states that "The Idaho Prevention and Treatment Research (PATR) Workgroup exists to develop a system of substance abuse related data collection, analysis and reporting that reflects substance abuse consumption and consequences throughout Idaho." This public site is accessible to all Idaho stakeholders and reflects 15 prevention risk factors, reported for each of Idaho's 44 counties resulting in a single source for 1,980 data points. Collected at the county level, the PATR website risk factor data (updated at least once every two years as new data is available) is a resource for state organizations, community members, prevention providers, researchers and coalitions needing data to develop substance abuse (including underage drinking) or other plans for their specific needs. Data graphed by county on this site is based on Hawkins and Catalano's (1992) risk factors. Data reflects domains related to school (i.e., incidents of bullying, suspensions, truancies), individual (i.e., adolescent pregnancy, juvenile arrests for alcohol related charges and juvenile arrests for drug related charges), family (child abuse and neglect, heavy drinking, illicit drug use), and community (i.e., adult arrests for alcohol related charges, adult arrests for drug related charges, free or reduced school lunch eligibility (K-12), impaired driving crashes, per capita sales of distilled spirits, unemployment rate). The PATR website uses data provided by the Idaho State Liquor Division, the Idaho State Police and the Idaho Departments of Education, Transportation and Health and Welfare.

In SFY 2016-2017, the Office of Drug Policy is responsible to contract for SUD prevention programs.

The Division of Behavioral Health has fully implemented WITS and developed standardized Dashboard reports which include 28 data analysis and reports utilized by DBH administration and regional program managers to monitor and inform services in the community regional behavioral health programs. Data is collected regarding priority populations including, access to care, enrollment, and discharges. Data is utilized to inform and support legislative proposals, grant reporting, budget allocations, supervision, and quality assurance. Efforts are underway to create a data sharing mechanism between WITS and the IDJC database to exchange necessary client data for common clients. Efforts are also underway for the WITS conversion for DSM-5 to ICD-10 to be fully implemented by October 1, 2015.

Unmet Service Needs and Critical Gaps

According to the U.S. Census Bureau data for 2014, Idaho's total population estimate was **1,634,464,** with an estimate of **1,208,215** aged 18 or older and an estimate of **426,249** under age 18. The SAMHSA/CMHS estimation methodology establishing prevalence indicates percentages for adults at 5.4% for Serious Mental Illness (SMI) and 2.6% for Serious and Persistent Mental Illness (SPMI). Five percent of the estimated SMI population is estimated to be homeless. Five percent of children/adolescents are estimated to have serious emotional disorder (SED) diagnoses. Based on these percentage estimates, it may be concluded that there are **65,244** adults in the state of Idaho with serious mental illness, **31,414** adults in the state of Idaho with serious and persistent mental illness, **3,262** adults with SMI who are also homeless and **21,312** children with serious emotional disorder diagnoses. Idaho's TEDS data for 2013 indicates a treatment admission rate of **4,604** aged 12 and older; an estimated **464** admitted per 100,000 population aged 12 and older; **844** primary alcohol admissions and **1,154** primary marijuana admissions.

The State Behavioral Health Planning Council with input from the Regional Behavioral Health Boards are 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 board completed a gap and needs analysis for 2015 which was submitted to the Governor, Legislature and Judiciary in the Planning Council's SFY2015 annual report which is included as an attachment.

The primary challenges identified by the Planning Council in Idaho's system of care are as follows:

1. Continued service gaps for persons below 100% of poverty, especially those with children.
2. Services and supports for both children and adults in crisis.
3. Respite care is a critical service for families that is not covered under Medicaid or most private insurance.
4. Financial support to establish additional community recovery centers in counties across the state.
5. Adults or juveniles must be criminally involved in order to access behavioral health treatment**.**
6. Accessing appropriate services for children with the most complex behavioral health needs.
7. A need for more psychiatrists, especially in rural and frontier areas of the state.

Summary of Regional Gaps and Needs Analysis
Regional Gaps and Needs General Overview April 2015

<u>Population Specific Concerns</u>
Mental Health Services*

- limited access in rural areas
- difficult to access without criminal justice involvement
- limited psych bed availability
- need for a back-up plan when psych beds unavailable
- more psychiatrists needed for treatment and medication management

Substance Use Disorder Services*

- limited access in rural areas
- lack of detox services
- gaps in funding, especially related to prevention and early intervention

Children's Behavioral Health Services*

- youth mental health court
- lack of services for non-criminally involved at-risk youth
- reduction in Community Based Rehabilitation Services(CBRS)
- need for day treatment and therapeutic foster care
- need for school-based MH/SUD services including prevention and intervention
- need for parent education and training
- need for post-adoption/reactive attachment disorder services and supports

System Concerns

- need better integration between MH and SUD services within the
- Medicaid/Optum system, as well as treatment and services for those with dual
- diagnosis (SUD and MH) *
- lack of payment to providers in order to create "process paperwork"
- lack of clarity around desired outcomes from behavioral health authority
- lack of preventative medical care for those with BH issues
- need for an integrated BH and physical health model
- specialty court client issues

Gaps in Support Services

- housing*
- transportation*
- interpreter and language services* (Spanish and deaf)
- employment opportunities for MH and SUD clients

Gaps in Clinical Services

- respite care (children and adult)
- crisis services (children and adult)*
- financial help for medication (children and adult)
- education (public outreach, awareness, media relations, early intervention and
- prevention, support groups, promotion of recovery, resiliency, and wellness)*

Other Needs

- CIT training
- trauma informed care
- drug endangered children's protocol

* These items were mentioned by at least five (5) of the six (6) regions that reported.

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.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Planning Steps
Quality and Data Collection Readiness

Idaho Response:

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

- Data for state funded non-Medicaid mental health and substance abuse treatment is collected through the use of a centralized electronic health record (EHR), Web Infrastructure for Treatment Services (WITS). Treatment data is entered into WITS by the service provider. Data is reported from the collected date through the user of Sequel Server Reporting Services (SSRS) and the use of the Idaho Department of Health and Welfare's data warehouse. The treatment data can be reported at the client, program, provider, and state level.

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

- The state electronic health record (EHR) is used for all non-Medicaid state funded treatment of substance abuse treatment as well as mental health treatment provided by the Idaho Department of Health and Welfare. The data is securely sent to the Idaho Department of Health and Welfare, Division of Behavioral Health, which then loads it into the department's data warehouse.

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

- Yes, Idaho is able to collect and report data at the individual client level. The electronic health record is currently being updated, which includes structural changes to the database which will require modification of reports, including those used for client level reporting.

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

- Not applicable

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Evidence-Based Programming

Priority Type: SAP

Population(s): Other (Primary Prevention, General Population)

Goal of the priority area:

Increase the number of prevention providers employing approved evidence-based environmental strategies

Objective:

Strategies to attain the objective:

Identify approved evidence-based environmental strategies and disseminate recommendations for evidence-based programs/practices

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of funded prevention providers implementing approved environmental strategies

Baseline Measurement: Number of funded prevention providers implementing approved environmental strategies as of June 1, 2015 is 3.

First-year target/outcome measurement: Number of funded prevention providers implementing approved environmental strategies as of June 1, 2016 will be 6.

Second-year target/outcome measurement: Number of funded prevention providers implementing approved environmental strategies as of June 1, 2017 will be 9.

Data Source:

Idaho Substance Abuse Prevention Data System (MOSAIX).

Description of Data:

Name of program/activity funded.

Data issues/caveats that affect outcome measures::

No data issues foreseen.

Priority #: 2

Priority Area: Workforce Development

Priority Type: SAP

Population(s): Other (Primary Prevention Providers, Coalition Members)

Goal of the priority area:

Idaho will increase the number of Certified Prevention Specialist from 3 to 12 as measured by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC) data base by June 30 2017.

Objective:

Strategies to attain the objective:

Provide training and technical assistance to local prevention providers to enhance quality prevention programming.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of Certified Prevention Specialists (CPS) registed in Idaho with teh IBADCC
Baseline Measurement:	Number of active Idaho Certified Prevention Specialists registered with the Ibadcc as of June 1, 2015, is 3
First-year target/outcome measurement:	Number of active Idaho Certified Prevention Specialists registered with the IBADXX as of June 1, 2016 will be 6.
Second-year target/outcome measurement:	Number of active Idaho Certified Prevention Specialists registered with the IBADXX as of June 1, 2017 will be 12.

Data Source:

Idaho Board of Alcohol/Drug Counselor Certification data base

Description of Data:

CPS Registration/Certification

Data issues/caveats that affect outcome measures::

No data issues foreseen.

Priority #:	3
Priority Area:	Outcome Measures
Priority Type:	SAP
Population(s):	Other (Prevention Providers)

Goal of the priority area:

Strengthen data collection and evaluation capacity to accurately measure outcomes.

Objective:

Strategies to attain the objective:

Provide training and technical assistance to enhance evaluation capacity for local prevention providers. Identify and Develop evaluation tools and resources to support local prevention providers to accurately evaluate their programs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of prevetnion providers accurately reporting program outcomes in state data management system.
Baseline Measurement:	No prevention providers have utilized the evaluation area of the state data management system for program outcomes as of June 1, 2015.
First-year target/outcome measurement:	Training and technical assistance provider to 100% of prevention providers funded with SABG funds.
Second-year target/outcome measurement:	35% of providers are accurately reporting outcome measures in data management system.

Data Source:

State Data Management System (MOSAIX).

Description of Data:

Evaluation data entered by providers

Data issues/caveats that affect outcome measures::

No issues foreseen.

Priority #: 4

Priority Area: Crisis Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Increase the number of Behavioral Health Crisis Centers to a total of three.

Objective:

To fully operatize two Behavioral Health Community Crisis Centers and have requested funding for a third Crisis Center by 6/30/2017.

Strategies to attain the objective:

The state has one fully operational Crisis Center located in Idaho Falls in the Eastern part of Idaho. Funding was approved by the SFY 2015 Legislature to fund a second Crisis Center to be located in Northern Idaho. The Division of Behavioral Health will support efforts to operationalize the second Crisis Center and will initiate a budget request for third crisis center.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Behavioral Health Crisis Centers to a total of three.

Baseline Measurement: There is one fully operationalized Crisis Center in Idaho.

First-year target/outcome measurement: Two fully operationlize Crisis Centers by 6/30/3016.

Second-year target/outcome measurement: Two fully operationalized Crisis Centers and a budet request submitted for a third Crisis Center by 6/30/2017.

Data Source:

DBH, WITS,

Description of Data:

Operational status will be monitored and reported to the Division of Behavioral Health. Service delivery data will be recorded in WITS.

Data issues/caveats that affect outcome measures::

Legislative approval is required to receive funding.

Priority #: 5

Priority Area: Accessing appropriate serivces for children

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Replace the current assessment tool, the CAFAS, with the Child and Adolescent Need and Strengths (CANS) assessment tool.

Objective:

Implement the CANS assessment tool statewide.

Strategies to attain the objective:

The Division of Behavioral Health will develop an Idaho Behavioral Health specific version of the CANS assessment tool, develop a training plan, provide training on the tool and implement the tool on a statewide basis.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Implemention of the CANS assessment tool statewide.
Baseline Measurement:	The current assessment tool utilzed for children's mental helath services is the CAFAS.
First-year target/outcome measurement:	Evaluation and requirements for the Idaho BH specific CANS assessment tool are completed by 6/30/2016.
Second-year target/outcome measurement:	CANS assessment tool implemented statewide 6/30/2017.

Data Source:

DBH, Interagency Governance Team (IGT), WITS

Description of Data:

The Division of Behavioral Health will provide training on the CANS assessment and a coordinate the development of the CANS assessment tools in collaboration with the IGT.

Data issues/caveats that affect outcome measures::

Funding availability, approval by the customized tool by the Owners of the tool.

Priority #:	6
Priority Area:	Respite Care
Priority Type:	MHS
Population(s):	SED

Goal of the priority area:

Increase access to respite care services for families with children with SED.

Objective:

Increase by 5 % the number of families receiving DBH funded respite care services.

Strategies to attain the objective:

The Division of Behavioral Health will request additional funding for respite care services. The Division contracts with a family run organization to provide training of respite providers and to maintain and respite information and referral center. The Division will coordinate a workgroup to identify respite care needs.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Increase by 5% the number of families receiving respite care services.
Baseline Measurement:	In SFY 2015, 128 unduplicated clients received DBH funded repite care services.
First-year target/outcome measurement:	135 unduplicated clients will have received respite care by 6/30/2016.
Second-year target/outcome measurement:	142 unduplicated clients will have received respite care by 6/30/2017.

Data Source:

WITS

Description of Data:

WITS is the electronic data record utilized by the Division of Behavioral Health. Data tracked includes unduplicated counts of clients receiving DBH funded respite services.

Data issues/caveats that affect outcome measures::

Funding is subject to legislative approval.

Priority #: 7

Priority Area: Service Gaps

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

The Division of Behavioral Health will implement a state certification for Peer Specialists and increase the number of trained and certified peer specialists in Idaho.

Objective:

Increase the number of trained and state certified Peer Specialist by 75.

Strategies to attain the objective:

The Division of Behavioral Health will develop and implement a state certification process for certifying trained peer specialists. The Division has developed Peer Specialist standards. and will also facilitate the development of three peer specialty endorsements. The Division will utilize contractors as needed to provide peer specialist training.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of trained and state certified Peer Specialist.

Baseline Measurement: There are approximatly 200 trained peer specialists in Idaho.

First-year target/outcome measurement: Implement a State certification process for trained peer specialists by 6/30/2016.

Second-year target/outcome measurement: Complete training and certification of an additional 75 peer specialist by 6/30/2017.

Data Source:

DBH, contract monitor, Contract provider

Description of Data:

DBH will contract with providers to provide training and will receive contract monitoring reports as required. DBH will implement a tacking system to document state certified peer specialists.

Data issues/caveats that affect outcome measures::

Training availability will be subject to available funding.

Priority #: 8

Priority Area: Access Behavioral Health Services

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Evaluate the impact of high utilization of services including inpatient and outpatient to the behavioral health service delivery systems and identify system improvements.

Objective:

Implement utilization and quality assurance review by the DBH of high utilizers of state operated or funded behavioral health services.

Strategies to attain the objective:

The Division of Behavioral Health will identify and define high utilization for service categories including inpatient and outpatient services and develop a utilization review protocol based on best practices.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Implement utlization review of high users of behavioral health services.
Baseline Measurement:	The DBH does not currently review highs use of of behavioral health services.
First-year target/outcome measurement:	DBH will identify and define high utilization for service categories including inpatient and outpatient services by 6/30/2016
Second-year target/outcome measurement:	DBH will and develop and implemt a utilization review process by 6/30/2017.

Data Source:

WITS, VISTA, Molina

Description of Data:

WITS is the electronic health record utilized for both DBH Mental Health and SUD service delivery systems. VISTA is the data system utilized by the two state hospitals. Molina is the data management contractor for Medicaid.

Data issues/caveats that affect outcome measures::

none known

Priority #:	9
Priority Area:	Parity
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

The Division of Behavioral Health as the state behavioral health authority has a role in providing education regarding the MHPAEA in the state.

Objective:

Increase awareness and understanding of the parity laws.

Strategies to attain the objective:

The DBH will contract with the Office of Consumer Affairs to provide education and information on parity to consumers of behavioral health services

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	DBH will implent one parity education and awareness intiative.
Baseline Measurement:	DBH has not provided or sponsored parity education and awaerness.
First-year target/outcome measurement:	DBH will contract for a parity education and awareness training by 6/30/2017.
Second-year target/outcome measurement:	One DBH sponsored parity education and awareness trainingg will be completed by 6/30/2107.

Data Source:

Contract monitoring, DBH

Description of Data:

Contract monitoring reports are utilized to ensure compliance with contract scope of work requirements. Updates will be provided to

DBH leadership.

Data issues/caveats that affect outcome measures::

Successful completion of a signed contract.

Priority #: 10

Priority Area: Service Gaps

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Regional Behavioral Health Boards (RBHB) will transition form being advisory to functional boards.

Objective:

RBHB's will be stood up by developing formal partnership with their public health districts.

Strategies to attain the objective:

The Division of Behavioral Health will support the establishment/infrastructure development of the RBHBs. The RBHB will demonstrate their readiness and their ability to provide guidance on behavioral health service delivery in their respective regions to the State Behavioral Health Planning Council. The RBHBs will enter into formal agreements with the local public health districts.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Five of the seven Regional Beahavioral Health Boards will by stood up by enteing into formal agreements with their public health departments.

Baseline Measurement: One RBHB has entered into a contract withpublic health.

First-year target/outcome measurement: Three of the seven Regional Beahavioral Health Boards will by stood up by enteing into formal agreements with their public health departments. by 6/30/2016.

Second-year target/outcome measurement: Five of the seven Regional Beahavioral Health Boards will by stood up by enteing into formal agreements with their public health departments by 6/30/2017.

Data Source:

Division of Behavioral Health, State Behavioral Health Planning Council, Regional Behavioral Health Boards

Description of Data:

Establishment of and readiness of the regional behavioral health boards.

Data issues/caveats that affect outcome measures::

None

Priority #: 11

Priority Area: System of Care

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Integration of behavioral health and primary care.

Objective:

The Division of Behavioral Health will partner with the Idaho State Healthcare Innovation Plan (SHIP) to conduct surveys of patient centered medical homes to determine levels of integration with behavioral health.

Strategies to attain the objective:

The Division is actively engaged in partnering with the transformation activities related to transforming primary care practices across the state into patient centered medical homes. The division will assist in the implementation of a survey to assess levels of integration.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Survey of patient centered medical homes completed and results evaluated.
Baseline Measurement:	Level in integration has not been assessed.
First-year target/outcome measurement:	Survey developed and impemented by 6/30/2016
Second-year target/outcome measurement:	Survey results evaluated and survey reporte completed by 3/30/017.

Data Source:

Survey results

Description of Data:

Survey results will be presented to Behavioral Health Integrations Primary Care Sub-committee and the Idaho Health Care Coalition.

Data issues/caveats that affect outcome measures::

None

Priority #:	12
Priority Area:	System of Care- Olmstead
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

Ensure behavioral health services are implemented in accordance with Olmstead and Title II of the ADA.

Objective:

Establish a plan specific to behavioral Health that addresses the state's obligations under Olmstead and Title II of the ADA.

Strategies to attain the objective:

The Division of Behavioral Health will review the Olmstead and the ADA regulations. Idaho does not have a state Olmstead plan and the Division in its ongoing transformation efforts to integrate behavioral health services will evaluate the service delivery system, identify partners and establish a plan that addresses Olmstead.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Establish a plan specific to Behavioral Health that addresses the state's obligations under Olmstead and Title II of the ADA.
Baseline Measurement:	Idaho does not have an Olmstead plan.
First-year target/outcome measurement:	The Division of Behavioral Health wil review the Olmstead desicion and requirmetns of the Title II ADA in assessing the serivcice deliviery sysytem needs for a plan by 6/30/2017.
Second-year target/outcome measurement:	The Divison of Behavioral Health will establish an Olmstead plan specific to behavioral Health by 6/30/2017.

Data Source:

Olmstead decision, Title II ADA

Description of Data:

The Division will review current regulation and Olmstead requirements and report to leadership the needs for the development of an BH specific plan.

Data issues/caveats that affect outcome measures::

None

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$6,447,327		$0	$2,659,716	$17,245,500	$0	$0
a. Pregnant Women and Women with Dependent Children*	$650,000		$0	$0	$0	$0	$0
b. All Other	$5,797,327		$0	$2,659,716	$17,245,500	$0	$0
2. Substance Abuse Primary Prevention	$1,812,999		$0	$1,500,000	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$9,525	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$220,600		$0	$0	$0	$0	$0
13. Total	$8,480,926	$0	$0	$4,159,716	$17,255,025	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$10,766,400	$5,600,000	$43,866,400	$0	$2,771,200
6. Other 24 Hour Care		$0	$289,800	$0	$6,138,000	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$3,974,040	$0	$7,113,750	$49,773,000	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$0	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$215,528	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$215,528	$360,200	$0	$0	$0	$0
13. Total	$0	$4,405,096	$11,416,400	$12,713,750	$99,777,400	$0	$2,771,200

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$	$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$1,813,000	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$724,270	$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$4,423,456	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$740,000	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$	$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$450,000	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$285,000	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$25,000	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$20,200	$
Total	$8,480,926	$0

Footnotes:

The $20,200 listed under other will cover the cost of drug testing.

The Division of Behavioral Health is unable to complete the MHBG planned expenditures because these block grant funds are used for Division personnel who deliver services. There is no system for documenting cost of services delivered by these staff.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$6,447,326
2 . Substance Abuse Primary Prevention	$1,813,000
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$220,600
6. Total	$8,480,926

* Prevention other than primary prevention

** 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 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 CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for 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 does not meet the AIDS case rate threshold for the fiscal year involved. 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 be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$349,651
	Selective	
	Indicated	
	Unspecified	
	Total	$349,651
Education	Universal	$831,549
	Selective	$9,409
	Indicated	
	Unspecified	
	Total	$840,958
Alternatives	Universal	$47,700
	Selective	$7,128
	Indicated	
	Unspecified	
	Total	$54,828
Problem Identification and Referral	Universal	
	Selective	
	Indicated	$96,388
	Unspecified	
	Total	$96,388

Community-Based Process	Universal	$82,678
	Selective	
	Indicated	
	Unspecified	
	Total	$82,678
Environmental	Universal	$58,783
	Selective	
	Indicated	
	Unspecified	
	Total	$58,783
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	$0
Other	Universal	
	Selective	
	Indicated	$128,257
	Unspecified	$201,456
	Total	$329,713
Total Prevention Expenditures		$1,812,999
Total SABG Award*		$8,480,926
Planned Primary Prevention Percentage		21.38 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Idaho does not expend primary prevention funding on Section 1926 Tobacco compliance activities.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$1,020,710	
Universal Indirect	$551,107	
Selective	$16,537	
Indicated	$224,645	
Column Total	$1,812,999	
Total SABG Award*	$8,480,926	
Planned Primary Prevention Percentage	21.38 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	c
Heroin	c
Inhalants	c
Methamphetamine	c
Synthetic Drugs (i.e. Bath salts, Spice, K2)	c
Targeted Populations	
Students in College	c
Military Families	b
LGBT	c
American Indians/Alaska Natives	b
African American	c
Hispanic	b
Homeless	c
Native Hawaiian/Other Pacific Islanders	c
Asian	c
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$42,002	$0	$0	$42,002
2. Quality Assurance	$52,918	$754,812	$0	$807,730
3. Training (Post-Employment)	$15,751	$0	$0	$15,751
4. Education (Pre-Employment)	$5,251	$0	$0	$5,251
5. Program Development	$18,962	$0	$0	$18,962
6. Research and Evaluation	$31,666	$0	$0	$31,666
7. Information Systems	$29,666	$75,000	$0	$104,666
8. Total	$196,216	$829,812	$0	$1,026,028

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	$40,000
MHA Administration	$215,528
MHA Data Collection/Reporting	$39,188
MHA Activities Other Than Those Above	$1,211,040
Total Non-Direct Services	$1505756

Comments on Data:

MHA Activities Other That Those Above:
Consumer & Family Empowerment $296,800
Suicide Prevention Council $20,000
Suicide Hotline $100,000
MH Peer Specialist Training $196,000
Family Run Organization $398,240
Certified Family Support Partner Training $200,000

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

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.[26] 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.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse 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.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment 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 electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, 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[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

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.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, 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.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] 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 illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

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

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Footnotes:

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

DECEMBER 20, 2013

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1

Introduction

Idaho stands at an important crossroad of designing and developing an integrated, efficient, and effective healthcare system in our State. The design of Idaho's new system, presented here in Idaho's Statewide Healthcare Innovation Plan (SHIP), is the result of an unprecedented stakeholder engagement initiative within the State, and has the endorsement of providers, consumers of healthcare services, and the largest public and private payers in the State. The product of this extensive stakeholder engagement process — an innovative, ambitious, forward-thinking plan for the State of Idaho — will be centered on building a robust primary care system statewide through the delivery of services in a patient centered medical home (PCMH) model of patient-centered, team-based, coordinated care. Care will be integrated and coordinated across all healthcare services in the State, yielding cost efficiencies and improved population health. Idaho will achieve its vision of system-wide reform that, with the commitment of commercial payers and Medicaid, will move Idaho from a system that rewards the volume of services (through predominantly fee for service (FFS) arrangements) to a system that rewards the value of services (through quality incentives, shared savings, etc.). Payment methods will incentivize providers to spread best practices of clinical care and achieve improved health outcomes for patients and communities. Key to the success of the model is the development of the Idaho Healthcare Coalition (IHC) and it's Regional Collaboratives (RCs) which will support practices at every level throughout and after the transformation to a PCMH. The newly formed IHC will oversee the development of this performance-driven model. Together, the IHC and RCs will support the PCMHs in activities to transform and improve the system, including collecting data required to monitor and establish performance targets, providing regional and PCMH-level performance feedback, identifying and spreading evidence-based clinical practice, and providing on-going resources and support to achieve the Triple Aim of improved health outcomes, improved quality and patient experience of care, and lower costs of care for all Idahoans.

At the crossroads of healthcare system design, Idaho looked at the trajectory of its current path: what lay ahead was simply more of what had been and where we are now. Today, the system is defined by severe workforce shortages across healthcare professions, limiting access to services; primary care practices without the resources and supports to implement quality initiatives, adopt advanced health information technology (HIT), and coordinate care, resulting in inefficient and often inadequate care; and lastly, a payment system that does not incentivize or reward quality care, resulting in ever rising healthcare costs but continued poor health outcomes. Knowing that change must occur, and with the goal of developing solutions to overcome such daunting barriers, Idaho engaged stakeholders from every component of the healthcare system to design a new health delivery model and change the course of healthcare in Idaho. Under the guidance and direction of a stakeholder Steering Committee, Idaho's model was developed through information and recommendations gathered from work groups, 44 focus groups, townhall meetings across the State, and discussions with Idaho's six federally-recognized American Indian and Alaskan Native tribes. The model developed is supported by the evidence base of research and other state and community experience. And while the road ahead is challenging, Idaho knows that through the commitment of providers, payers, and consumers of healthcare services, the State will be successful in transforming its healthcare delivery system and improving the health of its population.

This plan represents the continued growth of the PCMH model in Idaho, building upon the Idaho Medical Home Collaborative (IMHC), which began under Executive Order in 2010 and launched

PMCH pilots in January 2013. This plan also builds on current innovations and system assets in both urban and rural areas of the State. The end goal of this transformation is to create a system that promotes practice advancement under the PCMH model while respecting the long-standing culture in Idaho of provider and payer autonomy. As such, Idaho's model is a grassroots effort that builds collaboration and momentum for change rather than depending on mandates and legislative action.

Through the Model Design grant, the State was able to pursue a statewide assessment of strengths, barriers, and gaps to inform stakeholder deliberations. The gap analysis revealed important strengths in Idaho's system. Of important note is that over half of Idahoans receive health insurance coverage through commercial health insurers. An additional 15% are enrolled in Medicare and 15% are enrolled in Idaho's Medicaid program. For the 18% of Idahoans without health insurance coverage, local public health districts and non-profit federally qualified health centers (FQHCs) play a vital role in providing care throughout communities around the State. See Appendix B for a map of Idaho's seven local public health districts.

The gap analysis also confirmed Idaho's history of collaboration to pursue better care, as evidenced by the Idaho Primary Care Associations' work to evolve and expand PCMHs, the FQHC Advanced Primary Care Practice Demonstration, and the Children's Healthcare Improvement Collaboration Pediatric PCMH. Finally, the beginnings of an infrastructure to collect and analyze statewide data through the Idaho Health Data Exchange (IHDE), which facilitates health information exchange (HIE) in Idaho, is a critical asset as the State moves toward a performance-driven payment system.

The model proposed is designed to address many of the serious barriers identified through the system gap analysis. Of great concern is the fact that access to care in Idaho is a significant obstacle to successful health outcomes. One hundred percent of Idaho is a federally-designated shortage area in mental healthcare, and 96.7% of Idaho is a federally-designated shortage area in primary care. This, and the rural nature of the State, contributes to the severe unequal distribution of healthcare resources across the State and many under-served areas. Additionally, the use of electronic health records (EHR) and other advanced HIT is deficient in the State, with many providers experiencing significant barriers to adopting HIT such as connectivity issues and the high cost of HIT tools. As a result, data sharing is not comprehensive or complete. While repositories of statewide data exist for public health purposes (such as the vital statistics registry, the cancer registry and the registry of reportable diseases), these data collection and analytics efforts only present part of the picture of health in Idaho. Additional barriers to improved system performance reported by stakeholders include the predominant fee for service (FFS) compensation model which rewards volume of service rather than quality improvement.

Stakeholder Engagement in Model Design

The SHIP model design process included wide representation of stakeholders who together worked to identify current system strengths and weaknesses and generate a pathway to change. The information gathered through the stakeholder model design process has generated a SHIP that truly reflects the sentiment and solutions of Idaho's healthcare community. The deliberations among this broad group of stakeholders over the course of months are documented on Idaho's SHIP website (www.idahoshipproject.dhw.idaho.gov).

Stakeholder Engagement

- 11-member Steering Committee charged with overseeing model design.
- 13 Steering Committee sponsors with critical expertise and knowledge.
- 4 work groups (Clinical Quality Improvement, Network Structure, Health Improvement Technology and Multi-Payer Models) with 100+ members.
- 44 statewide focus group engagements.
- Townhall meetings.
- Meetings with tribal leaders.

Stakeholders with targeted expertise were identified to lead the process by participating on the SHIP Steering Committee. The Steering Committee was charged with overseeing the design of the model based on input received from statewide focus groups, recommendations from four stakeholder workgroups (on the topics of Clinical Quality Improvement, Network Structure, Health Information Technology, and Multi-Payer Models) and research of successful approaches to healthcare delivery, payment models, performance measurement, and other issues relevant to the model. It is important to note that consensus was derived concerning the major elements of the model. The Steering Committee's deliberations were aided by "sponsors," individuals who participated in the development of the IMHC model and others with critical expertise and knowledge. Payers, including Medicaid, Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource, which together cover a preponderance of beneficiaries in Idaho, participated in the Steering Committee as either a member or sponsor, and were critical to the construction of this model.

The Idaho SHIP Steering Committee was comprised of representation from the following organizations:

The Governor's Office	Idaho Medical Home Collaborative
Idaho State Senate	Idaho House of Representatives
Saint Alphonsus Health System	St. Luke's Health System
Idaho Academy of Family Physicians	Idaho Chapter of the American Academy of Pediatrics
Idaho Commission on Aging	Idaho Department of Health and Welfare (IDHW)
Idaho Hospital Association	Idaho Medical Association
Idaho Primary Care Association	Family Medicine Residency of Idaho
Independent physicians	Idaho Department of Insurance

Work Groups

Stakeholder work groups were at the core of the SHIP model design process. Representation on the work groups included payers, providers, professional associations, advocacy groups, legislative members, State staff, and consumers. The four work groups were engaged over a period of months and met regularly. The work groups created focus group questions to solicit public input on concepts and collect information to further develop the gap analysis. The work groups also identified current system assets and deficiencies through a structured system gap analysis, which exposed the need, early in the model design process, for a system-wide solution and an expansion of current PCMH efforts in the State. With this vision in mind, the work groups developed

recommendations in their respective areas of expertise for Steering Committee review. The purpose of each work group is described below:

- *Multi-Payer Models Work Group:* Propose payment model(s) for the new healthcare delivery system that promotes value (positive health outcomes) versus volume.

- *Network Structure Work Group:* Propose a community care network model to support medical home integration with other aspects of the healthcare system, to improve health outcomes and access through care management and care coordination across an integrated system.

- *Clinical Quality Improvement Work Group*: Propose standard, evidence-based guidelines for clinic practice and disease management strategies to address patient population needs, including high-risk and high-cost patient populations statewide.

- *Data Sharing, Interconnectivity, Analytics, and Reporting Work Group (also known as the HIT Work Group)*: Propose a strategy for developing a statewide HIT system that permits the analysis of clinical quality and utilization data throughout the healthcare system.

Focus Groups and Townhall Meetings

To ensure the broadest stakeholder input possible, focus groups and townhall meetings were held throughout Idaho. Focus group sessions were held to receive input from primary care providers (physicians, nurse practitioners, and physician assistants), consumers (patients), other service providers (behavioral health, long term services), and other entities critical to the design of transformation in Idaho. In addition, two separate focus groups – one for employers (both large and small, including self-insured employers) and one for hospitals were held in each focus group location. In total, 44 focus group engagements were held across the State.

During the focus group outreach effort, several stakeholders noted that participants in some rural and frontier counties would need to travel at great length to participate. In response, the State added six townhall engagements in the more rural areas of the State — this also included a townhall engagement on the Fort Hall Reservation.

Tribal Consultation

Idaho is home to six federally-recognized tribes[1]: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone–Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone–Paiute Tribe. All tribes were invited to participate in the work groups. In addition, IDHW held an informational session for tribes to ensure their understanding of the SHIP purpose and design process, and invited tribal leadership to request tribal consultation for further discussion and input. As a result, tribal consultation was held with the Nez Perce Tribe and a townhall meeting occurred with tribal members on the Fort Hall Reservation. Through these meetings, valuable input was provided regarding system deficiencies and health needs of tribal members.

Each aspect of the stakeholder engagement process brought forth invaluable knowledge, perspective, and insights that informed the model design. Idaho's SHIP is the result of the experience, wisdom, and collective work of Idahoans who care about the health of the State, believe in the vision of improved health, and are committed to bringing about the changes needed to have an effective, efficient, and quality healthcare system. Indeed, what sets Idaho's model apart

[1] Federal Register, Vol. 77, No.155. August 10, 2012.

from other states is the will and commitment of stakeholders across the entire healthcare system to implement the model.

The New Healthcare Delivery System

Idaho's PCMH model will achieve a two-pronged transformation. At the patient level, the model will improve individuals' health by delivering primary care services through a patient-centered medical home. Patient-centered care through the medical home will begin with a broad, comprehensive patient assessment that takes into account the individual's behavioral health and socioeconomic needs. The plan of care will reflect cultural knowledge and sensitivity, respect the individuals' rights and responsibilities in shared decision-making, and be built upon evidenced-based clinical practice. Recognizing the power of individuals to improve their health, the model will promote patient engagement, education, and self-management. The patient's team of healthcare professionals will be held accountable for coordinating care across the larger medical neighborhood that includes specialists, hospitals, behavioral health, and other services. EHRs and other HIT tools will be used to support care coordination through efficient, effective and timely communication, and the exchange of patient health data to inform clinical decisions.

The stakeholders who participated in designing Idaho's new model recognized the critical importance of integrating behavioral health at the primary care level. As detailed in the 2011 Idaho State Planning Council on Mental Health Report, Idaho is experiencing an increasing suicide rate, increased utilization of law enforcement, increased psychiatric hospitalizations, and increased utilization of community emergency psychiatric services. The Planning Council's Report also notes reduced life expectancy in persons with a mental illness. The Planning Council suggested adapting the Substance Abuse and Mental Health Services Administration's (SAMHSA) 10x10 wellness campaign in Idaho to reduce deaths and improve life expectancy among individuals with behavioral health conditions by 10 years, in 10 years. To assist Idaho in accomplishing this ambitious goal, the PCMH model will include a strong behavioral health component that will better equip the primary care community to prevent and treat co-morbid physical and behavioral health conditions. Integration of behavioral health in the new PCMH model will require PCMHs to focus on four essential strategies: (1) conducting a comprehensive needs assessment, (2) documenting individual needs planning, (3) developing communication tools and monitoring programs, and (4) facilitating access to needed services. The PCMHs will be supported in this work by the IHC, which will establish a behavioral health committee to identify screening and assessment tools for PCMH use and provide training and resources to the PCMHs to advance the integration of physical and behavioral health care in the model.

At the system level, the model changes the foundation of healthcare delivery in the State by establishing PCMHs as the vehicle for delivery of primary care services and integrating PCMHs into the larger healthcare delivery system. The model will impact, to varying degrees, all healthcare providers, e.g., primary care providers, specialists, allied practitioners across all disciplines, hospitals and other acute care facilities, nursing homes, FQHCs, and rural health clinics. By aligning payments, performance targets, data collection and other practice policies, Idaho will transform from a disease-focused system of care to a patient-centered, coordinated system that provides Idahoans access to quality care that will improve health outcomes and lower healthcare costs in the State.

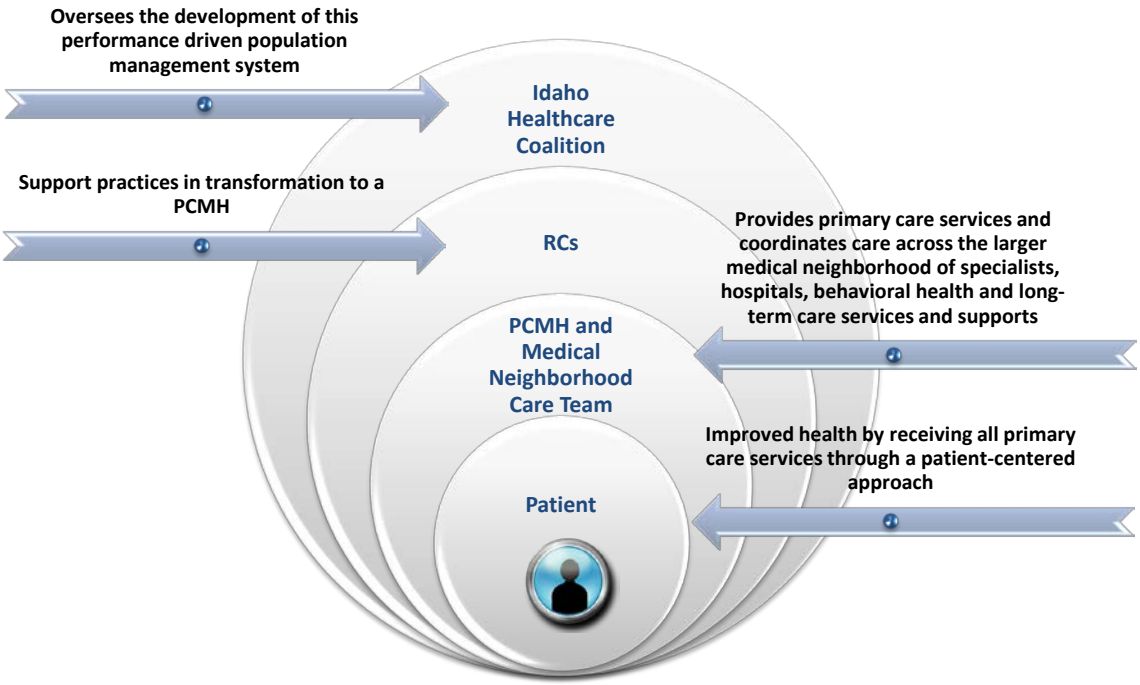
Transformation will be achieved at the patient and the system levels through oversight and supports provided by the Idaho Health Coalition (IHC) and Regional Collaboratives (RCs). A newly formed Idaho Healthcare Coalition (IHC) will support and oversee the transformation of practices to the PCMH model and the evolution of statewide population health management. Additionally, the IHC

will collaborate with other State and federal efforts to improve the delivery system and participate in national forums to both share and learn from the efforts of other states.

Recognizing the limited resources of most primary care practices in Idaho, the IHC will establish RCs at the local level to serve, along with the IHC itself, as a supportive network to provide technical assistance and resources across all levels of the model, in areas including but not limited to: data collection and performance reporting, quality improvement initiatives, evidenced-based practices, utilization of advanced HIT tools, integration of physical and behavioral health, comprehensive health assessments and delivery of coordinated care. The RCs will leverage regional resources and expertise and will work with local providers and non-health organizations to conduct regional health needs assessments and, with support from the IHC, implement regional quality improvement and wellness initiatives.

Idaho's model maximizes the use of the existing healthcare workforce by adopting a team-based model of care that allows each practitioner to practice at the top of their licensure. Using this approach, PCMHs will be led by physicians, nurse practitioners, or physician assistants under the supervision of a physician. Some Idaho communities are so severely under-resourced that they are unable to provide team-based care within the primary care setting. In these underserved areas, two practitioner types — community health workers (CHWs) and community health emergency medical services (EMS) personnel — will be developed and advanced as key components of PCMH team-based care. Idaho's unique PCMHs will be "virtual PCMHs," as the team working together to provide coordinated primary care will be staffed across multiple agencies in the community or region. Section 4 describes Idaho's strategies to both maximize the existing workforce and expand the healthcare practitioners throughout the State.

Summary of the New Model



The delivery of care through the PCMH model will maximize the use of Idaho's limited healthcare workforce by sharing resources across PCMHs in the medical neighborhood and RCs, and encouraging teamwork and coordination among healthcare providers to provide patients better access to care and a greater role in making care decisions. Key attributes of this model will result in a high-performance healthcare delivery system that ensures:

- Health care is patient centered and the approach to health is comprehensive, taking into account all the factors — social, economic, psychological, etc. — that impact a person's health.
- Patient health care information is available to all providers at the point of care, enabling providers to make informed health decisions with their patients.
- Patient care is coordinated among multiple providers and transitions across care settings are actively managed.
- Providers in the patient's healthcare team both within and across care settings are accountable to each other.
- Patients have easy access to appropriate care and information, even after working hours.
- Patients are satisfied with their experience of care.
- Providers and payers are continuously innovating and learning in order to improve patient experience and the quality and value of healthcare delivery.
- Provider incentives move from volume to value, and payment approaches are coordinated across payers.

Beginning in the model implementation phase and throughout the three year testing phase (and five year demonstration period), the model will be developed statewide. There will be no regional phase-in. Instead, all regions will begin implementation activities immediately.

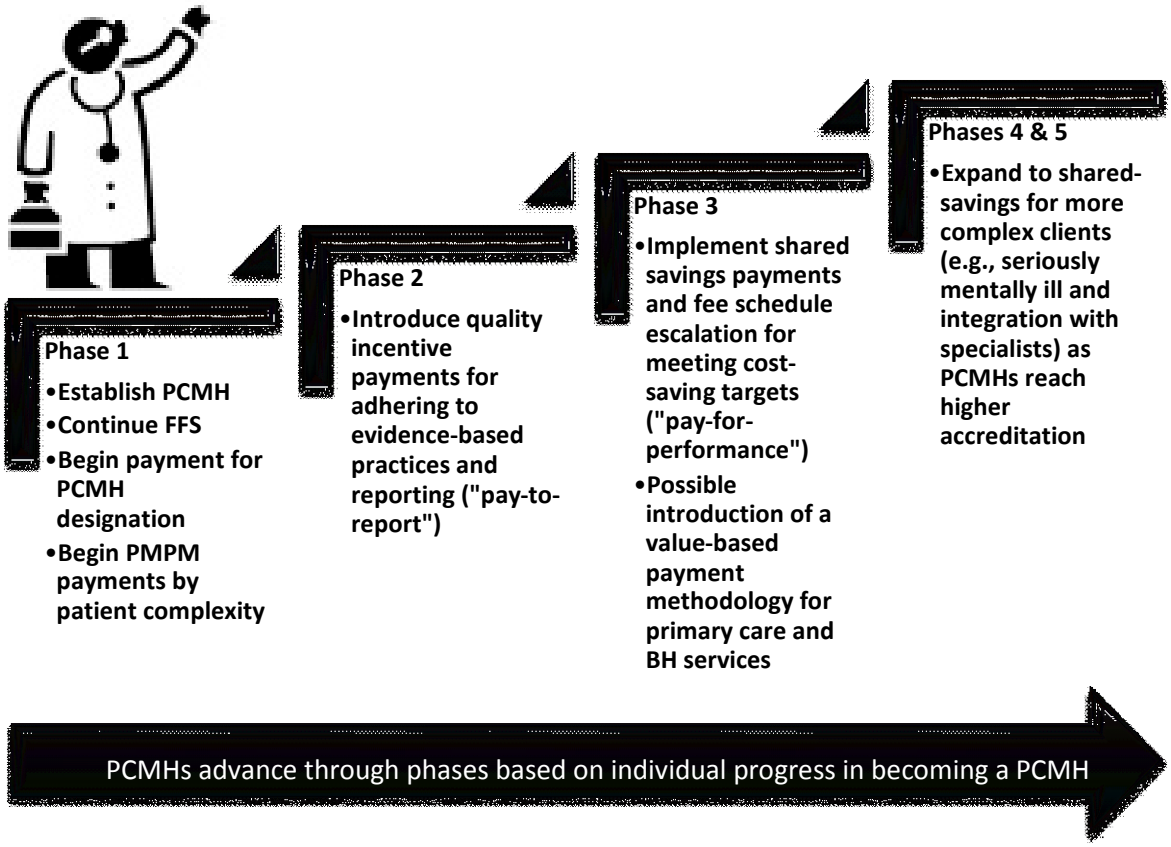
The transformation of Idaho's health system will be supported by a payment methodology that incentivizes quality instead of quantity of care. The IHC will work to facilitate alignment of payment methodologies among participating payers that reward quality care and improved health outcomes.

New Payment Model

Idaho's current payment methods are heavily reliant on fee for service (FFS) arrangements that reward quantity of care. As a result, the current payment system rewards providers that generate a high volume of services for the purpose of attaining financial viability over providers that establish patterns of clinical services for the purpose of attaining good health outcomes for their patients. History in Idaho has shown that the unfortunate consequence of this arrangement is that, too often, services are duplicated and care is uncoordinated.

Idaho will transition to incentivizing value as opposed to volume by aligning payment mechanisms across payers. The new payment model will be phased-in as depicted in the graphic below. The components of the new payment model are:

Transformation, start-up payments and accreditation payments provided to the PCMH through the IHC,
Per member per month (PMPMs) for care coordination,
Total cost of care shared savings arrangements, and
Quality incentives provided through the payers participating in the model.



A description of each component of the new payment model is found in Section 2 of the SHIP.

Performance Measurement and Population Health Management

Today, no standardized data collection or performance reporting across payers or populations exists in Idaho. While performance measurement data is collected by IDHW (including the Division of Public Health, the Division of Behavioral Health and the Division of Medicaid), commercial payers, Medicare, and the local public health districts, measures are reported in various forms and in silos that make it difficult or impossible to measure population health changes across Idaho. As such, Idaho does not currently have a mechanism to conduct statewide measurement of the health of Idahoans or evaluate the performance of its healthcare delivery system.

The IMHC PCMH pilot opened new opportunities to assess the performance of Idaho's healthcare delivery system. Through the pilot, public and private payers are, for the first time in Idaho, jointly requiring providers to report on performance measures. Clinical quality data are reported for two to

three clinical quality measures as well as two practice transformation measures. Each payer specifies additional reporting requirements.

To address the lack of standard performance measures across public and private payers or programs, Idaho will develop an Initial Performance Measure Catalog (Catalog). Initial performance measures to be included in the Catalog were targeted because they represent the areas with the most need for health improvement across all Idahoans.

The IHC will task its quality committee to identify from the Performance Measure Catalog those measures that will be mandatory for reporting in Year 2 and a process for inclusion of additional measures that develop over time in response to performance evaluation and community need.

Idaho's Initial Performance Measure Catalog

Measure Name (and Source)	Measure Description	Rationale for the Measure
Screening for clinical depression.	Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow up plan documented.	In Idaho, 22.5% of persons aged 18 or older had a mental illness and 5.8% had SMI in 2008–2009 while 7.5% of persons aged 18 or older had a major depressive episode (MDE). During the period 2005–2009, 9% of persons aged 12-17 had a past MDE. Suicide is the second leading cause of death for Idahoans aged 15–34 and for males aged 10–14. This measure aligns with Healthy People 2020.
Measure pair: (a.) Tobacco use assessment. (b.) Tobacco cessation intervention (SIM)	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.
Asthma ED visits.	Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	While asthma prevalence (those with current asthma) in Idaho was 8.8% in 2010, reduction of emergency treatment for uncontrolled asthma is a reflection of high quality patient care and patient engagement.
Acute care hospitalization (risk-adjusted).	Percentage of patients who had to be admitted to the hospital.	While Idaho has one of the country's lowest hospital admission rates (81/1000 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Readmission rate within 30 days.	Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	Data currently unavailable. Metric will be used to establish baseline.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of a hospital ED.	While Idaho has one of the country's lowest hospital ED utilization rates (327/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of emergency services, as well as a reflection of quality and patient engagement in primary care related to avoidable treatment.
Elective delivery.	Rate of babies electively delivered before full-term.	Data currently unavailable. Metric will be used to establish baseline.
Low birth weight rate (PQI 9).	This measure is used to assess the number of low birth weight infants per 100 births.	While Idaho's percentage of low birth weight babies is low compared to the national average, the opportunity to improve prenatal care across settings is an indicator of system quality. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia (HEDIS).	The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Idaho has a 100% shortage of mental health providers statewide. Without these critical providers, there is little or no support for patient engagement and medication adherence. Improved adherence may be a reflection of improved access to care and patient engagement.
Weight assessment and counseling for children and adolescents (SIM).	Percentage of children, two through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.	In 2011, 13.4% of children were overweight as defined by being above the 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th percentile for BMI by age and sex.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Comprehensive diabetes care (SIM).	The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.	Adult diabetes prevalence in 2010 was 8.0%. Overall, this represented one in 12 people in Idaho had diabetes.
Access to care.	Members report adequate and timely access to PCPs, BEHAVIORAL HEALTH, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes access to the appropriate level of care.
Childhood immunization status.	Percentage of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	While there have been significant improvements in immunization rates, Idaho ranks 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Non-malignant opioid use.	Percent of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.

The timeline for developing a baseline and establishing performance reporting to achieve population health management is outlined below.

- The IHC will establish a baseline for each of these measures in Year 1 of model testing.
  - Due to the lack of uniform reporting that exists today, the IHC will develop a baseline from the pockets of information that are currently available across payers and populations. An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline by the end of Year 1.

- In Year 2, the IHC will select four core performance measures from the initial Performance Measure Catalog to be reported by all PCMHs in Year 2.
  - The statewide performance measures for Year 2 will include the three SIM measures: tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care.

- In consultation with the IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3.
  - The additional measures collected in Year 3 may vary from region to region depending on performance and regional health needs and will be informed by community health assessments and regional specific clinical data.

During the first year of implementation and model testing, the IHC will analyze the current system capabilities and constraints regarding statewide data collection and reporting. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will have been developed. The IHC will engage stakeholders in this discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho.

The development of a Performance Measure Catalog and reporting of statewide performance measures across multiple payers and populations is a major first step for Idaho as we move toward population health management.

Cost Savings

Idaho's SHIP is designed to lower the overall cost of care for Idahoans. By transitioning to a PCMH model of care, Idaho has the opportunity to eliminate expenses through proactive care and care coordination. Five key categories of expenses were identified as having a high potential to yield

cost savings but other categories of healthcare expenditures are anticipated to also yield cost-savings. The initial five cost targets are: increase appropriate generic drug use to 85% of overall drug spend, reduce hospital readmissions by at least 5%, reduce overall hospitalizations by at least 1%, reduce non-emergent emergency department (ED) usage by 10%, and lower premature births by 20% through prenatal care.

The table below details the estimated cost savings associated with reaching each of these goals, as well as additional cost savings estimates for other categories of service.

Savings Assumptions by COS

	PMPM								
	Medicaid/CHIP				Private/Other		Medicare		
Categories of Services	Adult	Child	Duals	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	Fee for Service/Non-Duals (Parts A and B)	Medicare Advantage Part C
Inpatient Hospital	-4.14%	-4.14%	-4.14%	-4.14%	-4.14%	-4.14%	-3.02%	-3.02%	-3.02%
Outpatient Hospital (total)	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%
Emergency Dept (subtotal)	-1.13%	-1.13%	-1.13%	-1.13%	-0.90%	-0.90%	-1.13%	-1.13%	-1.13%
Professional Specialty Care	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Diagnostic Imaging/X-Ray	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
DME	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Professional Other (e.g., PT, OT)	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Prescription Drugs (Outpatient)	-0.75%	-0.75%	-0.75%	-0.75%	-2.50%	-2.50%	0.00%	0.00%	0.00%

As shown in the table, savings were also calculated by payer type. Medicaid is projected to reduce costs by $8 million, commercial insurance by $22 million, and Medicare by $41 million over three years (The savings calculations for Medicare assumes that provider efforts will naturally affect all types of patients, not just those outside of Medicare. Therefore behavior and utilization will improve across the board, and providers will treat patients/members similarly whether or not they are on Medicare). Inpatient hospital expenses are expected to save $73 million in total, outpatient and ED visits should be reduced by $20 million, pharmacy by $9 million, and another $7 million saved by reductions in specialists, therapists, and diagnostics. Those savings are offset by the supplemental costs in increased PMPMs to PCMHs for primary care and care coordination efforts later detailed in the SHIP.

The implementation of Idaho's proposed PCMH model is expected to save $70 million in three years after factoring in an increase in payment to primary care physicians for care coordination and adherence to the PCMH model. The projected cost savings for public payers (Medicare and Medicaid) is $48 million.

Savings Estimation Methodology: To determine cost savings from the model, a comparison model of care was built using fee-for-service data supplied by IDHW, from CMS, and from Mercer's proprietary commercial claims database. Mercer also used payers' public filings to the extent that they were available. Those costs were trended forward using actuarially sound methods to determine expected expenses without implementing the SHIP, establishing a baseline for comparison. Using savings assumptions based on data obtained from initiatives in other states and other public sources, five areas were determined to have high potential savings for Idaho. The savings assumptions called for reductions in ED usage, hospitalizations, re-hospitalizations, NICU, and an increase in the generic fill rate for pharmaceuticals. In addition, expenses related to diagnostic imaging and durable medical equipment were also introduced. The baseline data was

then projected taking into account those savings assumptions, offset by increased costs to primary care physicians. The resulting data was then compared to the baseline data to determine three and five year costs savings.

Next Steps

What follows is the SHIP, intending to address all of the terms and conditions that accompany the Model Design Award. In addition, it includes the product of the work groups and Steering Committee as supplemented and matured by the various subject matter experts. Each major element of the model has been fully vetted and approved by the Steering Committee by a majority vote (and in most cases through unanimous decision).

Idaho's Department of Health and Welfare will submit a Model Testing Proposal in pursuit of financial support for the implementation and testing of the model. However, Idaho does not intend to wait on grant funding before proceeding further in planning and model development. The SHIP Steering Committee is continuing in its role of overseeing development of the model. In preparation for the implementation and testing phases, the Steering Committee will establish interim sub-committees to address critical start-up issues that will lay the groundwork for implementation.

The Steering Committee will continue to define implementation details and move component pieces of the SHIP forward until the IHC is fully formed and able to assume its responsibility.

Ongoing Community Awareness of and Engagement in SHIP Implementation

The backbone of Idaho's healthcare transformation is the strength of its local communities. Community engagement was a critical component that led to the success of the SHIP model design process through the input received from community members who participated in the focus groups and work groups. The work groups considered ways to continue to engage communities in the SHIP implementation phase and to promote awareness of the SHIP activities both in Idaho and around the country as lessons learned begin to emerge. Idaho will continue to use its SHIP website (www.idahoshipproject.dhw.idaho.gov) to post news and updates regarding the development of the SHIP model. The website will serve as a resource for researchers and other interested parties, as well as the general public, to learn more about implementation activities and, later, regarding results in achieving access, quality, and cost goals. The State will also facilitate townhall engagements to gauge public sentiment regarding model implementation and continue to ensure alignment with patient and system needs in Idaho. Through participation in CMMI – hosted conferences and other national forums, Idaho will also have the opportunity to share experiences with federal partners as well as states that join them in health transformation.

2

Idaho's Healthcare System Transformation

Vision

Idaho will deliver integrated, efficient and effective primary care services, supported and incentivized by value-based payment methods, through the patient-centered medical home model and, in doing so, improve the quality and experience of care for Idahoans while improving health outcomes and effectively controlling healthcare costs.

The following is Idaho's vision for health system transformation, as approved by the Steering Committee:

Idaho stands at an important crossroads of designing and developing an integrated, efficient, and effective healthcare system. This system will be a regional-facing model built for each Idaho community (including rural and frontier areas) on a robust primary care based system with an empowered PCMH. The PCMH is led by a primary care provider (in conjunction with other healthcare team members), and empowers a broad-based healthcare team to integrate and coordinate care for the patient in a cost-effective and high-quality way. This system will be a robust "medical neighborhood" integrating additional community support consisting of secondary care providers and consultants, community home health agencies, hospitals, and other ancillary healthcare provided in those communities. All of this will be integrated electronically with EHRs and other HIT tools, such as telehealth, so that clear and timely communication can occur, all with the central premise that high-quality, evidence-based care occurs as close to home as possible. Payment systems will be aligned to support these practices to be a blended and bundled system that is responsible and accountable to a value-driven system that enhances patient's health as affordably as possible. This system will be patient-centered and will partner with engaged and accountable patients in shared decision making. Health promotion and wellness will be central tenets of Idaho's healthcare redesign. All of these principles will be combined at the community level to help create the sustainable healthcare system that Idaho needs.

Our goal for health system transformation is to achieve the Triple Aim in Idaho. Specifically, our goals are to:

- Improve the quality and patient experience of care for each Idahoan.
  - Individuals can get the care and services they need, as close to home as possible, and care will be coordinated regionally with access to statewide resources when needed.
  - 80% of Idahoans will have access to a recognized PCMH by 2019.
  - Physical health and behavioral health are integrated and coordinated, and prioritize prevention and wellness strategies that keep individuals healthy rather than only caring for them when they are sick.
  - Care is evidence-based, and evaluation of care is transparent to stakeholders, and supported by performance measure analysis and reporting.
- Improve the health of Idahoans (see the Initial Performance Measure Catalog for specific health improvement measures).
- Improve affordability as measured by reductions in the total cost of care.
  - Costs are reduced through new payment systems and standards that emphasize outcomes and value rather than volume, and make care more affordable for everyone.

Idaho's Driver Diagram

TRIPLE AIM ← **PRIMARY DRIVERS** ← **SECONDARY DRIVERS**

By 2019, Idaho will:

1. Improve health outcomes
2. Improve quality and patient experience of care
3. Reduce healthcare costs by $70 million.

Specifically, Idaho will:

Increase appropriate generic fill rate
Decrease re-hospitalizations
Decrease acute care hospitalizations
Decrease non-emergent ER use
Decrease early term deliveries
Increase tobacco use assessments and tobacco cessation interventions (SIM measure)
Increase weight assessments for kids and adolescents (SIM measure)
Increase rates of comprehensive diabetic care (SIM measure)

IHC will identify additional measures after Year 1 among the following:

Increase screening rates for clinical depression
Increase adult BMI assessment
Patient satisfaction
Decrease asthma ED rates
Decrease ER visits
Decrease low birth weight babies
Increase adherence to antipsychotics among patients with schizophrenia
Increase childhood immunization rates
Decrease non-malignant opioid use

- **80% of Idahoans** access primary care via an **accredited PCMH.**
  - Primary care practices become PCMHs, some rural practices become **virtual PCMHs**.
  - **State/regional support** for practice transformation.
- PCMH reimbursements **incent quality of care**.
  - Payers adopt **total cost of care shared savings** reimbursement models.
  - PCMHs develop **sustainable pricing models**.
- Health care is **patient-centered**.
  - PCMHs engage patients throuch **comprehensive assessments, wellness activities and technology**.
  - PCMHs coordinate care with all providers in the patient's **medical neighborhood**.
- Adequate team-based **primary care workforce**.
  - Expand the primary care workforce.
  - Train lay healthcare professionals (**community health workers and community paramedics**).
- **State and regional population health focus**
  - Link data and services with **other federal, state and tribal agencies**
  - Adopt and track core **statewide** measures plus **regional** measures.
  - **Regional health needs assessments**.

Current Healthcare Delivery System Models in Idaho

Idaho's current healthcare delivery systems reflect the vastly rural nature of the State. A little over 1.5 million Idahoans live in its 44 counties, 35 of which are rural counties (those with no cities over 20,000 residents) accounting for approximately 88% of the State's land area. See Appendix C for a map of Idaho's population distribution. Residents of these counties generally receive their care through small physician practices or solo practices. The State's 12 non-profit FQHCs and 1 FQHC "look alike," located in 37 counties, expand the choice of care for Idahoans in rural and medically underserved areas and function as a critical care provider for the uninsured. As in many rural states, Idaho's public health system also plays a critical role as a service provider. Direct services offered by the 7 local public health districts range from community and home health nursing to dental hygiene and nutrition.

Idaho has five large population centers: Boise (population 205,000), Nampa (81,000), Meridian (75,000), Idaho Falls (56,000), and Pocatello (54,000) and seven additional cities with population sizes ranging from 20,000 to 50,000. Idahoans living in these cities have a greater choice in care than their rural neighbors. Choice in care ranges from large private healthcare systems, such as St. Luke's and Saint Alphonsus health systems, to smaller physician practices. Large private healthcare systems, which group together networks of hospital facilities and outpatient clinics, are becoming increasingly prevalent in Idaho.

The Idaho health care delivery system is challenged by a shortage of primary care providers and large rural areas that limit accessibility. These obstacles, which have impeded the development of an integrated health care delivery system, have also been a source of innovation. The independent primary care providers in solo and group practices by necessity have used limited resources to deliver evidenced based care and begin the transition to patient centered medical homes. For example, Dr. Keith Davis is the sole physician in Lincoln County, Idaho — an area about the size of Rhode Island with a population of more than 5,000. It is hard to find a health care program in the community that has not been impacted by Dr. Davis. In addition to running the Shoshone Family Medical Center, Dr. Davis is the medical director of a local hospice, the county coroner, an ER physician at St. Luke's Jerome Medical Center, and the emergency medical services director for Lincoln and nearby Jerome counties. To help meet the needs of the community, Dr. Davis has brought additional patient-centered medical services into Lincoln County. He hired two licensed clinical social workers to provide behavioral health services to county residents. He has also expanded his practice to offer patients an American Diabetes Association-recognized diabetes education program. Dr. Davis's office uses electronic medical records, maintains an active internet site where patients can access their health information, and employs a nurse practitioner to expand access to care. Dr. Davis was recently named the American Academy of Family Physicians' Family Physician of the Year.

Current Provider Models

- Large public provider systems, such as the Veteran's Affairs (VA) system.
- Large private healthcare systems, such as the St. Luke's and Saint Alphonsus systems.
- Group physician practices.
- Solo physician practices.
- 13 community health centers.
- 44 rural health clinics (RHCs).
- Indian Health Services and tribal health programs.

Contributing significantly to the health of Idahoans is Idaho's commercial payers, as over half of Idahoans

are covered through commercial plans. The top three commercial payers are Blue Cross of Idaho, Regence BlueShield of Idaho (Regence), and PacificSource Health Plan Group (PacificSource). In 2011, these three payers accounted for approximately 92% of the individual market, 95% of the small group market, and 97% of the large group market. Both Medicaid and Medicare play a major role in the current Idaho health market, with Medicare beneficiaries representing about 15% of the State's population and another almost 15% enrolled in Idaho Medicaid/Children's Health Insurance Program (CHIP).

Further description of the current healthcare delivery system can be found in Appendix D.

Today, the patient's experience of care, which plays such a critical role in patient wellness in terms of prevention, diagnosis, and treatment adherence, is not always positive in Idaho, particularly in rural areas. Based on stakeholder engagement and focus groups throughout the SHIP model design process, consumers have articulated several recurring themes about today's patient experience. Stakeholders reported lack of provider choices, especially in the areas of behavioral health providers and diagnostic technologies, as well as limited provider use of HIT tools, such as patient portals, that facilitate patient access to health information. Stakeholders also reported primary care providers being rushed or overloaded and not spending enough time with their patients, challenges in accessing specialty care including out-of-state travel in many situations, and limited primary care after-hours access.

In many situations, responsibility has fallen on the patient to coordinate their own care. Often, the integration of specialist and ancillary care depends on the patient's own ability to effectively understand and navigate the health care system to find providers, obtain referrals for services, and share information among providers in their care team. However the patient cannot always be the best advocate, and often patients receive the wrong care at the wrong place at the wrong time, which can lead to unnecessary services and cost, or, worse, overall decline in health status.

Current Public Behavioral Health Model

Idaho is actively working to build a more integrated behavioral health system that coordinates mental health and substance abuse services and integrates these services to a greater degree into physical health care models. While significant strides have been made, integration of behavioral health into the physical health arena is extremely limited in Idaho and is an area for continued collaboration and focus.

Behavioral health services are available for Idaho Medicaid participants through a Section 1915(b) waiver that authorizes the Idaho Behavioral Health Plan (IBHP), which was implemented September 1, 2013.

Idaho contracts on a capitated basis with a single, statewide managed care entity, Optum Heath, to administer behavioral health services to eligible Medicaid members. The contractor provides behavioral health services, including outpatient community-based mental health services, substance use disorder treatment, and case management services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), as well as any adults or children who have symptoms of mental illness. The contractor will begin offering three new services: peer support services, family support services, and community transition support services in approximately February, 2014. The IBHP contract includes financial incentives for the stabilization and reduction of inpatient hospitalization costs.

The Children's Mental Health (CMH) program is a developing partnership of community-based systems of care for children with a SED and their families.[2] While most children in the CMH program are served by private providers reimbursed through Medicaid, the CMH program enhances the private network with 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.

Idaho also provides State-funded and State-operated voluntary outpatient mental health services for adults with severe and persistent mental illness (SPMI) through regional mental health centers (RMHCs). RMHCs, which are located in each of the seven health districts, provide mental health services through a system of care that is both community-based and consumer-guided. Adult outpatient services for eligible individuals include: crisis screening and intervention, psychiatric clinical services, case management, individual and group therapy, psychosocial rehabilitation, assertive community treatment, patient assistance program, benefit assistance, co-occurring disorders treatment, pharmacological education, and short-term mental health intervention. Community health centers also offer limited behavioral health services, though a common practice is to refer more complicated cases to the RMHCs.

Inpatient services are offered through community psychiatric hospitals and state psychiatric facilities. There are two state psychiatric facilities in Idaho, one in the northern and one in the southern parts of the State. State Hospital North is a 55-bed adult psychiatric facility, while State Hospital South has 90 adult psychiatric beds, 29 skilled nursing beds, and 16 beds for adolescents. These state facilities, which only accept involuntary admissions, run at capacity most of the time. Unfortunately, many Idahoans in need of behavioral health inpatient services must receive their care through facilities far from home, which isolates them from their support systems and community services that are crucial for recovery.

The Idaho State Planning Council on Mental Health was established in 1990 by Executive Order of the Governor and pursuant to Public Law 102-321. The functions of the Planning Council are to advocate for children and adults with mental health issues; advise the State Mental Health Authority on issues of concern, policies and programs; provide guidance in the development and implementation of the State Mental Health Systems Plan; monitor and evaluate the allocation and adequacy of mental health services within the State, and serve as a vehicle for intra and inter-agency policy and program development.

At the local level, regional mental health boards oversee the activities of the regional public behavioral health system and encourage inter-agency collaboration. The boards are comprised of county commissioners, law enforcement, consumer representatives, advocates or family members, IDHW employees representing the mental health system within the district, a physician or other licensed practitioner of the healing arts, a mental health service provider, a representative of a hospital within the region, and a member of the regional substance abuse advisory committee. A representative from each of the seven regional mental health boards is appointed to the State Planning Council. The role of the regional mental health boards is to advise the State Planning Council on local mental health needs and progress, assist and monitor the formulation of an operating policy for the regional services, interpret the regional mental health services to the citizens and agencies of the region as needed, collaborate with the regional substance abuse advisory committee, and promote improvements in the delivery of mental health services and coordinate/exchange information regarding mental health programs in the region.

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[2] IDHW Facts, Figures, and Trends Report 2012-2013, viewable at http://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2012-2013LR.pdf

Idaho is actively working to improve coordination between mental health and substance abuse services. Currently, substance abuse services are offered through Idaho's 68 substance abuse providers who serve 132 locations throughout the State as well as 35 stand-alone recovery support service providers at 65 locations statewide. Substance abuse treatment services include detoxification, outpatient therapy, and residential treatment. Recovery support services include case management, family life skills, adult safe and sober housing, childcare, transportation, and drug testing. Specialized services are available for pregnant women, women with dependent children, and adolescents. Services are funded through Medicaid, other federal funds, and state funds.

Significant movement has been made in recent years towards using drug, mental health, and veteran's courts to provide substance use treatment to offenders as an alternative to other sentences, including incarceration. In SFY 2012, these courts offered community services and supervision to 2,216 felony, misdemeanor, and juvenile offenders.[3]

The efforts made in recent years to better coordinate and integrate services both within and between physical health and behavioral health delivery systems have played an important role in expanding awareness of the benefits of integrated care and has laid the groundwork for the design and implementation of the SHIP model presented here.

Bridge to Healthcare Delivery System Reform

In recent years, stakeholders in Idaho's healthcare system have made efforts to begin integrating the network concept into the delivery of better coordinated and more efficient and effective care. A key initiative is the Idaho Medical Home Collaborative (IMHC). The IMHC provides a springboard to the statewide, ambitious reform that Idaho will pursue through the SHIP.

Idaho Medical Home Collaborative

In January 2010, Governor Butch Otter established the IMHC to address gaps in the current healthcare delivery system. Recognizing the success of the patient-centered medical home model in delivering integrated, cost-effective care in other states, Governor Otter tasked the IMHC with developing recommendations regarding policies and activities needed to establish PCMHs in Idaho. The pilot launched on January 2, 2013, and 36 provider practices have agreed to achieve at least Level-1 PCMH recognition from the National Committee for Quality Assurance (NCQA) within the two years of the pilot. In order to track improved outcomes, practices that participate in the IMHC are required to build and maintain a patient disease registry and report data on a variety of measures regarding clinical quality, preventive quality, and practice transformation. All three of Idaho's major commercial payers (Blue Cross of Idaho, Regence, and PacificSource) as well as Idaho's Medicaid program participate in the IMHC pilot. The payers support the PCMHs through PMPM payments for patients who have specified chronic conditions (the payment amount and patient eligibility criteria vary by payer and are negotiated directly between the payers and the practices).

The IMHC has been successful not only in recruiting providers to transform their practices to a PCMH model, but importantly in bringing together a wide range of health system stakeholders around system transformation to create stronger, more integrated networks of care. This success provides a critical foundation that will enable stakeholders to continue to evolve the system from a FFS volume-driven model to a value-based, coordinated system of primary care where reimbursement is based on improved health outcomes for all Idahoans.

[3] "Smart Justice: Saving Prison Beds, Tax Dollars, and Lives." Report to Governor C.L. "Butch" Otter and the 1st Regular Session of the 62nd Idaho Legislature from the Idaho Judiciary.

Innovative and Visionary Primary Care Leaders

As noted earlier in describing the work and impact of Dr. Keith Davis, the innovation and success of the IMHC and other healthcare delivery system initiatives could not be achieved without the vision and dedication of Idaho's physicians working to rise above the challenges of rural, medically under-resourced communities. Dr. Scott Dunn, a member of a family practice group in a smaller community in northern Idaho, is another example of this leadership and dedication. As the co-chairman of the IMHC, he has led the collaboration of primary care physicians, private health insurers, healthcare organizations, and Idaho Medicaid to make recommendations to Governor Otter on the development, promotion, and implementation of a PCMH model of care statewide. Dr. Dunn's own practice utilizes electronic medical records, encourages patients to use a secure internet portal for accessing their health information, and as part of the clinic's transformation to a patient centered medical home, uses care plans for high risk patients.

Recognition of gaps in the delivery system and the need for better collaboration and integration has long existed among Idaho's healthcare practitioners. In 1994, the providers of the five north Idaho counties formed the North Idaho Health Network (NIHN).The NIHN is a nonprofit organization that collects member fees and manages risk-based shared-savings programs. Currently, more than 200 physicians located in five north Idaho counties participate in the network, which contracts with the largest commercial payers in Idaho. The NIHN is run by a Board of Directors, including community employer representatives, and has an executive director and medical director. A medical management team oversees clinical initiatives. The NIHN exemplifies the effective leadership of Idaho's healthcare community that has long existed within Idaho. Dr. Mike Dixon, NIHN Executive Director, shared his experience and lessons learned through the NIHN as he chaired the Network work group and provided leadership in the formation of the network model.

Another example of leadership that bridges the gap from the current system to more integrated and innovative care is the Primary Health Medical Group (PHMG), a predominantly primary care independent medical group in southwest Idaho that has over 250,000 patient visits a year. PHMG established "combination clinics" providing both family practice and urgent care at the same sites. Through this model, services are provided to over 8,000 Medicaid patients annually, enabling increased access to appropriate care and reducing emergency room visits. Unlike the traditional model, the urgent care and appointment providers work synergistically to address patient's episodic and chronic care needs. The efficiency of sharing resources and offering both services at one location ensures lower costs for the patient. With support of a grant from PacificSource, PHMG is providing "virtual" coordinated care for 2,000 adult diabetics and has data demonstrating improved compliance and better laboratory results. Primary Health Pediatric Clinic, currently attesting for level III NCQA patient centered medical home designation, is managing 400 asthmatic children with care plans, regular follow up, and coordinated care.

Impetus for Statewide Health Innovation

While efforts have been made to realign healthcare delivery systems in Idaho towards achieving the Triple Aim of quality care, improved health outcomes, and lowered costs, these initiatives are still smaller in scale. The majority of Idahoans still receive care through system models that are fragmented and misaligned to reward volume and the treatment of disease as opposed to rewarding value and the promotion of wellness. The gap analysis performed by the work groups revealed the need for solutions that engage patients to seek healthy behaviors, incentivize providers to partner with patients, help providers share healthcare data among all providers in the patient's care team, and hold all participants in the system accountable for improving patient outcomes and experience of care. The gap analysis identified the need to take bold steps towards aligning current systems — regardless of payer source or practice size — to deliver on a commitment to statewide health system transformation that will impact all Idahoans.

Stakeholder Model Design Deliberations on Future Healthcare Delivery System

Input from Tribal Health

Consideration of tribal communities' health needs and coordination with tribal health service providers was a discussion among stakeholders, in workgroups, and between IDHW and tribal leaders and representatives. Six tribes reside in Idaho: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribe. In the model design phase of the SHIP, IDHW Director Richard Armstrong and Deputy Director Denise Chuckovich hosted an informational session for all tribes on the purpose of the SHIP and the process for its development. Following the informational session, each tribe received a letter from Director Armstrong inviting them to request a formal tribal consultation. A formal consultation was held with the Nez Perce tribe and a tribal townhall was held with Shoshone-Bannock tribal members and service providers on the Ft. Hall Indian Reservation. Tribes were also encouraged to participate in workgroups. Discussions with tribal community members and service providers, such as Indian Health Service (IHS) providers, focused on identifying tribal health needs and how the model could coordinate with and improve services provided to tribal members. Tribal representatives reported great difficulty in accessing adequate specialty services for their patients, in particular behavior health. Coordination of care with providers outside the tribal community can also be challenging, making it difficult for the primary care provider in the tribal health center or IHS to establish continuity in care for individuals with chronic or complex medical conditions. It was noted that it is important to include IHS and tribal health centers in improved communications across the medical neighborhoods in order to benefit tribal health members. Also, discussed was the need for telehealth expansion in order to increase access to specialty services, particularly behavioral health, for tribal members.

Input from Work Groups, Focus Groups and Townhall Meetings

The information gathered at the 44 focus group meetings and multiple townhall engagements, as well as the diligent work by four stakeholder work groups, all under the direction and leadership of the Steering Committee and its sponsors, has generated a model for healthcare delivery that truly reflects the sentiment and solutions of Idaho. Some examples of the discussions and recommendations of stakeholders that led to the development of the delivery system design are noted below. The full deliberations among this broad group of stakeholders over the course of months are documented on Idaho's SHIP website (www.idahoshipproject.dhw.idaho.gov).

The importance of a patient-centered model was a topic of significant discussion in Network work group meetings and focus groups held throughout the State. Stakeholders uniformly agreed that Idaho needs a model that is responsive to the individual's complete health needs and engages the individual to fully participate in healthcare and wellness activities. Patient engagement at the practice level was identified by stakeholders as being vital to improving health status and increasing compliance with care plans. They stressed that physician practices should offer patients the tools and education they need to take care of themselves. The Network work group suggested expanding patient engagement techniques that Idaho physician practices, payers, and employers are already using to varying degrees such as: having a patient portal where patients can access their health information, using motivational interviewing techniques with patients to engage them in creating a realistic and manageable care plan, and providing patients access to wellness programs and chronic disease self-management programs. Some stakeholders, including members of the Network and Multi-Payer work groups, also suggested using financial incentives for patients based on changes in behaviors and outcomes (e.g., premium reductions).

The Network and CQI work groups considered methods for achieving greater coordination between healthcare providers, public health authorities, community services and supports, and patients in the new system. Referring to this larger network as the "medical neighborhood", work group members agreed that promoting integration and collaboration between providers, patients and community-level resources and supports should be one of the model's guiding principles. Work group members also agreed that public health authorities are valuable resources in Idaho because they are aware of community health needs, have working relationships with stakeholders, and are familiar with the community's strengths and weaknesses. To promote collaboration, it was recommended that the IHC and RC work with public health to conduct community assessments, using the tool currently used by public health, the CDC's Community Health Assessment tool. At the RC level, the representatives of the local provider community, community organizations and public health authorities will collaborate in reviewing community health needs assessments, reporting to the IHC on local PCMH and public health activities, and advising the IHC on how to improve collaboration at the State and regional levels.

Integration of physical and behavioral health was also identified by Network work group members and stakeholders as necessary to better identify and respond to patients' needs. Valuing the independence and autonomy of providers, particularly in rural areas of the State, stakeholders did not recommend mandating integration but encouraging better coordination and eventual integration through the use of behavioral health screening tools and increased access to behavioral health specialists at the local level through improved care coordination.

The Clinical Quality Improvement (CQI) work group proposed that the public health infrastructure be utilized as the framework for the regional networks. It was noted that there is a history and inclination of public health entities to work with other public entities, private agencies, and not-for-profit organizations, which supports the goals of the SHIP, enhances the creation of PCMHs and the delivery and coordination of healthcare services. However, after discussion at the Steering Committee level, it was decided that the RCs are best constructed as extensions of the IHC in order to quickly implement the model and promote consistency across the State.

In every stakeholder discussion, the issue of Idaho's healthcare workforce shortage emerged as a significant problem. Across all stakeholder types, it was understood that the healthcare delivery model must be supported by strategies to expand the workforce but yet be a model that can work within the current capacity of the workforce. The Network work group identified the importance of aligning the workforce efforts implemented through the SHIP with work being done by the Idaho Health Professions Education Council, established by Governor Otter through executive order in 2009. The Council has been working to develop healthcare workforce objectives for the State and recommend strategies to address healthcare shortage across a range of professions.[4] The Network work group recommended that many of the Council's recommendations be incorporated into the Idaho SHIP strategies for workforce improvement, including expanding family medicine residency slots in rural track programs, expanding existing loan repayment programs, establishing preceptor programs to increase specialty training for primary care physicians (PCPs) in medically under-served areas, and expanding training programs for mid-level support practitioners.

The Network work group considered several methods for improving Idaho's PCP workforce beyond the Council's recommendations. Incorporated in the SHIP is the Network work group's recommendation that "virtual patient-centered medical homes" be developed in communities without the resources to perform all the functions of a PCMH. The virtual PCMHs, as later described

[4] Idaho Health Professions Education Council, 2013 Annual Report to Governor C. L. "Butch" Otter, submitted August 13, 2013 available at http://gov.idaho.gov/HealthCare/PDF/2013%20IHPEC%20Annual%20Report.pdf

in this document (page 26), would use CHWs and community emergency medicine personnel to perform many key functions of a PCMH in workforce shortage areas.

Of great concern to stakeholders was the lack of behavioral health professionals. The entire State of Idaho is a federally-recognized health professional shortage area for behavioral health providers. Stakeholders recommended expanding telehealth technologies across the board, but particularly for the purpose of increasing access to behavioral health services. Specific telehealth activities are described in Section 5.

Many of the PCMH model components will be new functions for the majority of Idaho's physician practices. All four work groups were concerned about providers' willingness to incorporate many of these functions into their practice due to the associated costs and the fact that physicians are already overworked and under-resourced. Workgroup members considered whether policies mandating some key functions, in particular EHR utilization, patient registries, data collection and performance reporting, should be pursued. However, it was recognized that mandates would be unsuccessful in Idaho and that more important would be the provision of statewide and local supports and resources to assist practices in the transformation process. As such, the IHC and RCs were recommended as key structures for providing critical supports needed to implement and sustain the model.

More information regarding stakeholder deliberations regarding specific components of the existing and future models can be found throughout the SHIP.

Future Healthcare Delivery System Model

Idaho will transform its healthcare delivery system from a disease-focused, volume-driven model to a value-based model that builds a system of primary care upon the foundation of the PCMH model. PCMHs will be integrated with the larger healthcare delivery system through coordinated care between the PCMH and specialist and ancillary providers as well as collaborative quality improvement efforts at the regional level to improve health outcomes. Idaho's model will be patient-centered, delivering care that is individualized, culturally sensitive, and responsive to the patient's needs. Services delivered through the model will include the full range of primary care services for all age groups, across multiple payers, and will include, but not be limited to, prevention and wellness activities, routine healthcare services and evidence-based care of chronic and complex conditions. PCMHs will deliver team-based, coordinated care using advanced HIT to increase efficient and timely communications and appropriate data sharing. Performance targets will be established and monitored across PCMHs, regions and statewide. Payment methodologies will align with the value-driven goals of the model, and include quality and performance incentives and shared savings.

Idaho's vision for a patient-centered, value-driven model of healthcare is rooted in supporting primary care practices in becoming PCMHs. The transformation of primary care practices to the PCMH model will be supported and facilitated by a new statewide entity, the Idaho Healthcare Coalition (IHC). The IHC will be established as an independent non-profit organization with a Board of Directors to whom IHC staff will be accountable. The role of the IHC will be to facilitate and incentivize transformation and provide necessary tools, resources, and performance monitoring to achieve the goals of the model. The IHC will establish support at the local level through regional collaboratives (RCs). Given Idaho's diverse geographic differences, it is expected that the levels and types of assistance required by primary care practices will vary. The RCs will be responsible for helping primary care practices identify gaps in their practice and providing the assistance needed to facilitate the transformation process. RCs will also assist established PCMHs' as they endeavor to enhance their capacity within the model.

The model will be implemented statewide, with all regions beginning implementation activities at the onset of the model testing phase. The model's impact will extend, to varying degrees, to all healthcare providers, e.g., primary care providers, specialists, practitioners across all disciplines, hospitals, FQHCs, rural health clinics, etc.

The delivery of care through the team-based PCMH model will maximize the use of the State's limited healthcare workforce. Through the use of multi-disciplinary teams in the PCMH, the model will compensate, in part, for the shortage of healthcare providers by allowing each team member to practice at the top of their license and achieve efficiencies by delivering care at the appropriate level. In other words, physicians will be able to focus their time on clinical care requiring physician-level assessment and practice while other staff, i.e., nurses, CHWs, medical assistants, etc., provide care within the appropriate framework of their scope of practice. Additionally, the model encourages sharing of resources across PCMHs, which generates efficiencies in the system, and establishes RCs to help PCMHs initiate and support efficient sharing of resources. More information regarding workforce development strategies in Idaho's SHIP can be found in Section 4.

Idaho's model adopts some of the core components and lessons learned from Community Care of North Carolina (CCNC). However, Idaho's model goes beyond the CCNC model to include all patients, not just Medicaid participants or those with chronic conditions or complex health needs. Idaho's model spans multiple payers as the PCMHs will serve patients across Medicaid, Medicare, and commercial insurers. As a result, it is most important that three major commercial payers, Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource, have participated in developing the model and are strong partners in Idaho's SHIP. The cooperation and participation of other payers, such as smaller insurers, self-funded plans, hospitals, and FQHCs is also recognized as vital to the successful adoption of the model throughout the State.

The three levels of the stakeholder designed delivery system model, i.e., PCMHs, the RCs and the IHC, are discussed in detail in the following section. In addition, the role of IDHW in model implementation is also discussed as IDHW is the single State authority of the Medicaid program and potential grant administrator for model testing.

Idaho's Patient-Centered Medical Homes

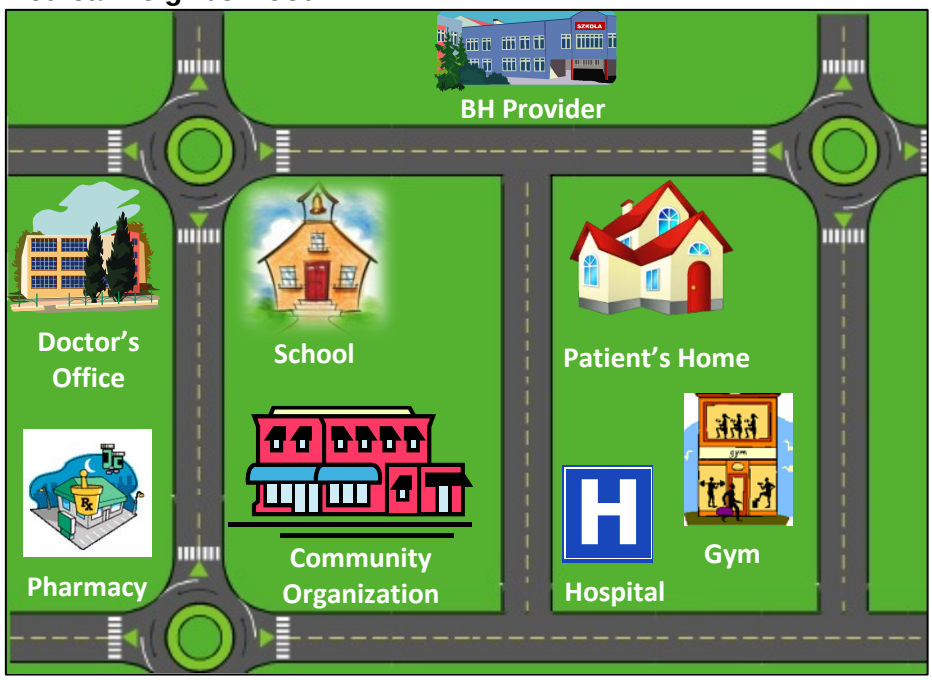
In Idaho's new model, PCMHs will be the vehicle by which primary care services are delivered, establishing patient-centered healthcare as the foundation of the State's delivery system. Equally important is the role PCMHs will play in moving Idaho's healthcare delivery system from its current fragmented, siloed approach to a cohesive healthcare system of coordinated services.

Clinical leadership of the PCMH will be provided by a physician, nurse practitioner, or physician assistant under appropriate supervision by a physician. As noted elsewhere in this SHIP, Idaho is a workforce shortage area. To support the expansion of a coordinated, team-based primary care system within a PCMH, Idaho proposes to pursue several strategies to expand the State's healthcare workforce, as described in Section 4.

Idaho recognizes that one's health is greatly impacted by factors beyond medical services, notably culture, lifestyle, nutrition and socio-economic factors. As such, the model acknowledges the importance of the medical neighborhood, which includes community services and supports, hospitals, specialty services, behavioral health, public health, long term services and supports and other organizations. The model requires that linkages and coordination of services occur across the medical neighborhood in order to establish and maintain shared knowledge of the "complete picture" of the individual's health status and care across all service providers. The PCMH will be

responsible for establishing formal communication protocols with other service providers and organizations within the medical neighborhood, and will be supported in this effort by the RCs. Coordination of care will occur with all existing service delivery systems in the State that are involved in the care of patients enrolled within the PCMH, including the VA system, tribal clinics, IHS, public health clinics, behavioral health centers, school-based services, and long term service and support providers. Clinical care coordination will be performed by a variety of different practitioners, including registered nurses, social workers, licensed advanced practice nurses, etc.

Medical Neighborhood



HIT is a critical component of the model. At the PCMH level, as a requirement of PCMH accreditation, practices will use EHRs and patient portals to centralize health data, share appropriate health information with other care providers to coordinate care and allow efficient, timely communications in urgent situations, and provide patients with tools and information needed to engage in effective self-management. PCMHs will also use clinical decision-support tools to expand evidence-based practices, reduce medical errors, and promote good health. By the end of the five-year project period, Idaho intends to have every PCMH using HIT to support efficient and effective care coordination and communications.

Key Functions of the PCMH

The key functions of the PCMH will be to:

- Implement evidence-based practice guidelines for clinical care and demonstrate performance on identified measures.

- Provide screening for physical and behavioral health needs and refer as appropriate.

- Develop a comprehensive care plan for patients based on a comprehensive assessment. The PCMH will plan and deliver care that is based on a holistic and comprehensive assessment of the person's health needs, and that is respectful of the person's culture, preferences, and shared decision-making responsibilities.

- Coordinate the delivery of care with the patient and his/her specialty providers and organizations in the patient's medical neighborhood to ensure a coordinated and patient-centered delivery plan.

- Identify and collaborate with community resources.

- Implement strategies to enhance patient engagement and active participation in health and wellness.

- Implement quality improvement activities that address local needs, as well as provide information needed for regional and statewide performance measurement reporting.

- Maintain a central registry or database containing all pertinent patient medical home information.

- Effectively use certified EHRs to support the delivery of care.

- Communicate with patients across multiple formats, e.g., email, telephonic consultation, and follow-up.

- Submit performance data to the IHC and/or its data and evaluation subcontractors. The PCMH will work with the RCs and the IHC to examine and use data to drive quality improvement.

- Utilize decision support tools in the provision of care, e.g., clinical guidelines, condition-specific order sets, diagnostic support, computerized alerts of reminders of care, etc.

- Arrange for the provision of 24/7 care for patients enrolled in the PCMH. Care may be provided through the medical neighborhood instead of by the PCMH itself. However, the PCMH must both arrange the 24/7 hour care and ensure that the emergency department is not the only option for after-hours care.

In recognition of the challenges that practices will face in assembling the resources needed to perform as a PCMH, Idaho has included in its model the establishment of a statewide IHC and RCs to support practices in the transformation process and provide ongoing assistance to functioning PCMHs. The support at both the regional and State level is critical to assuring successful transformation throughout Idaho and the delivery of care to 80% of the state's population through this model.

Virtual Patient-Centered Medical Homes

To build a robust primary care system based on the PCMH model in Idaho, the State must look beyond traditional practitioners, e.g., physicians, nurses, etc., as the primary care team, given that many communities lack primary care practices with the resources to provide team-based care with all the functions of a PCMH as listed above. In these underserved areas, two practitioner types – community health workers (CHWs) and community health emergency medical services (EMS) personnel – will be developed and advanced as key components of PCMH team-based care. Idaho's unique PCMHs will be "virtual PCMHs," as the team working together to provide coordinated primary care will be staffed across multiple agencies in the community or region.

In developing the concept of a virtual PCMH, Idaho reviewed existing Idaho-based models and researched and reviewed efforts of other states and nations to establish primary care systems in

rural and underserved areas. In Alaska, California, and many areas around the world, CHWs are a key contributor to an effective primary care extension system. Recently, the Annals of Internal Medicine published the results of a study that concluded that adding "care guides to the primary care team can improve care for some patients with chronic disease at low cost."[5] A September 2013 article in the New England Journal of Medicine discussed three models for organizing CHWs in the healthcare system: (1) as extensions of the hospital or clinic system to provide clinical services most generally for individuals with a chronic disease; (2) perform health educational activities and outreach, e.g. nutrition, diabetes, and behavioral health, as part of a community-based nonprofit organization; and (3) work as part of an organization of CHWs integrated with clinical and community organizations to perform various activities, such as increase self-management support in community settings, assist primary care coordination for chronic conditions, etc.[6] Regardless of the model used to develop and integrate CHWs in the healthcare system, Idaho recognizes that CHWs can play a vital role in improving population health across underserved areas.

At least two counties in Idaho (Bonner and Ada counties) have community health EMS/Community paramedic programs. In this model, EMS personnel function outside their usual roles of emergency response and transport to increase access to primary care in medically underserved communities, provide in-home monitoring or follow up, and/or facilitate reductions in inappropriate or overuse of EDs. For example, in Bonner County,[7] community EMS personnel provide preventive medical care in the home when other in-home providers are not present due to cost or availability. Bonner County community EMS personnel also work in conjunction with the patient's physician and other healthcare providers as a team to provide health education and disease management and monitoring of chronic conditions in their home.

Some of the initiatives of the Ada County Community Paramedic Program[8] include the Community Paramedic System Wide Field Referral Program. This program was designed to give Ada County paramedics and area fire department personnel the opportunity to refer patients to a program where the community paramedic may be able to assist with patient care coordination. This care coordination includes home environment and fall risk assessment, medication education, and assisting the patient in finding a PCP. The care coordination also includes information about area resources ranging from mental health programs to dental and nutritional programs. Ada County community paramedics have also partnered with several healthcare providers on pilot programs for in-home patient follow up with specific patient types. This follow up includes physical assessment, disease and medication education and management, home environment assessment, and assisting the patient in actively managing his/her own healthcare. In Ada County's 911 Community Paramedic program, the community paramedic is functioning within the 911 setting as a single person emergency response unit. On low acuity call types, the community paramedic arrives on scene with the responding paramedic unit. Depending on the patient complaint and resulting paramedic assessment, the community paramedic releases the 911 ambulance crew back into service, and the community paramedic stays on scene with the patient and coordinates alternate transport to a more appropriate healthcare facility such as an urgent care clinic. The community paramedic works with the patient's PCP in setting up a care plan in combination with clinic visits.

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[5] Adair, Richard, M.D., et al. "Improving Chronic Disease Care by Adding Laypersons to the Primary Care Team" Annual of Internal Medicine, 159(3): 176-184, August 2013.

[6] Singh, PraBehavioral healthjot, M.D. et al. "Community Health Workers – A Local Solution to a Global Problem" New England Journal of Medicine, 369: 894-896, September 5, 2013.

[7] http://www.bonnerems.com/wp-content/uploads/PDF%20and%20documents/StrategicPlanNarrative2013DRAFT03-07-2013_000.pdf

[8] http://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/CommitteesandWorkingGroups/CommunityHealthEMS/tabid/2179/Default.aspx

The IHC will build off the Bonner and Ada county programs, as well as that of other states, to encourage the development of CHWs and community health EMS personnel/community paramedics as part of PCMH team-based care in rural, medically-underserved communities. The IHC will partner with local experts to train CHWs and community health EMS personnel/community paramedics to provide healthcare services in response to identified community needs. CHWs' activities are likely to include providing health education to individuals with chronic conditions, performing protocol-driven early risk detection or providing primary care coordination. Community health EMS personnel/community paramedics may provide home checks following hospital discharge and for individuals at risk for hospitalization, provide mobile immunizations, and/or be trained to assess and divert to appropriate care instead of transporting to the ED. The actual services provided by CHWs and community health EMS in a particular community/region will be determined by local needs as identified through community health assessments and/or by regional/community clinical data.

CHWs and community health EMS personnel/community paramedics will receive training through the IHC using a variety of training methods, including videoconference technology. Training will be conducted by subject matter experts on topics such as preventive medicine, diabetes management, and patient-assessment skills.

Similar to New Mexico's Project ECHO (Extension for Community Healthcare Outcomes), Idaho will use telehealth technology to increase the trained workforce in underserved areas across the range of primary care and associated health professions that will comprise the virtual PCMHs. As described in Section 5, the IHC will work with Idaho's Telehealth Task Force to expand telehealth capacity in the State. Partnerships with community, county, and State organizations with videoconference technology will be facilitated by the RCs to provide access to telehealth training. The IHC will work with the Idaho Area Health Education Center (AHEC) and the RCs to identify healthcare experts to provide training in response to community needs.

RCs will work with communities to determine the need for a virtual PCMH within the region. Community needs assessments and clinical data will be used to determine service gaps in the community and determine the role of the CHWs and community health EMS personnel/community paramedics in the virtual PCMHs.

Further development of the model will be developed by the IHC with stakeholder input.

Integrating Behavioral Health into Patient-Centered Medical Homes

Idaho recognizes the critical importance of integrating behavioral health into the PCMH model in order to increase quality of life and life expectancy for individuals with behavioral health conditions. The 2011 Idaho State Planning Council on Mental Health Report suggested adaptation of SAMHSA's 10x10 wellness campaign in Idaho to reduce deaths and improve life expectancy among individuals with mental health and substance abuse conditions by 10 years, in 10 years. This cannot be accomplished without primary care integration to assist the behavioral health community in prevention and treatment of associated co-morbid chronic behavioral health and medical conditions.

Successful integration of behavioral health into the PCMH model will require practices to implement four essential strategies: (1) conducting a comprehensive needs assessment, (2) documenting individual needs planning, (3) developing communication tools and monitoring programs, and (4)

facilitating access to needed services.[9] Idaho's PCMH model will support practices in implementing these strategies through technical assistance around any needed practice transformations, identifying and sharing community resources, aligned payment incentives and strong monitoring by the IHC and its RCs.

The IHC will establish a behavioral health committee during the early days of its formation in order to develop further the strategy for behavioral health integration in the PCMH model. The behavioral health committee will be tasked with identifying evidence-based screening tools appropriate for use in the PCMH setting. The RCs will then work with the PCMHs to incorporate use of these tools in the practice. The behavioral health committee also will examine tested local and national evidence-based practices and select models that are most likely to be effectively adopted by Idaho practitioners. Training on selected models will be offered to PCMH providers.

The behavioral health committee will consider lessons learned from two models that have been effectively integrated with the physical health delivery system in Idaho and have shown promising outcomes. The first is the Integrated Outpatient Care Program (IOCP) model which is currently established in Idaho through Regence BlueShield of Idaho.[10] Regence participated in a pilot program in Puget Sound, and, as a result of the pilot, expanded IOCP to other service areas, has helped shepherd the use of IOCP with sister Blue Cross Blue Shield plans throughout the country, and has advocated for use of the program nationwide. The IOCP is one of the few programs to show improvements in not only cost, but functional scores in those with chronic illness – including mental health.[11]

The second model the IHC's behavioral health committee will consider is the IMPACT model, a collaborative, stepped-care management intervention for depression and anxiety used in a wide range of primary care practices.[12] The IMPACT model is established in Idaho through a grant from the John A. Hartford Foundation to expand IMPACT depression care model into western states and Alaska. The IMPACT model has shown that at 12 months, 50% of clients reported at least a 50% reduction in depressive symptoms, compared with only 19% of those in usual care.[13] A four-year study examined healthcare costs and found that IMPACT resulted in substantial savings compared with usual care. IMPACT participants had lower mean healthcare costs per patient ($29,422) compared with usual care per patient ($32,785), representing a cost savings of $3,363 per patient during the study.

The IMPACT program offers practices onsite and online training on topics such as systematic diagnosis, stepped care, and monitoring for success with validated tools. IMPACT participants also receive evidence-based treatment training on topics such as antidepressant medication adherence, referral to psychotherapy and how to improve the satisfaction of care.

Patient-Centered Medical Home Accreditation

Primary care practices will be accredited as a PCMH through a national accrediting body. The IHC will identify several national accrediting organizations from which PCMHs can choose to pursue

[9] C. Boult, G.Wieland, Comprehensive Primary Care for Older Patients with Multiple Chronic Conditions "Nobody Rushes You Through" JAMA. 2010;304(17):1936-1943
[10] See Regence's website at http://www.regence.com/about/awards.jsp
[11] A. Milstein, Are Higher-Value Care Models Replicable? Health Affairs November/December 2009 http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/
[12] IMPACT is a program of the University of Washington, Department of Psychiatry & Behavioral Sciences http://impact-uw.org/about/research.html
[13] J Unützer Collaborative Care Management of Late-Life Depression in the Primary Care Setting A Randomized Controlled Trial, *JAMA.* 2002;288(22):2836-2845.

accreditation. PCMHs will receive resources and supports to achieve accreditation and incentives to advance in accreditation levels as later described in this Section.

The IHC will establish a minimum set of core operational and staffing requirements that a primary care practice must attain in order to be designated as a PCMH. All primary care practices that desire to become PCMHs and be designated as such must meet the core minimum requirements of a PCMH. Designation as a PCMH may be obtained prior to achieving Level 1 PCMH accreditation, and will allow the receipt of PMPM payments to support care coordination and other functions of a PCMH.

Idaho recognizes that not all primary care practices may be able to achieve higher levels of accreditation because of the extreme resource-limited area in which they practice. For example, Lincoln County has one physician that serves the entire county. Because Idaho believes that the value-driven, coordinated care approach will improve the health of its residents, it chooses to make healthcare delivery system transformation available throughout all its communities. To achieve the larger goal of transformation and improved health outcomes, Idaho recognizes that there are unique differences between communities and that the model must include resources and supports to develop opportunities for all practices to transform. As such, all practices will be provided supports to be designated as a PCMH and delivery quality care, but not all PCMHs will be required to pursue higher levels of accreditation in order to participate in the model.

While advanced accreditation status may not be attainable by all PCMHs, the provision of high quality care through the PCMH is expected and established as a primary goal. Quality improvement initiatives and supports will be integrated into all levels of the model. The capacity to collect and report performance measurement data will be a core requirement to be designated as a PCMH. PCMHs will be required to implement quality initiatives to improve practice performance, manage population health, and improve health outcomes. PCMHs will be offered technical assistance from quality improvement experts, provided through either the IHC or the RC, to help the PCMH attain the highest level of quality care.

Idaho Healthcare Coalition

Idaho will develop an independent non-profit organization with responsibility for supporting and overseeing system implementation and population management statewide, including supporting physician practices in all stages of PCMH development, facilitating the expansion of evidence-based practices, measuring and improving population health, and advancing coordination with medical neighborhoods, including hospitals, specialists, behavioral health, tribal/IHS programs, long term care providers, and social service organizations. The Idaho Healthcare Coalition (IHC) will establish RCs to provide supports at the local level in addition to those provided by the statewide IHC.

The role of the IHC and its RCs is critical to ensure consistency and accountability for performance and providing technical assistance and resources to improve the quality of care and the population's health throughout the State. Due to the current lack of performance reporting across payers and populations in the State, an initial priority for the IHC will be to establish baseline data for statewide population health management. An external organization will assist the IHC in collecting baseline data in Year 1. The IHC will also obtain the services of quality experts to provide training and technical assistance to practices so they can begin data reporting on statewide metrics in Year 2.

The IHC will partner with Idaho's Health Quality Planning Commission (HQPC) in the pursuit of improved health outcomes. The HQPC was established by legislation to "promote improved quality

of care and improved health outcomes through investment in HIT and in patient safety and quality initiatives in the State of Idaho."[14] The Commission, whose membership is appointed by the Governor, will have representation on the IHC's Board of Directors to facilitate the development of strategies to identify and measure the quality of care delivered by the PCMHs. The goals of this partnership will be to advance the development of technology and information sharing that supports the PCMH model, and to partner on quality initiatives that address the health and safety needs of the citizens of Idaho by promoting participation in the PCMH model.

The HQPC is charged with performing the following duties:

1. Monitor the effectiveness of the IHDE.

2. Make recommendations to the legislature and the department on opportunities to improve the capabilities of HIT in the State.

3. Analyze existing clinical quality assurance and patient safety standards and reporting.

4. Identify best practices in clinical quality assurance and patient safety standards and reporting.

5. Recommend a mechanism or mechanisms for the uniform adoption of certain best practices in clinical quality assurance and patient safety standards and reporting including, but not limited to, the creation of regulatory standards.

6. Monitor and report appropriate indicators of quality and patient safety.

7. Recommend a sustainable structure for leadership of ongoing clinical quality and patient safety reporting in Idaho.

8. Recommend a mechanism or mechanisms to promote public understanding of provider achievement of clinical quality and patient safety standards.[15]

The IHC's role and functions will change as the model is established throughout Idaho. Initially the core functions of the IHC will be to support and oversee statewide transformation of the delivery system, which includes facilitating practice transformation to the PCMH model through technical assistance and resources, initiating performance reporting and population health management, and working with payers to achieve payment reform that supports the PCMH model. After the model has been fully implemented and primary care is delivered predominantly through the PCMH model, the IHC will shift its primary focus from facilitating practice transformation to quality and population health management. The IHC will maintain and update the Performance Measure Catalog, adding new measures and adjusting targets to continuously improve the population's health. Using performance reported data and community health needs assessments, the IHC will provide feedback to PCMHs and regions on performance and assist them in identifying and implementing appropriate quality improvement activities. The IHC will continue to serve as a vehicle for spreading best practices through learning collaboratives, trainings and other forums. Lastly, the IHC will work closely with payers so that clinical practice, performance targets and payment methods within the model align with the goals of payers.

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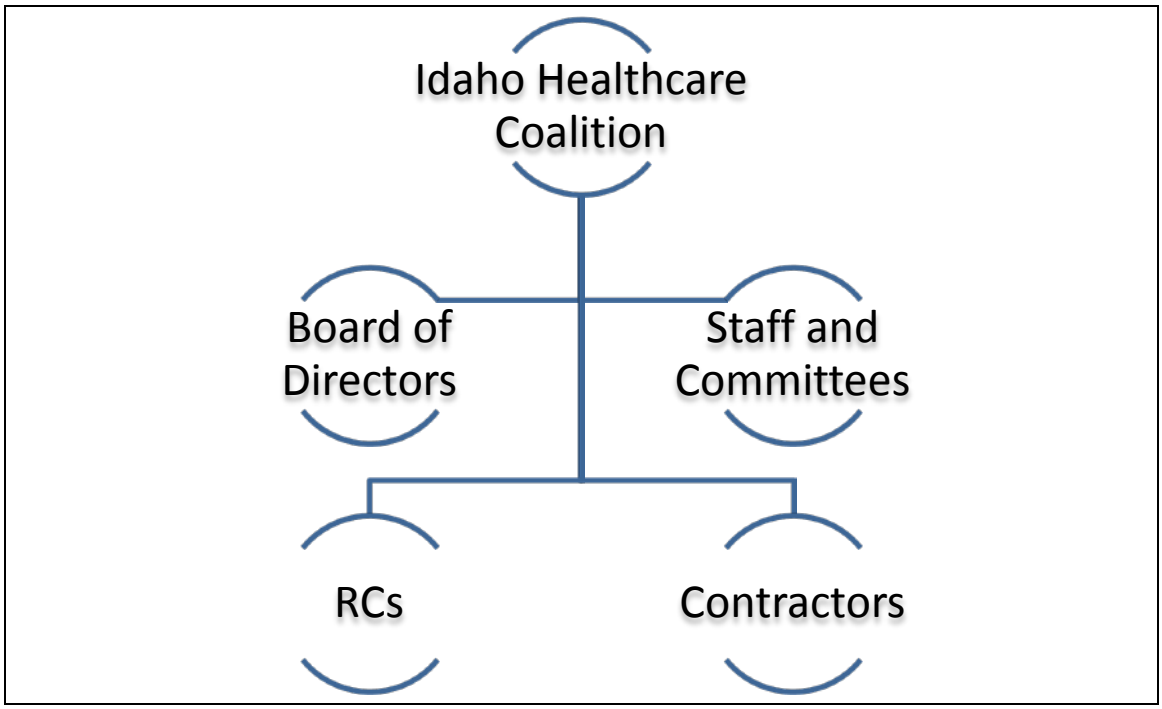
[14] Idaho House Bill 494, 2010 Legislature.

[15] Idaho Code §56-1054



In sum, the functions of the IHC include:

- Provide ongoing support, encouragement and consultation to practices endeavoring to transform to a PCMH, both directly and through the IHC's RCs. Examples of assistance include:
  - Assisting PCMHs in identifying strategies and resources needed to sustain practice changes.
  - Facilitating resources needed across the various levels of the model to achieve transformation goals.
  - Facilitating spread of best practices.
  - Providing education and technical assistance on data collection methods and performance reporting.
  - Providing training and support in the establishment of patient registries and the adoption and utilization of HIT tools, (e.g. EHRs, patient portals).

- Administer and monitor funding to assist PCPs with up-front costs of implementing the PCMH model.

- Develop basic core requirements for designation as a PCMH, assess practices' fulfillment of the requirements and designate practices that meet the core requirements as PCMHs. Practices designated as a PCMH must obtain at least Level 1 PCMH accreditation from a national accrediting body within a timeframe to be established by the IHC.

- Identify national accreditation organizations which will be recognized as accrediting bodies within the model. Provide technical assistance, supports and resources to practices as they work to achieve PCMH accreditation. Provide incentives to PCMHs to advance in accreditation levels.

- Develop statewide baseline data on the measures that comprise Idaho's Performance Measure Catalog (further described in this section) and set statewide performance targets.

- Evaluate performance measures at the state, regional and PCMH level. Provide feedback to PCMHs and RCs on performance trends and facilitate the implementation of quality initiatives to improve performance and health outcomes.

- Partner with State and local public health districts to conduct, review, and analyze the results of the regional community needs assessments (using the CDC Community Health Assessment and Group Evaluation tool) and work with the RCs to implement activities to target improvement in identified areas of need.

- Recruit practitioner and medical neighborhood participation in the model through physician and community educational materials and other educational forums. Work with payers, provider associations, State agencies, community-based organizations and others to facilitate understanding and expansion of the model.

- Convene payers to establish parameters for components of the payment arrangement, including patient population risk stratification and patient attribution.

With the evolution of the IHC's responsibilities over time and the need to operationalize the IHC quickly in order to enter the model testing phase, the IHC must have the flexibility to hire staff quickly and provide resources and supports in response to the needs of practices, medical neighborhoods, and regional networks. Stakeholders recommended that the IHC not be established as a governmental or quasi-governmental entity in order to allow the organization the flexibility and responsiveness that the growing system will demand.

Idaho's commitment to healthcare system reform is evident in the decision of the SHIP Steering Committee to continue its work to further refine the model and prepare for its implementation. The Steering Committee has identified several tasks that need to occur prior to the model testing period, including establishing the IHC and developing an initial IHC staffing plan, to be finalized by the IHC's Board of Directors. Key initial positions are likely to include an executive clinical director, staff with expertise in quality, information management, and finance, and regional collaborative staff. Due to the potential for the IHC's staffing needs to change over time, some key functions of the IHC will be initially fulfilled through contractual arrangements with technical experts in the areas of quality, data management, and clinical care. The IHC's staffing needs may change over time as its role changes in the developing system.

The SHIP Steering Committee will develop criteria and a process for the selection of the IHC Board of Directors and will oversee Board appointments. Under the direction of the Board, the IHC will establish a committee structure to research, evaluate, and make recommendations in targeted areas. Committees will advise in areas of behavioral health integration, quality improvement including performance evaluation and feedback, HIT standards and improvements, clinical care, evidence-based practices, and other key areas of focus related to advancement of the model and population health management.

Regional Collaboratives

The challenges that all primary care practices, but especially small practices, face in becoming a PCMH are well documented. Recent studies have shown that PCP practices transition to PCMH status more easily and more quickly when practice support tools are available close to the practice

level.[16] A wealth of research from the CCNC model and other similar models has also shown the value of building regional networks to support physician practices.

The IHC will establish RCs to provide support services to local practices endeavoring to become PCMHs and to existing PCMHs as they work to enhance their capacity to provide comprehensive, coordinated, high quality care. Lessons learned from the IMHC pilot identified the need for support at the local and regional level in addition to statewide oversight. Participating practices in the IMHC pilot receive technical assistance and guidance from the statewide collaborative but physician practices have no regional forum for navigating their local health system, sharing best practices, and collaborating with other practices that face similar challenges in their area. A key lesson learned from the IMHC is that support for practices is needed at the local level to achieve the greatest impact in an efficient manner.

The mission of the RCs is to help practices transform to the PCMH model and provide high quality care in an efficient and cost-effective manner through the model. The RCs will be a regional extension of the IHC and in this capacity will facilitate, at the local level, the integration of PCMHs in the larger healthcare system. RCs will play a critical role in establishing referral and communication protocols between the PCMH and other providers in the medical neighborhood, e.g., specialty care, hospitals, behavioral health, IHS and tribal programs, elder care services, social service organizations. RCs will also support public health and local organizations' efforts to assess the health needs of the community through the CDC's Community Health Assessment and Group Evaluation tool and provide a forum for sharing assessment results with PCMHs. The RCs will work with PCMHs and others in the community to implement activities in response to the identified health needs and support local innovation.

A key role for the RCs is assisting practices in implementing quality improvement initiatives. The focus of these initiatives will include activities to advance fulfillment of PCMH requirements, expand the use of evidence-based clinical care within the practice, improve performance in targeted areas, and implement activities and services in response to community health needs. Together the IHC and RCs will provide feedback to the PCMH regarding practice performance and identify resources needed to help the practice improve the quality of care and patient experience. Through these supports, Idaho's primary care practices will move beyond an individual, disease-specific focus to functioning as a key driver in population health management.

As noted previously in the SHIP, the capacity of practices to fulfill all the requirements of a PCMH will vary by practice. Practices in under-resourced areas will receive additional supports from the RC, including providing direct resources for critical components of the model such as care coordination, arranging for after-hours care, and behavioral health specialty consultation.

In sum, the key function of the RCs will be to support practices and the PCMH model through a variety of activities, including the following:

- Encourage adoption of the PCMH model through physician and medical neighborhood education. This will be achieved through numerous approaches, including training and toolkits related to clinical, quality improvement, and HIT improvements, evidence-based best practices and Health Insurance Portability and Accountability Act (HIPAA) security efforts.

- Facilitate implementation and accreditation of the PCMH by providing resources and supports, such as trained facilitators, to guide practices through the transformation process.

[16] http://link.springer.com/article/10.1007/s11606-013-2386-4

- Ensure ongoing success of the PCMHs by supporting regional and practice-level data gathering and analytics using systems and reports created at the IHC.

- Partner with local public health experts to conduct the periodic community needs assessment using the CDC's Community Health Assessment and Group Evaluation tool. Use assessment results to identify additional activities, services, and practice improvements that are needed to improve the community's health.

- Advise the IHC on effective quality initiatives for their region and PCMHs based on local knowledge of communities and cultures.

- Provide on-the-ground assistance to the PCMHs, or secure the technical assistance from the IHC on behalf of the region, in order to attain improved quality care and achieve good health outcomes within the region.

- Facilitate coordination and integration of services through strengthening relationships between the PCMHs and the medical neighborhood. Assist the PCMH in establishing formal communication and referral protocols between the practice and medical neighborhood.

- Provide support for under-resourced practices that need help in fulfilling the requirements of a PCMH. Support may be provided through contractual arrangements, staffing, and/or facilitation of shared resources across PCMHs.

Idaho Department of Health and Welfare

To achieve total transformation of Idaho's healthcare system, the model encompasses a multi-payer approach. This requires participation, collaboration, and partnership with many key entities across the State. Most notable are the three major commercial payers: Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource. IDHW is another large payer in Idaho's healthcare system as the single State agency for Medicaid. While the role of each payer, large or small, is valued and deemed important to the success of the model, special note is given to the role of IHDW in the future system for a number of reasons. First, IDHW is uniquely positioned to facilitate the integration of publicly funded behavioral health and long term care services in the model as the administrator of those programs. Through changes to those programs' policies and payment mechanisms to better align programs at the State level, the current siloed systems can become better coordinated to provide more effective and efficient care for the individual. IDHW will embrace the opportunity to develop program policies, establish contract requirements, and implement payment mechanisms across Medicaid primary care, public health, behavioral health, and long term care services and supports (i.e., home- and community-based services (HCBS)) to support the coordination and integration of these services within the PCMH and across the medical neighborhood.

Secondly, through education and outreach to its sister agencies administering elder care, correctional health services, education and juvenile justice programs, IDHW will further advance understanding and support of the PCMH model. IDHW will advocate and support coordination of program requirements, policies, and payment mechanisms across programs whose services are to be integrated at the community level in order to best support improved community health. Through collaboration at the State level, partnerships at the community and regional levels will more easily be formed and supported. More information regarding how existing State and federal health initiatives will be leveraged in the new model can be found in Section 6.

IDHW will also seek grant funds and potentially other sources of revenue to support the implementation of the model.

As noted previously, true transformation of the system cannot be achieved without participation of multiple payers, all of which are important partners in the State's healthcare system. As Idaho moves from implementation of the new system to sustaining the integrated, comprehensive system, IDHW and other major payers will continue to play an important role in supporting PCMHs and improving health outcomes for the State's residents.

Payment Model

Current Payment Methods

Fee for service (FFS) payment is the most common payment method, across the private and public market, in Idaho today. Commercial payers have a significant role in Idaho's healthcare delivery system as over half of Idahoans are covered through commercial plans. Among commercial payers, the dominant plan type is preferred provider organizations (PPOs). The prevalence of health maintenance organizations (HMOs) is small, with only a 5.4% penetration rate in July 2011 as compared to 22.5% nationally.[17]

In 2012, there were 242,889 Medicare beneficiaries in Idaho,[18] representing about 15% of the State's population. Approximately 70% of these Medicare beneficiaries received services on a FFS basis, and 30% (70,562) were enrolled in a MA plan offered by various insurers, including the three major insurers. Many of the Medicare beneficiaries in MA plans (38,861) were in local PPOs, while 24,454 were enrolled in HMOs and 6,815 in private FFS (PFFS) plans.[19] There were only 632 beneficiaries enrolled in a Special Needs Plan for Duals (D-SNP) for persons on both Medicare and Medicaid.[20]

The Idaho Medicaid Program is administered by the Division of Medicaid, which is located in the IDHW. In federal FY 2012, 237,801 average monthly eligibles were enrolled in Idaho Medicaid/CHIP, which represented an estimated 14.8% of the State's population that year.

The Idaho Medicaid State Plan offers four benefit packages: the Standard State Plan, which provides mandatory minimum benefits, and three benefit plans that are aligned with the health needs of specific populations and include an emphasis on prevention and wellness. The Basic Plan is for low-income children and adults with eligible children who have average healthcare needs. The Enhanced Plan is for participants with disabilities or special health needs. The Medicare-Medicaid Coordinated Plan is for participants who are enrolled in both Medicare and Medicaid. Participants in the Medicare-Medicaid Coordinated Plan can voluntarily elect to receive some of their Medicaid coverage through Blue Cross of Idaho, which is an MA Plan.

Most participants in the Medicaid Basic or Enhanced Plan must enroll in Healthy Connections, a mandatory primary care case management (PCCM) program that was implemented in 1992. Under

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[17] [17] The Kaiser Family Foundation State Health Facts, viewable at http://kff.org/other/state-indicator/hmo-penetration-rate/

[18] Henry J. Kaiser Family Foundation, State Health Facts: Total Number of Medicare Beneficiaries. Referenced on August 7, 2013 viewable at http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/

[19] Henry J. Kaiser Family Foundation, State Health Facts: Medicare Advantage: Total Enrollment, by Plan Type. Referenced on August 7, 2013 viewable at http://kff.org/medicare/state-indicator/total-enrollment-by-plan-type/

[20] Henry J. Kaiser Family Foundation, State Health Facts: Medicare Advantage: Special Needs Plan (SNP) Enrollment by SNP Type. Referenced on August 7, 2013 viewable at http://kff.org/medicare/state-indicator/snp-enrollment-by-snp-type/

this program, Medicaid participants must select or be assigned to a PCP. The PCP is responsible for coordinating care and providing referrals for most medically necessary services not provided by the PCP. In addition to reimbursement for services rendered, PCPs enrolled in Healthy Connections are paid a monthly case management fee. The fee is increased by $0.50 PMPM when the PCP's office offers extended hours of service to see patients equal to or greater than 46 hours per week.

Most Medicaid services are paid by IDHW on a FFS basis. However, Idaho Medicaid does provide some services through capitated managed care contracts. The Medicare-Medicaid Coordinated Plan is provided through a capitated contract with Blue Cross of Idaho. Idaho Medicaid contracts on a capitated basis with a transportation broker to administer, coordinate, and manage all non-emergency medical transportation (NEMT) for eligible Idaho Medicaid participants. Dental services for all participants are provided through a capitated contract with Blue Cross of Idaho and its subcontractor DentaQuest. Since September 1, 2013, Idaho Medicaid also contracts on a capitated basis with Optum to administer behavioral health services to eligible Medicaid participants.

Bridge to Payment Model Reform

All three of Idaho's major commercial payers and Medicaid participate in the IMHC. Through this initiative, new payment methods have been piloted. Blue Cross supports medical homes in the IMHC pilot with a tiered PMPM structure. Providers meeting the mandatory participation criteria are eligible for a PMPM for patients with qualified chronic conditions (asthma, diabetes, and/or congestive heart failure) who opt in to the program. Practices meeting additional optional participation criteria are eligible for an enhanced PMPM. Regence supports participating providers with a PMPM to support an embedded registered nurse (RN) care manager for the top 3%–5% of the sickest patients attributed to the practitioner/clinic, supporting participating clinics with a PMPM for members who meet eligibility criteria, including diagnosis of severe and persistent mental illness (SPMI)/ SED, diabetes and asthma, diabetes and a co-morbidity or specified risk factor, or asthma and a co-morbidity or specified risk factor.

The Idaho Medicaid program has implemented health homes pursuant to Section 2703 of the ACA and is part of the IMHC. The Medicaid health homes program is an enhancement of the IMHC for persons with a qualifying chronic health diagnosis. The additional Medicaid requirements include providing 46 hours of clinic access per week for patient care and providing timely clinical advice by telephone during office hours (NCQA Standard 1; Element A; Factor 2), or by secure electronic messages during office hours (NCQA Standard 1; Element A; Factor 3).

Medicare is funding payment method reform initiatives in Idaho to move from reimbursement of volume towards reimbursement of value through ACO and PCMH initiatives. The St. Luke's Clinic Coordinated Care ACO will distribute shared savings from improved outcomes and lowered costs to the providers participating in the joint venture through an arrangement that dictates 25% for strategic infrastructure investments; 25% for care process redesign; and 50% for provider compensation. These payment model innovations are beginning to change the way that Medicare pays for health services in Idaho, laying a foundation for Medicare's role in the new PCMH model.

Gaps in Current Payment Methods

As noted above, Idaho's current payment methods are still heavily reliant on FFS arrangements that reward quantity of care. As a result, stakeholders identified that the volume of services is too often driven by financial incentives rather than the needs of patients. The current payment system rewards providers that generate a high volume of services for the purpose of attaining financial viability over providers that establish patterns of clinical services for the purpose of attaining good health outcomes for their patients. History in Idaho has shown that the unfortunate consequence of

this arrangement is that, too often, services are duplicated and care is uncoordinated. For the patient, staying healthy in this system can be burdensome, as the patient is caught in the role of being his or her own care coordinator. For the provider, the quality of the patient relationship is diminished and the provider is frustrated because they often just do not have the tools to provide the best possible care. The net effect of this payment system is that care is costly and outcomes are often poor.

Stakeholder Deliberations Regarding Payment Model Reform

The Multi-Payer work group, comprised of representatives from Idaho's three major commercial payers, two largest hospital systems, the Idaho Hospital Association, Idaho Medicaid, the local public health districts, employer groups, including self-insured employers, and the Idaho Department of Insurance and physicians, met regularly to discuss the transition from FFS payment (payment based on volume), to payment based on outcomes. The work group began by discussing a spectrum of delivery system/reimbursement model options from FFS to fully integrated models (ACOs, MCOs). Given the geographical complexities of Idaho, and the starting point of Idaho's current care delivery system, the group thought moving directly to fully integrated care and reimbursement models for all of Idaho might be difficult and proposed taking an incremental step of moving Idaho's medical delivery system to PCMH networks. This would not exclude organizations from moving to more advanced integrated care models.

After deciding on a phased approach for the delivery system, payment options were discussed. Options considered were combinations of PMPMs, quality incentives, shared savings, risk-sharing, partial capitation, and full capitation. Consensus around a blend of PMPM payments, quality incentives, and shared savings was immediate, although the work group thought it should be a phased approach. Capitation and risk-sharing were deemed unlikely to succeed or gain enough support in Idaho. This is due in part to Idaho's low average healthcare costs. Physicians were also skeptical of risk-based payments without including some incentive for patient compliance to prescribed treatment.

Innovative concepts around payment for telehealth and non-face-to-face (e.g., phone or email) consults and visits were deemed necessary because of the rural nature of Idaho. All payer representatives deemed payment for these non-traditional visits necessary but agreed that it would take some time to determine appropriate payment levels and update provider contracts.

Regarding PCMH payment, stakeholders that were participants in the IMHC pilot were quick to point out that the PMPMs paid in the IMHC, which was designed for patients with chronic conditions, only covered about half of the costs necessary to maintain the PCMH. In order to make the concept financially feasible, more patients would need to be attributed to the PCMH, including attribution of healthy consumers that rarely use medical services.

Payment approaches for PCMHs from other states were considered, such as the up-front payment used in Southeast Pennsylvania; payment for achieving higher NCQA PCMH recognition status, like in Colorado; and payment based on the complexity of the patient, like Minnesota. The work group agreed to adopt all of these payment approaches as part of Idaho's model. CCNC was also discussed but not deemed an appropriate model since it was Medicaid-only and would not generate the multi-payer, statewide reform that Idaho envisions.

PCMH attribution methodologies discussed included retrospective attribution based on claim and utilization history, patient selection, and prospective PCMH assignment. The work group decided to propose all of these methodologies, except that prospective assignment will include the option for the patient to change the PCMH assigned. Each payer will determine which attribution methodology

(ies) to use as negotiated with its contracted PCMHs. Both Medicaid and the three major commercial payers (including for their MA Plans) agreed to attribute membership. However, the commercial payers may implement attribution using a phased approach (e.g., patients with chronic conditions first).

Future Payment Model

Idaho will transition to incentivizing value as opposed to volume by aligning payment mechanisms across payers. The components of the new payment model are transformation start-up payments and accreditation payments provided to the PCMH through the IHC, PMPMs for care coordination, total cost of care shared savings arrangements, and quality incentives provided through the payers participating in the model. Details of these components are described below.

Transformation Start-Up Payments

Payments to support practice transformation to a PCMH will be distributed by the IHC and financed through Model Testing Proposal grant funding. The funding is intended to support practices endeavoring to meet, at a minimum, Level 1 PCMH accreditation requirements. The IHC will be responsible for determining eligibility criteria for receipt of funding. Funding will only be provided to those practices that identify resources needed based on a readiness review (developed by the IHC) that identifies practice gaps and needs. The start-up payments are intended to be sufficiently high to recruit existing and new practices to become PCMHs by covering most of the costs associated with becoming a PCMH, including establishment of patient registries, system and practice process changes, and time spent training physicians. The amount of the funding will vary depending on the estimate of the costs associated with building a practice's capacity to achieve Level 1 accreditation. Milestones for closing the gap and achieving practice transformation will be established by the IHC for each practice and monitored with the aid of the RCs. Practices that are not achieving adequate progress toward accreditation will not receive the balance of their approved funding. Moreover, if a practice does not meet the minimum level of PCMH accreditation within the specified timeframe, the practice will have to return funding per policies and controls established by the IHC.

Current PCMHs in the State will also be eligible for "start-up" funding, though this funding will be used to help defray their costs of further enhancing their functionality as a PCMH. Examples of established PCMH activities eligible for funding are adoption and training in the use of clinical decision tools, improvements of EHR and HIT functionality, expansion of patient registries, advancement of telehealth within the practice and community, and other tools and activities that support the advancement of the model and improved health outcomes. The IHC will determine eligibility criteria and the process for applying and receiving funds. As with non-PCMH practices, milestones, and conditions for continued funding and/or recoupment of funds will be established and monitored by the IHC.

Accreditation Payments

To encourage practices to achieve higher levels of accreditation, the IHC will also use Model Testing Proposal grant funds to provide PCMHs with tiered accreditation payments. Practices will receive one-time payments upon achieving each level of the accreditation by a nationally recognized accreditation organization, as approved by the IHC. These payments are intended to reimburse practice costs related to building functionality in order to perform as a more advanced PCMH.

Per Member per Month Payments

Payers will provide PCMHs achieving at least State designation as a PMPM to support ongoing PCMH activities (e.g., care coordination, patient management). PCMHs already established will

receive PMPM payments to expand their efforts from their previous focus on chronic disease patients to all patients. Payers will negotiate PMPMs with PCMHs through their regular contract negotiation processes. PMPMs are expected to escalate based on patient complexity. During the Implementation period, the IHC will convene the participating payers to set parameters for the payer's patient population risk stratification methodology upon which the payers will build their PMPM amounts. Payers will require PCMHs to complete evidence-based education and training in chronic care models and behavioral health programs in order to qualify for higher PMPMs based on patient complexity. The IHC will work with payers to establish standards for training requirements.

Total Cost of Care Shared Savings Arrangements

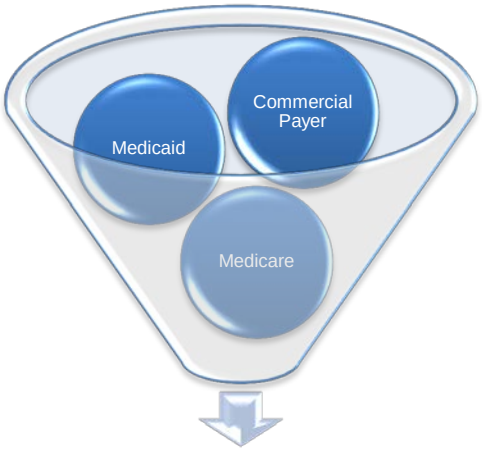
As the cost of care begins to decrease through decreased emergency department visits, decreased use of non-generic drugs, etc., payers will begin to incorporate total cost of care shared savings arrangements in contract negotiations with their PCMHs. The IHC will expect that total cost of care shared savings arrangements follow CMS guidelines. If a significant portion of the payment to the PCMH is tied to the shared savings arrangement, the provider may be required to hold stop loss insurance.

Quality Incentive Payments

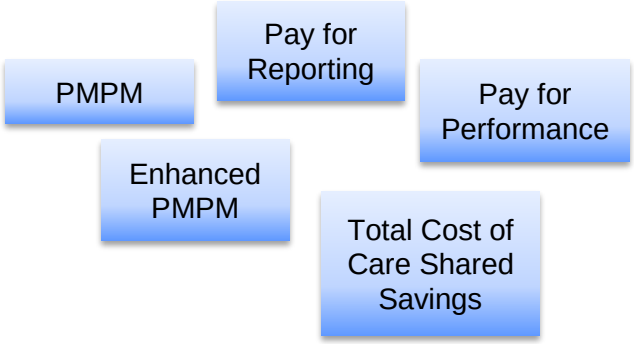
To incentivize PCMHs to report quality data and improve outcomes, the payers will also begin to incorporate quality incentives in their contractual arrangements with PCMHs that achieve at least a Level 1 accreditation. This will begin as a "pay for reporting" payment and will evolve into a "pay for performance" payment. The specifics of the payments will be negotiated between the payers and the PCMHs. As previously mentioned in the SHIP, the IHC and its RCs will provide technical assistance to PCMHs to assist with meeting "pay for reporting" then "pay for performance" requirements.

Summary of the Future Payment Model

Idaho's future PCMH model has higher up-front costs as compared to FFS but is designed to reduce future costs by transforming how care is organized and delivered. Payments to the PCMH as detailed above will be additive as the PCMH grows capacity. As shown in the graphic below, practices desiring to transform to a PCMH will receive transformation start-up payments to facilitate increased capacity to perform the functions of a PCMH. Practices that meet the requirements for State PCMH designation will be eligible to receive PMPMs for PCMH activities through the payers. As the PCMH continues to expand its capacity as a PCMH and meet accreditation requirements, it will become eligible for the accreditation payments and eventually for quality incentives and shared-savings payments. Practices that are already PCMH-accredited or are further along on the path towards PCMH accreditation, such as the practices that are currently participating in the IMHC, will qualify for the PMPMs, quality incentives and shared-savings payments more quickly.



Multi-Payer Model



Performance Measurement and Population Health Management

Current Performance Measures

General

The major entities involved in measuring and evaluating Idaho's current healthcare system are IDHW (including the Division of Public Health, the Division of Behavioral Health and the Division of Medicaid), commercial payers, Medicare, and the local public health districts. However, no standardized data collection or performance reporting across payers or populations exists today. Measures are reported in various forms and in silos that make it difficult or impossible to measure population health changes across Idaho. As such, Idaho does not currently have a mechanism to conduct statewide measurement of the complete picture of health of Idahoans or evaluate the performance of its healthcare delivery system.

Some of the main sources of healthcare performance data collected and used by IDHW are the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Tracking System (PRATS), the Vital Records, and community health surveys conducted by Idaho's providers and local public health districts using the CDC's Community Health Assessment and Group Evaluation tool. Other sources of healthcare performance data are reportable disease tracking, the Cancer Data Registry of Idaho, and the Idaho Trauma Registry. Based on information from these data sources and other assessments of public health indicators, IDHW has developed its 2011-2014 strategic plan, which includes the following objectives aimed at improving health:

- Improve healthy behaviors of adults to 75.40% by 2015. This measure is a composite of five healthy behavioral indicators: (1) not a current smoker (2) consumes five or more fruits and

vegetables a day, (3) not a heavy drinker of alcoholic beverages, (4) participates in leisure time physical activities and (5) has not used illicit drugs in the past 12 months.

- Increase the use of evidence-based clinical preventive services to 70.33% by 2015 as measured by the Clinical Preventive Services Composite. The performance measure is a composite of six evidence-based clinical preventive service indicators that impact health. They are the number of: (1) adults screened for cholesterol in the last five years, (2) adults 50 and over who have ever received colorectal cancer screening, (3) women age 40 and over who received a mammogram in the last two years, (4) adults who had a dental visit in the last 12 months, (5) women who received adequate prenatal care and (6) children 19–35 months whose immunizations are up to date.

Currently, IDHW also publishes performance measures on its CHIP population in the State's annual CHIP report. In the 2012 report, the performance measures and current performance levels were:

- Chlamydia screening (34.76%),
- Well-child visits in the first 15 months of life (38.22% for 6+ visits),
- Well-child visits in the third through sixth years of life (51.4%),
- Adolescent well-care visits (30.53%),
- Access to primary care practitioners (91.65% for 12–24 months, 75.79% for 25 months–6 years, 61.9% for 7–11 years, and 61.13% for 12–19 years),
- Appropriate testing for children with pharyngitis (72.3%),
- Emergency department visits (11.5 visits per 1,000 member months), and
- Asthma patients with one or more asthma-related emergency department visit (2.99%).

The State's quality goals for the CHIP population include 95% of children having a medical home (current rate is 93%) and 90% of two-year olds having up to date vaccinations (current rate is 68.9%).

Similar to the IDHW, the local public health districts produce an annual strategic plan and an annual performance measurement report. The performance measures in the 2012 performance measure report[21] include measures from the BRFSS (percent of adults who smoke, percent of adults with diabetes, percent of adults who are overweight and/or obese, and percent of adults with asthma) and Vital Records (teenage pregnancy rate 15–19 years of age).

There is very little public information on the performance of Idaho's commercial payers or providers. While a select few commercial payers in Idaho (Aetna, SelectHealth, and United HealthCare) are NCQA-accredited, none of the three major commercial payers are currently NCQA-accredited. However, BlueCross of Idaho and PacificSource are scheduled to have NCQA accreditation reviews in early 2014 for their exchange products. PacificSource's review will also include its

commercial PPO. Regence is in the process of obtaining Utilization Review Accreditation Commission health plan accreditation.

Current Health Status of Idahoans

The limited State-level information available through State and national sources indicate that the health status of Idahoans is generally considered to be average as compared to other states.[22] However, there are areas of concern. These include childhood immunizations, obesity, diabetes, tobacco use, and mental health disorders.

- In 2010, **62.9%** of adults were overweight and **26.9%** were obese
- In 2010, **one of every 12** adults had diabetes
- Idaho ranked **fifteenth** in the country in prevalence of adult smokers
- In 2008–2009, **22.5%** of Idahoans age 18 or older had a mental illness
- Idaho ranked **fortieth** in the nation on the number of suicides per 100,000 population
- In 2011, **13.4%** of children were overweight, while **9.2%** were obese
- In 2012, Idaho ranked **forty-third** for the percent of children ages 19 to 35 months who received all recommended vaccines

[22] See, e.g., *America's Health Rankings®*— 2012 Edition, which is available at www.americashealthrankings.org and the 2011 National Healthcare Quality Report, available at http://statesnapshots.ahrq.gov/snaps11/

One area in which Idaho ranks poorly compared to other states is childhood immunizations. According to America's Health Rankings 2012,[23] Idaho ranked forty-third for the percent of children ages 19 to 35 months who received all recommended vaccines. Similarly, the 2011 National Healthcare Quality Report (NHQR) ranked Idaho as forty-ninth on this measure.[24]

Another area of concern is the number of Idahoans who are overweight or obese. In 2010, 62.9% of adults in Idaho were overweight (i.e., had a BMI of 25 or greater) and 26.9% were obese (i.e., had a BMI of 30 or higher).[25] Since 2003, there has been a significant increase in the percentage of Idaho adults who are overweight and obese. Men are significantly more likely to be obese than women. College graduates are significantly less likely to be obese than those with lower levels of education. In 2011, 13.4% of Idaho's children were overweight as defined by being above the eighty-fifth percentile but below the ninety-fifth percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the ninety-fifth percentile for BMI by age and sex.[26]

In 2010, the prevalence of diabetes among adult Idahoans was 8.0%. Overall this represented one in 12 people in the State.[27] Those with incomes below $25,000 were twice as likely to have diabetes as those with incomes of $25,000 or more.

In 2010, 16.9% of adult Idahoans were smokers, which meant that Idaho ranked fifteenth in the country in prevalence of adult smokers, and Idaho's smoking-attributable mortality rates ranked eighth among the states.[28]

As previously mentioned in the SHIP, behavioral health conditions are a significant area of concern in Idaho. In 2008–2009, 22.5% of Idahoans age 18 or older had a mental illness and 5.8% had a severe mental illness.[29] According to the 2011 National Healthcare Quality Report,[30] Idaho ranked fortieth on the measure of suicide deaths per 100,000 population. In 2010, suicide was the second leading cause of death among Idaho residents ages 15 to 34.[31]

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[23] *America's Health Rankings®*— 2012 Edition is available at www.americashealthrankings.org

[24] See the 2011 National Healthcare Quality Report, available at http://statesnapshots.ahrq.gov/snaps11/

[25] *Idaho Behavioral Risk Factors: Results from the 2010 Behavioral Risk Factor Surveillance System*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx

[26] Results of the 2011 Idaho Youth Risk Behavior Study, Published by the Idaho Department of Education, viewable at http://www.sde.idaho.gov/site/csh/docs/YRBS%202011.pdf.

[27] 2010 Report: At A Glance. Published by IDHW, Public Health Division, Bureau of Community, and Environmental Health published 2011 viewable at http://www.healthandwelfare.idaho.gov/Portals/0/Health/ataglance_LR.pdf.

[28] Center for Disease Control-Tobacco Control State Highlights for 2010 published in 2011 viewable at http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/pdfs/states/idaho.pdf.

[29] Mental Health, United States, 2010 Report produced by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration viewable at http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf

[30] See the 2011 National Healthcare Quality Report, available at http://statesnapshots.ahrq.gov/snaps11/

[31] *Idaho Behavioral Risk Factors: Results from the 2010 Behavioral Risk Factor Surveillance System*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx

Additional information regarding current population health statistics and delivery system performance can be found in Appendix F.

Bridge to Performance Measurement Reform

The IMHC pilot has opened new opportunities to assess the performance of Idaho's healthcare delivery system in a more comprehensive manner. Through the pilot, public and private payers are, for the first time in Idaho, jointly requiring providers to report on performance measures. Participating practices report data for two clinical quality measures from the list below unless asthma is chosen, which requires all three asthma-related measures to be reported:

- Diabetes: Hemoglobin A1c Testing (NCQA – NQF # 57).
- Diabetes HbA1c Poor Control (NCQA – NQF # 59).
- Controlling High Blood Pressure (NCQA – NQF # 18).
- Hypertension: Blood Pressure Measurement (AMA – PCPI – NQF # 13).
- Anti-Depressant Medication Management; Effective Acute Phase and Effective Continuation Phase Treatment (NCQA – NQF # 105).
- Screening for Clinical Depression (CMS – NQF # 418).
- Asthma Assessment (AMA – PCPI – NQF # 1).
- Asthma Pharmacologic Therapy (AMA – PCPI – NQF # 47).
- Management Plan for People with Asthma (IPRO – NQF # 25).

In addition to the above measures, IMHC also specifies that participating practices report on two practice transformation measures. Each payer has specified additional reporting requirements. For example, Regence requires its providers to report on three HEDIS measures: low-density lipoprotein (LDL) control for cardiovascular conditions, LDL control for diabetes, and adult body mass index (BMI) value. Performance targets for these measures are set by the payers and will be monitored by the payers and IMHC.

Gaps in Current Health System Performance Measurement

As part of the model design process, an environmental scan of clinical quality and beneficiary experience outcomes was conducted. As noted above, the analysis revealed that there are currently no standard performance measures across public and private payers or programs. Providers collect and report data according to specific payer requirements but there are no uniform reporting requirements that provide statewide assessment and performance targets.
Statewide population health information is available through IDHW's annual reports and the IDHW website but the ability to analyze this data by region or other variables is limited. Additional pockets of information regarding quality and cost of care is available, but is restricted to specific systems, provider groups, or payers, and is often proprietary. Across providers and health systems, there is a lack of a consistent model or approach to defining, collecting, reporting, and utilizing performance measure data. At the provider level, practices often lack the tools and technology necessary to report data needed for system-wide analysis to inform the development of system-wide performance measures.

Future Performance Measures

Performance Measure Catalog: Initial Set of Performance Measures

To address the lack of standard performance measures across public and private payers or populations in Idaho, the CQI work group identified the need for a performance measure catalog, such as the Massachusetts Quality Measure Catalog which is an inventory of the healthcare quality measures currently in use in Massachusetts. Idaho's initial performance measure catalog was developed by the CQI work group and adopted by the Steering Committee. The development of this catalog by stakeholders that represent a cross-section of providers, payers and other health system participants, is an innovative and important step forward for Idaho, and will ensure alignment of quality measurement and improvement activities across the State. The performance measures selected for inclusion in the catalog were targeted because they represent the areas with the most need for health improvement across all Idahoans, and also represent a balance of short-term and long term goals.

Idaho's Initial Performance Measure Catalog

Measure Name (and Source)	Measure Description	Rationale for the Measure
Screening for clinical depression.	Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow up plan documented.	In Idaho, 22.5% of persons aged 18 or older had a mental illness and 5.8% had SMI in 2008–2009 while 7.5% of persons aged 18 or older had a major depressive episode (MDE). During the period 2005–2009, 9% of persons aged 12-17 had a past MDE. Suicide is the second leading cause of death for Idahoans aged 15–34 and for males aged 10–14. This measure aligns with Healthy People 2020.
Measure pair: (a.) Tobacco use assessment.	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.	In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.
(b.) Tobacco cessation intervention (SIM).	Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	
Asthma ED visits.	Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	While asthma prevalence (those with current asthma) in Idaho was 8.8% in 2010, reduction of emergency treatment for uncontrolled asthma is a reflection of high quality patient care and patient engagement.
Acute care hospitalization (risk-adjusted).	Percentage of patients who had to be admitted to the hospital.	While Idaho has one of the country's lowest hospital admission rates (81/1000 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Readmission rate within 30 days.	Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	Data currently unavailable. Metric will be used to establish baseline.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of a hospital ED.	While Idaho has one of the country's lowest hospital ED utilization rates (327/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of emergency services, as well as a reflection of quality and patient engagement in primary care related to avoidable treatment.
Elective delivery.	Rate of babies electively delivered before full-term.	Data currently unavailable. Metric will be used to establish baseline.
Low birth weight rate (PQI 9).	This measure is used to assess the number of low birth weight infants per 100 births.	While Idaho's percentage of low birth weight babies is low compared to the national average, the opportunity to improve prenatal care across settings is an indicator of system quality. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia (HEDIS).	The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Idaho has a 100% shortage of mental health providers statewide. Without these critical providers, there is little or no support for patient engagement and medication adherence. Improved adherence may be a reflection of improved access to care and patient engagement.
Weight assessment and counseling for children and adolescents (SIM).	Percentage of children, two through 17 years of age, whose weight is classified based on BMI, who receive counseling for nutrition and physical activity.	In 2011, 13.4% of children were overweight as defined by being above the 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th percentile for BMI by age and sex.
Comprehensive diabetes care (SIM).	The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.	Adult diabetes prevalence in 2010 was 8.0%. Overall, this represented one in 12 people in Idaho had diabetes.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Access to care.	Percentage of members who report they have adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes access to the appropriate level of care.
Childhood immunization status.	Percentage of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	While there have been significant improvements in immunization rates, Idaho ranks 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.
Non-malignant opioid use.	Percent of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.

The development of an Initial Performance Measure Catalog and reporting of statewide performance measures across multiple payers and populations is a major first step for Idaho as we move toward population health management. Idaho will continue to advance slowly but with a definite and unyielding commitment to gather the data and information needed to ascertain the health needs of Idahoans and build a system fully responsive to those needs.

Phased Approach to Building Performance Measure Reporting and Analytics

Idaho proposes to phase in the performance measure reporting and related quality activities, including providing feedback to providers, developing community initiatives, and making performance measure results available to the public.

In Year 1 of model testing, the IHC will establish a baseline for each of the performance measures in the catalog. Due to the lack of uniform reporting that exists today, the IHC will develop a baseline from the pockets of information that are currently available across payers and populations. An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline by the end of Year 1.

During Year 1 of model testing, the IHC will also analyze the current system capabilities and constraints regarding statewide data collection and reporting. The IHC will engage stakeholders in discussion and analysis to ensure that a statewide solution to data collection remains viable and acceptable to the different healthcare communities in Idaho. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will be developed.

In Year 2, the IHC will select four core performance measures from the initial Performance Measure Catalog to be reported by all PCMHs in Year 2. The mandatory statewide performance measures for Year 2 will include the three SIM measures: tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care.

In consultation with the IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3. The additional measures collected in Year 3 may vary from region to region depending on performance and regional health needs and will be informed by community health assessments and regional specific clinical data.

Additional details regarding the proposed performance measure reporting activities by year are described below.

Primary Focus of Year 1

- The IHC gathers baseline data on each performance measure in the Performance Measure Catalog. Baseline data is gathered by an independent, external quality review organization tasked with obtaining data from the various sources and compiling and analyzing the data to establish baselines.

- The IHC educates providers about the Performance Measure Catalog. Providers will receive a toolkit detailing information on the performance measures including explanations and instructions on data collection. Wherever the technical specifications of the measures allow, the toolkit will include pre-formatted templates for data collection to ensure consistency across reporting PCMHs. The RCs will provide on-the-ground training and technical assistance to practices in preparation for performance reporting in Year 2.

- At the end of Year 1, the IHC and RCs will review the baseline data and select four performance measures to be targeted statewide in Year 2, three of which will be the SIMs performance measures of tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care. A fourth required measure will be selected from the Performance Measure Catalog by the IHC after review of the results of baseline data. Statewide performance targets will be set on the four required performance measures via a process that includes the following activities:
  - Research available national benchmarks and evaluate each region's baseline data relative to the benchmark.

- Compare key health system or community initiative elements that support improvement of the measure in regions that do not meet the benchmark target.
- Adjust initial national benchmark targets where necessary to reflect the need for system or program developments that support performance measure improvements.

- The IHC and RCs develop quality initiatives, along with educational campaigns and community initiatives, to support activities to improve selected performance measures that do not meet benchmarks/targets.

Primary Focus of Year 2

- The activities from Year 1 (education, mentoring, developing community initiatives, etc.) continue.

- PCMHs begin reporting on the four required performance measures electronically or via paper records, depending on their reporting capacity.

- A SHIP website is implemented to provide information and education on the PCMH model.

- At the end of Year 2, the IHC and the RCs review regional performance and provide feedback to each PCMH.

- Quality initiatives are developed and implemented to improve performance.

- The IHC and RCs report the number and percent of practices participating as PCMHs and the accreditation phase. This information will be used to update community needs assessments as a part of the continuous quality improvement process.

- The RCs, in consultation with the IHC, identify additional performance measures beyond the initial set of four measures to be reported in Year 3 for their respective regions. Regional-specific performance measures are determined after consideration of both performance results and regional health needs as determined by community health assessment and other clinical and service data. The IHC sets targets for the regional-specific performance measures.

- The IHC, working with the RCs, identifies new measures to add to the Performance Measure Catalog. The IHC's quality committee will have primary responsibility for researching, maintaining, and updating the quality performance measure catalog with new measures and establishing baselines and targets.

Primary Focus of Year 3

- The activities from Years 1 and 2 (identifying new measures, developing baselines and targets, PCMH reporting, providing performance feedback, and implement quality initiatives) continue.

- PCMHs report on statewide performance measures and regional-specific measures.

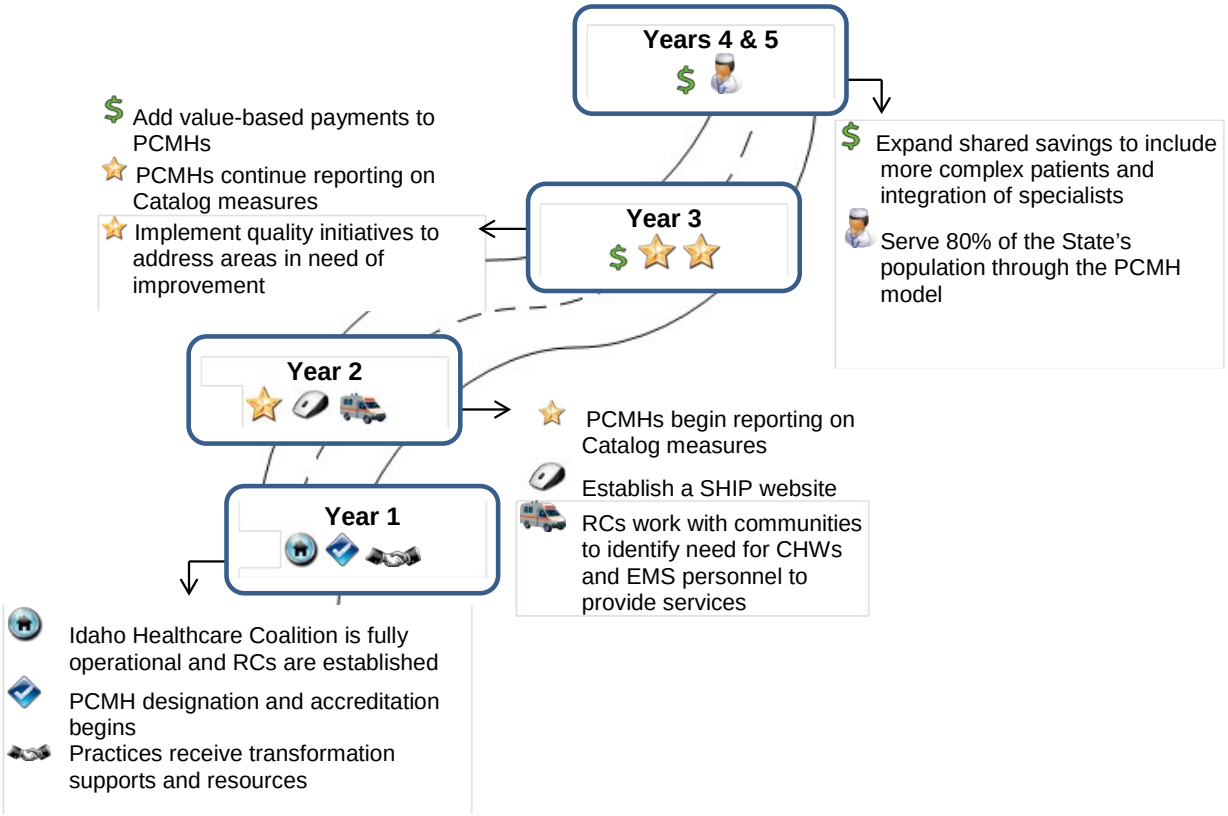
- Additional measures recommended in Year 2 by the IHC's quality committee are added to the Performance Measure Catalog

- At the end of Year 3, the IHC and RCs review performance results and select statewide performance reporting requirements from the expanded Catalog.

- The IHC publishes regional PCMH performance measure results through the SHIP website.

- The IHC and RCs identify additional performance measures to be reported by RCs within their region. Regional-specific performance measures are selected using performance data and results from community health assessments, and may vary from region to region.

Summary of General Roadmap to Model Implementation



3

Financial Analysis

The Populations Being Addressed and Their Respective Total Medical and Other Services Costs as PMPM and Population Total

Idaho's SHIP is designed to lower the overall cost of care for Idahoans, generating savings for the healthcare system. To determine that savings, the multi-payer workgroup began by classifying Idaho's population by payer type: Medicaid, Medicare, and commercial insurance. Medicaid was further divided into dual-eligible recipients, aged and disabled non-dual eligible recipients, children, and adults that did not fall into any other category. Commercial insurance participants were classified by the number of people on their policy: individual or family. Medicare participants were classified into dual-eligible, fee-for-service non-duals, and those with Medicare Advantage Part C coverage.

Medicaid

State projections show that Medicaid recipients are expected to cost nearly $1.4 billion in State Fiscal Year 2014 (SFY 14). 72% of Medicaid recipients in Idaho are children, but children represent only about 29% of the annual Medicaid expenses, or $203.21 monthly per member (PMPM). An area of high cost for this group includes Newborn Intensive Care Unit (NICU) costs for newborns needing neonatal care. A 3.6% annual growth trend, including inflation, would increase the cost of providing care to children to $242.27 PMPM by Year 3 of SHIP model testing without intervention.

The highest cost population among Medicaid recipients is the adult population that is dually eligible for Medicaid and Medicare (known as dual-eligibles), primarily due to the presence of chronic conditions. Costs projected for this population is $1,672.45 PMPM, and $8 million in total expenses in the base year which represents 18% of the Medicaid costs. The adult dual-eligibles are followed closely by the aged/disabled non-dual population, which cost $1,512.40 PMPM. The State projects that annual costs will rise for these populations by 5.1% and 2.6%, respectively, which increases costs to $1,940.17 PMPM and $1,635.73 PMPM in three years, respectively, without any intervention. These groups utilize Emergency Department services (ED) at a higher rate than normal, and have a higher rate of hospital admissions and high-end diagnostic services. Other cost drivers for the Medicaid population in general include behavioral health drugs. Roughly one-third of the total costs of Medicaid pharmaceutical drugs are spent on behavioral health drugs. The remaining adult Medicaid population projects a growth of 5.1%, going from $606.16 PMPM to $703.81 PMPM in three years without intervention.

Commercial Insurance

Commercial insurance expenses are projected to be roughly $940 million in SFY14. Commercial insurance costs are driven by specialty care, high-cost prescription drugs, radiology and laboratory services, outpatient care including surgeries, and inpatient maternity. Emergency room utilization growth, at 7%, is also a cost driver. Trends for both individual and family plans ran at 10.2% due to high emergency room usage, as well as high cost diagnostics. While individual plans make up approximately 17% of commercial insurance membership, only about 5% of the overall commercial insurance expenses can be attributed to this population. Without intervention, individual per capita costs are projected to grow from $80.24 to $107.30 PMPM over the three year testing period. Family per capita costs are projected to grow from $317.73to $424.89 PMPM over the same time period.

Medicare

Medicare is projected to spend $1.5 billion in SFY14. While ED usage was not available in the data, prescription drugs, home health, and inpatient hospital project aggressive growth for both fee-for-service Medicare and Medicare Advantage Part C membership from the base year to year 3 of the model testing period. Duals have a Medicare PMPM of 138.58 in the base year growing to $184.05 PMPM in year 3 without intervention – a 9.9% annual trend. Fee for service Medicare projects slightly lower trends of 7.9% growing from $674.54 PMPM to $847.09 PMPM by year 3 without intervention. Finally, Medicare Advantage shows a 9.9% trend with PMPM growth of $791.57 to $1051.31 without intervention over three years.

Estimated Cost of Investments to Implement the Plan

The overall budget projected to implement and test Idaho's PCMH model is $34,000,000 to $45,000,000. The budget includes costs to support implementation at all levels of the model as well as self-evaluation. More information regarding specific costs in the budget will be detailed in the Model Testing Proposal Budget Narrative.

Anticipated Cost Savings and Level of Improvement by Target Population

Savings Assumptions

By transitioning to a PCMH model of care, Idaho has the opportunity to eliminate expenses through proactive care and care coordination. While Idaho has historically spent less on healthcare as a percentage of the gross State product than the US average, there are certain trends evolving within the State that will escalate healthcare costs if left in the current state. For example, Idaho's share of the population aged 65 years and older is projected to increase to 18.3% of the total projected population in 2030, leading to increased healthcare spending in Idaho consistent with the US overall. Idaho's rate of adult smokers is also increasing. Idaho ranked third in lowest state smoking rate in 2004, but in 2010, 16.9% of the adult population were smokers (>187,000 individuals). This increase is significant because healthcare costs for smokers are as much as 40% higher than for non-smokers. Similar to much of the country, there is also a high prevalence of obesity and overweight in Idaho. In 2010, 62.9% of adults in Idaho were overweight, and 26.9% were obese. The increased costs of heart disease and diabetes-related care accounts for as much as 27% of per-capita health spending.

Strategies for Cost Reduction

Lowering and containing the cost of healthcare is a key goal of Idaho's transformation efforts. Idaho's PCMH model will not only change how healthcare services are delivered with a strong focus on primary and preventive care and more effective care management, but will also change how providers are reimbursed for the services they provide.

Strategies that will support cost-containment include but are not limited to:

- Increased access to PCMHs will reduce ambulatory-care sensitive hospital admissions and potentially avoidable ED visits.

- Coordination of care and transition management by PCMHs will reduce duplicative care and decrease hospital readmission rates.

- Alternative payment strategies, such as incentive payments tied to performance measure improvement, will reduce escalating physician costs by rewarding high quality care instead of high volume care, while also expanding access to care.

- Better informed consumers participating in shared decision making and using innovative health communication tools will have reduced ED visits through increased coordination with their primary care physician. An increase in the generic fill rate is also expected.

Cost Targets

The Multi-Payer work group identified five key categories of service as having the highest potential to yield cost savings. Targets were then set in each category of service:

Issue	Target	Target Phases	Mechanism to Reach Target
Appropriate Generic Drug Use	Generic fill rate of 85%	25% of target in Year 1 one, 50% in Year 2 and 25% in Year 3	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%-1.0% in Medicaid and 2%–3% in commercial payer)
Re-hospitalizations	5%–10% reduction	10% of target in Year 1, 20% in Year 2 and 70% in Year 3	20% of all hospitalizations are preventable re-hospitalizations
Acute Care Hospitalizations	1%–5% reduction in total hospitalizations	0% of target in Year 1, 25% in Year 2 and 75% in Year 3	PCMHs reduce acute hospitalizations with IMPACT and IOCP training
Non-Emergent ED use	5%–10% reduction in total ED use	25% of target in Year 1, 50% in Year 2 and 25% in Year 3	10%–30% of ED visits are non-emergent (best in class commercial rates are 120-150/1000)
Early Deliveries (in weeks 37–39 of gestation)	20% improvement over baseline or all hospital report <5% 37-39 weeks	50% of target in Year 1, 50% in Year 2	1%–4% of total NICU admissions ($40-$70K/admit) are preventable with later deliveries

The table below details the estimated cost savings associated with reaching each of these goals, as well as additional cost savings estimates for other categories of service.

Savings Assumptions by COS									
	PMPM								
Categories of Services	Medicaid/CHIP				Private/Other		Medicare		
	Adult	Child	Duals	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	Fee for Service/Non-Duals (Parts A and B)	Medicare Advantage Part C
Inpatient Hospital	-3.27%	-3.02%	-3.02%	-3.02%	-3.27%	-3.27%	-3.02%	-3.02%	-3.02%
Outpatient Hospital (total)	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%
Emergency Dept (subtotal)	-0.63%	-0.63%	-0.63%	-0.63%	-0.50%	-0.50%	-0.63%	-0.63%	-0.63%
Professional Specialty Care	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Diagnostic Imaging/X-Ray	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
DME	0.00%	0.00%	-0.25%	0.00%	0.00%	0.00%	-0.25%	0.00%	0.00%
Professional Other (e.g., PT, OT)	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Prescription Drugs (Outpatient)	-0.50%	-0.50%	-0.50%	-0.50%	-2.00%	-2.00%	0.00%	0.00%	0.00%
Total									

As shown in the table, savings were also calculated by payer type. Medicaid is projected to reduce costs by $8 million, commercial insurance by $22 million, and Medicare by $41 million over three years. Inpatient hospital expenses are expected to save $73 million in total, outpatient and ED visits should be reduced by $20 million, pharmacy by $9 million, and another $7 million saved by reductions in specialists, therapists, and diagnostics. Those savings are offset by the supplemental costs in increased PMPMs to PCMHs for primary care and care coordination efforts detailed in Sections 2 and 6.

Expected Total Cost Savings and Return on Investment

The implementation of Idaho's proposed PCMH model is expected to save $70 million in three years after factoring in an increase in payment to primary care physicians for care coordination and adherence to the PCMH model. The projected cost savings for public payers (Medicare and Medicaid) is $48 million.

The projected return on investment overall is 98% in total for three years and 115.8% for five years. The projected return on investment for Medicare and Medicaid only is 57.4% for three years and 58.6% for five years.

Plan for Sustaining the Model over Time

Idaho is similar to many states that desire to promote practice advancement under the PCMH model while respecting the long-standing culture of provider and payer autonomy. It is for this reason that Idaho chose to design its new delivery system through a massive stakeholder process that involved representatives of nearly the entire State's healthcare delivery system. The failures and strengths of the healthcare system are best understood by individuals receiving services, healthcare practitioners, patient advocates, and payers. For this reason, Idaho, in gathering stakeholder input, set out to include all communities in the State. This resulted in approximately 44 focus group meetings and multiple townhall engagements spread across the following locations: Boise, Coeur d'Alene, Twin Falls, Idaho Falls, Sandpoint, Salmon, Orofino, Moscow, Pocatello, and the Fort Hall Reservation. In addition, several virtual focus groups and ad hoc focus groups were held. Idaho's innovative approach began with the recognition that if healthcare system stakeholders came together to design *and* implement a new system, then true transformation and lasting change could be achieved. Through its grassroots process, Idaho has garnered the commitment of payers and providers to the model, eliminating dependence on legislative or executive mandates to require participation.

Idaho's expanded PCMH model establishes several new and innovative system elements that can support the long term funding and continued development of the system. The IHC will be financially sustained through membership fees paid by PCMHs. Upon designation as a PCMH, the practice will pay a membership fee to the IHC for continued support and resources to enhance its capacity and capability as a PCMH. The PMPM paid by payers will be sufficient to help offset the cost of the membership fee. IDHW and the IHC will work with CMMI and its evaluation team to ensure the model is designed and modified as necessary to generate sufficient revenue and funding to support continued activities.

Should Idaho not receive grant funds to support model testing, implementation of the model will proceed at an extremely limited level. Without grant funds, Idaho will be limited to implementing the model through expansion of the IMHC and its PCMH pilots. At the end of phase 1 of the IMHC pilots (January 2015), Idaho will evaluate whether the 36 pilots can support expansion beyond the chronically ill population they currently serve to include the non-chronically ill, i.e., healthy, individuals in the PCMH. At that time, IMHC will also evaluate whether they can expand the number of pilots beyond the original 36 that exist today. While Idaho is committed to moving forward with healthcare delivery system reform, the reality is, without the support of grant funds and CMMI assistance, Idaho will not be able to test its model and achieve statewide transformation and population health management that will improve the health of Idahoans.

4

Idaho Healthcare Workforce

Idaho's health system transformation is geared at achieving the Triple Aim of improved health outcomes, improved quality and patient experience of care, and lowered healthcare costs by addressing barriers and filling gaps in the current system. Primary among these barriers, as identified by the stakeholders in the model design process and noted previously in the SHIP, are severe workforce shortages in Idaho across professions and across geographic regions of the State that must be addressed in order to truly transform healthcare in Idaho. One hundred percent of Idaho is a federally-designated shortage area in mental healthcare, and 96.7% of Idaho is a federally-designated shortage area in primary care. Recognizing the access barriers presented by this shortage, Idaho has designed a model that maximizes the current workforce while designing comprehensive strategies to increase practitioners of all types throughout the system.

What follows is a description of the current healthcare workforce and its limitations, stakeholder deliberations in designing solutions to address these issues, and the recommendations included in Idaho's new model to strengthen Idaho's healthcare workforce to ensure its future ability to provide the best possible care for patients.

Current Provider Network

Physicians

The AAMC's 2011 State Physician Workforce Databook, which uses 2010 data, shows that in 2010 there were 2,873 active physicians in Idaho (184.2 per 100,000 residents), which includes 2,610 doctors of medicine and 263 doctors of osteopathic medicine. Of these, 987 were PCPs who self-reported that their practice type was direct patient care. Idaho ranked forty-ninth among the 50 states in terms of number of physicians per capita.[32]

Data compiled by Idaho's Department of Labor using physician counts provided by the Idaho Medical Association shows the following distribution of physician types:

Idaho's Physician Workforce		
Physicians	Count	Percent
Anesthesiologists	122	4%
Family Medicine and General Practice	758	25%
Internists	270	9%
Obstetricians and Gynecologists	155	5%
Pediatricians	145	5%
Psychiatrists	100	3%
Surgeons	367	12%
All Other Physicians	1,116	37%
TOTAL	3,033	100%

The Idaho Board of Medicine is the primary source for information on licensing, but does not have information on which physicians are active practitioners or where they are practicing. In 2012, the

[32] https://www.aamc.org/download/263512/data/statedata2011.pdf

Department of Labor, with a grant from Health Resources and Services Administration (HRSA), completed a study of Idaho's primary care workforce using licensure data and data from the Idaho Medical Association. The Board of Medicine and the Department of Labor are now working on a project to cross reference data by developing a new database that will capture information not only on the number of licensed physicians, but on which physicians are actively practicing and where they are practicing. This collaborative effort will provide critical data as the IHC partners with other State efforts to target workforce expansion in under-served areas of the State.

Federally Qualified Health Centers and Rural Health Clinics

Idaho has 13 non-profit community health centers (often referred to as FQHCs); 12 receive federal grant funding and the thirteenth has attained FQHC "look-alike" status. Idaho's FQHCs serve nearly 150,000 residents through 41 community sites and provide primary medical, dental, and behavioral health services. Idaho also has 46 rural health clinics (RHCs), which are family medicine clinics that provide outpatient primary care health services, including diagnostic and laboratory services. The clinics are staffed by mid-level practitioners 50% of the time the clinic is open.[33] RHCs are certified by the IDHW Division of Medicaid's Bureau of Facility Standards. To be certified as an RHC, a clinic must be located in a non-urban area as defined by the US Census Bureau and a federally-designated medically-underserved area (or a governor-designated shortage area) or serve a designated population group or geographic health professional shortage area.

Idaho's FQHCs are innovators in developing practice standards that are based on patient-centered, team-based care, often co-locating primary care and behavioral health services, and offering care coordination to patients. Several of Idaho's FQHCs participate in the FQHC Advanced Primary Care Practice Demonstration, operated by CMS in partnership with HRSA that will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for Medicare patients. Participating FQHCs are expected to achieve Level 3 PCMH recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. FQHCs are paid a monthly care management fee of $6.00 for each eligible Medicare beneficiary attributed to their practice to help defray the cost of transformation into a person-centered, coordinated, seamless primary care practice. This payment, which will be made quarterly, is in addition to the usual all-inclusive payment FQHCs receive for providing Medicare covered services. Based on their experience as leaders in patient-centered primary care, Idaho's FQHCs are well positioned to be a valuable resource to private practices in their efforts to build capacity around the components of the PCMH model. The IHC and its RCs will seek to leverage this expertise where possible by encouraging practice mentor opportunities to help practices learn from each other's lessons and prior experience.

Nurses, Nurse Practitioners, and Physician Assistants

Nurses and physician assistants (PA) are important participants in Idaho's team-based PCMH model. In 2011, there were 11,660 total employed registered nurses (RNs) in Idaho, or 736 per 100,000 residents and 658 nurse practitioners (NPs), or 42 per 100,000 residents.[34] There are 684 physician assistants with active licenses in Idaho.[35] PAs and NPs play a vital role in extending access to services in Idaho, particularly in rural communities. For this reason, many stakeholders were in favor of allowing PAs and NPs to, along with physicians, lead the PCMH in Idaho's model.

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[33] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RRHC.pdf

[34] Kaiser State Facts (http://kff.org/other/state-indicator/total-registered-nurses/

[35] https://isecure.bom.idaho.gov/BOMPublic/LicenseTypeCount.aspx?Board=PAC

Behavioral Health Professionals

The shortage of behavioral health professionals in Idaho creates substantial barriers for Idahoans with mental health conditions and substance use disorders. As of September 15, 2013, there are 427 substance abuse counselors in Idaho who have active certifications by the Idaho Board of Alcohol/Drug Certification[36] and 3,513 social workers with active licenses from the Idaho Board of Social Work Examiners.[37] There are 322 psychologists with active licenses from the Idaho Board of Psychologist Examiners. (Note: this does not include professionals with temporary psychology licenses or service extenders.)[38]

Telehealth is used to a limited extent in some rural communities to provide access to behavioral health services. Currently, Idaho Medicaid pays for specific behavioral health services delivered via telehealth technology. The policy allows behavioral health services provided via telehealth to be reimbursed if the following conditions are met:

Must be provided by a physician.
Covers the following behavioral health services:

- Psychiatric services for diagnostic assessments.
- Pharmacological management.
- Psychotherapy with evaluation and management services 20 to 30 minutes in duration.[39]

Stakeholders in both focus groups and the Network work group discussed the importance of expanding the use of telehealth services, particularly in rural and underserved areas of the State. It was recommended that the Idaho Medicaid and commercial payers expand their telehealth policies to include a broader array of reimbursable behavioral health services.

Additional information on Idaho's healthcare workforce, including numbers of other practitioner types and hospitals, can be found in the Appendix G.

The future of Idaho's healthcare workforce

Stakeholders noted that establishing good, basic primary care, particularly in rural and underserved areas, is the key to improving Idaho's healthcare system. To accomplish this goal, stakeholders recommended that strategies to improve the workforce target a range of professions, including physicians, behavioral health professionals, PAs, NPs, social workers, and nurses.

Stakeholders noted that this approach is being taken by the Idaho Health Professions Education Council (Council), established by executive order by Governor Otter in 2009. The Council has been working to develop healthcare workforce objectives for the State and recommend strategies to address healthcare shortage across a range of professions.[40] The Network work group recommended that many of the Council's recommendations be incorporated into the Idaho SHIP strategies for workforce improvement. While Idaho will not request Model Testing Grant funds for workforce strategies, the IDHW and the IHC will work closely with the Council during the model testing phase to ensure that SHIP activities, such as training opportunities for primary care practices and new data sharing arrangements, align with the Council's workforce development strategies and support their efforts wherever possible.

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[36] http://ibadcc.org/

[37] http://ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=swo

[38] http://ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=PSY

[39] IDAPA 16.03.09.502: http://adminrules.idaho.gov/rules/current/16/0309.pdf

[40] See the Idaho Health Professions Education Council, 2013 Annual Report to Governor C. L. "Butch" Otter, submitted August 13, 2013 available at http://gov.idaho.gov/HealthCare/PDF/2013%20IHPEC%20Annual%20Report.pdf

Stakeholders identified one serious challenge facing Idaho's future supply of physicians is that the current workforce is aging, and not enough younger physicians are establishing practices in Idaho to replace the physicians who are or will soon be retiring. The AAMC data shows that, of the total active physicians in Idaho in 2010, 23.3% were over 60, while only 13.9% were under 40. For this reason, Idaho's strategies include a strong focus on providing opportunities for young Idahoans to become part of the future workforce.

Idaho is extremely successful in retaining new physicians who graduate from residency programs in Idaho. In 2010, 56.9% of Idaho medical residents were practicing in-state, which was the eighth highest retention rate in the nation.[41] The State has also worked hard to increase graduate medical education opportunities by 56.4% from 2000 to 2010. A third family medicine residency program affiliated with the University of Washington Family Medicine Residency Network is expected to begin in 2014 in Coeur d'Alene. Building on Idaho's success in retaining medical residency graduates, the IHC will work with legislators, State officials and academic centers to further expand medical education in the State.

Based on recommendations made by the Network work group, the IHC, in partnership with the Council, will work on the following workforce expansion initiatives:

- Medical education – advocate for funding of residency programming including Family Medicine, Psychiatry, and Internal Medicine Residency Programs in addition to increased access to medical school education for Idaho students.

- Health education expansion – explore the feasibility of a statewide AHEC grant with three regional centers to promote enhancement and coordination of health education across disciplines and around the State.

- Nursing education – updating Idaho higher education articulation agreements between Idaho nursing education institutions to increase access and pipeline into advanced nursing degrees in Idaho to increase the number of Master and Doctoral prepared faculty members to ensure that schools of nursing are adequately staffed to continue educating nurses.

- Public health – support the training, recruitment, and retention of providers critical to the functioning of public health in Idaho including mid-level providers specifically working with local public health districts, registered dental hygienists, and registered dietitians.

- Social work – support the training, recruitment, and retention of key social work providers in Idaho including social work faculty as well as a rural social worker's program with an emphasis on behavioral health.

The Network work group agreed that equally important to having enough physicians is having the right physicians — those who are trained to provide services in a rural community. Rural family physicians deliver babies, provide emergency services, provide pediatric care, treat mental health conditions, and perform critical triage services. Focus group participants also noted that a significant challenge facing Idaho's healthcare workforce is an unequal distribution of providers between urban and rural settings.

[41] https://www.aamc.org/download/263512/data/statedata2011.pdf

Stakeholders agreed that expansion of medical school slots is needed to build the necessary and well-proportioned physician workforce in Idaho. Additional slots should be at medical schools with training tracks in rural healthcare, such as the University of Washington's Targeted Rural and Underserved Track (TRUST) program, and the slots should be designated for such programs. Students interested in working in Idaho's rural areas should be targeted for admission to the expanded slots. Work group members also agreed that medical school scholarships and loan repayment programs are valuable tools in recruiting students to medical professions and encouraging them to practice in Idaho. The suggestion was made that Idaho provide more substantial financial assistance to students in healthcare programs (e.g., medical, social work, nursing, dental school, etc.), who would be required to practice in Idaho for a set period of time upon their completion of the program. Another suggestion was to expand existing loan repayment funding (existing funding sources include the federal National Health Services Corps program and Idaho's own Rural Health Care Access Program (RHCAP) and Rural Physician Incentive Program) to encourage residency graduates to practice in Idaho.

Presently, Idaho ranks forty-ninth in the nation in the number of residency slots available. The work group agreed that State funding is needed to support an increase in residency slots that include a rural under-served area training track, as physicians who train in Idaho's rural areas as residents tend to stay for practice.

While some residency programs include learning opportunities for providing care in a rural setting, additional support and mentoring is needed as physicians establish their rural practice. The work group recommended having a preceptor program to enhance educational resources for PCPs at the community level. A central agency, such as the AHEC, could perform the function of linking preceptors to the primary care "learners." This agency would compile and maintain a database that includes preceptor information, such as: name, medical specialty, preference regarding learner type, e.g., practice, location, etc., the best way to contact the preceptor and a calendar of dates and times when the preceptor is available to volunteer his/her time to the learner. The agency would connect learners and preceptors to create a learning environment at the local level in addition to providing opportunity for preceptor development.

Stakeholders participating in focus groups recommended using alternative providers to supplement the healthcare workforce. The Network work group specifically recommended using CHWs as an alternative provider to expand the healthcare workforce. As discussed by the work group members and focus group participants, in workforce shortage areas it is most important that each healthcare professional work at the upper limits of their scope of practice. The recruitment and addition of CHWs in the PCMH is a valuable tool for both achieving community connections necessary for coordinated care but also for maximizing productivity of the State's healthcare workforce.

Focus group participants consistently reported that licensing requirements are burdensome and a barrier to efficient hiring practices. Some stakeholders reported that the licensing process was so lengthy that it was common to lose potential hires (physicians) because the individual would accept another position in another state before their license could be approved in Idaho. Stakeholders recommended that Idaho's State medical board consider broadening its conditions for allowing reciprocity of a medical license in other states and to streamline the licensing process.

Strategies for expanding Idaho's healthcare workforce

A substantial financial investment is required to expand Idaho's current healthcare workforce and overcome barriers to access. Currently, Idaho spends millions of dollars to pay for healthcare services based on volume. Improving care and improving health outcomes requires a shift in what and how Idaho purchases healthcare. For Idaho to shift from funding a volume-based healthcare

delivery system to a value-based system, there must be a commitment to expanding the primary care workforce upon which the value-based system is created. The IHC will work with the Council, AHEC, the Governor's Office, state agencies, the legislature and communities to advocate for appropriate funding levels and support the implementation of the strategies below.

Workforce Issues and Strategies

Issue	Strategy
Shortage of physicians, particularly in rural, underserved areas.	Fund residency programming, including family medicine, psychiatry, and internal medicine residency programs. Increase medical education slots at medical schools with training tracks in rural healthcare, such as the University of Washington's TRUST program, and target students interested in working in Idaho's rural areas for admission to the expanded slots. Fund medical school scholarship for Idaho students and require students receiving substantial financial aid to practice in Idaho for a set period of time upon their completion of their medical training. Expand existing loan repayment funding (available through the National Health Services program, Idaho's own RHCAP, and Rural Physician Incentive Program) to encourage residency graduates to practice in Idaho. Increase residency slots that include a rural under-served area training track. Establish a preceptor program to enhance educational resources for PCPs at the community level.
Nurse shortage.	Update Idaho higher education articulation agreements between Idaho nursing education institutions to increase access and pipeline into advanced nursing degrees in Idaho. Master level and Doctoral prepared faculty members are needed to ensure that schools of nursing are adequately staffed for educating nurses.
Limited public health services.	Support the training, recruitment, and retention of providers critical to the functioning of public health in Idaho including mid-level providers specifically working with local public health districts, registered dental hygienists, and registered dietitians.
Shortage of behavioral health practitioners.	Support the training, recruitment, and retention of key social work providers in Idaho including social work faculty as well as a rural social worker's program with an emphasis on behavioral health.
Overall shortage of healthcare workforce.	Increase financial assistance to students across healthcare educational programs (e.g., nursing, dental school, etc.), and require those who receive substantial financial aid to work in Idaho for a set period of time upon their completion of the program.

Issue	Strategy
Health education expansion.	Consider a statewide AHEC grant with three regional centers to promote enhancement and coordination of health education across healthcare disciplines.
Licensing barriers.	Encourage Idaho's State medical board to consider broadening its conditions for allowing reciprocity of a medical license in other states and to streamline the licensing process.

5

Health Information Technology

HIT enables a successful PCMH model by serving as the platform for which data is collected and made available to participants for purposes of extraction, patient collaboration, patient engagement, continuous quality improvement, reporting, and analytics. Through the use of advanced health technology, such as telehealth, EHRs, patient portals and clinical decisions tools, Idaho will reduce its barriers to access for those living in rural areas, improve provider collaboration and coordination, increase patient engagement, increase training and specialized care in geographically isolated areas of the State, and gather statewide data that informs the activities needed to improve the quality of care, control healthcare costs, and achieve improved health outcomes.

Idaho has not fully developed the capacity to collect and analyze statewide data largely due to the limited opportunities to coordinate data collection and analysis across payers and populations. A preliminary plan for data collection has been developed and presented in Idaho's SHIP but further analysis is needed to finalize the approach. During the first year of implementation and model testing, the IHC will analyze the current system capabilities and constraints regarding statewide data collection and reporting. The IHC will engage stakeholders in the discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will have been developed.

Current state of Health Information Technology in Idaho

Electronic Health Records

EHR adoption is critical to enabling the exchange of clinical and other information between providers and other organizations. A key driver to EHR adoption in Idaho has been the Washington & Idaho Regional Extension Center (WIREC), which received funding from the Office of the National Coordinator for HIT (ONC) to help primary care providers adopt and use EHRs.[42] WIREC, led by Qualis Health, provides vendor-neutral HIT consulting services related to the successful adoption, implementation, and utilization of EHRs for the purposes of improving care. These services include HIT outreach and education, EHR procurement guidance, workflow redesign, implementation support, and assistance on optimizing the use of EHRs, such as data and systems management support. WIREC provides guidance to eligible healthcare professionals as they endeavor to achieve meaningful use of EHRs and qualify for CMS incentive payments. WIREC collaborates with Medicaid, Medicare, the statewide HIE, the Beacon Community, public health departments, stakeholders involved with workforce development, and the many professional organizations that support healthcare providers. WIREC's common goal is to ensure that healthcare providers have the information they need to successfully adopt EHRs.

The HIT work group, using broad-based stakeholder input, identified the following challenges and opportunities regarding the use of EHR technologies among providers in Idaho:

[42] http://www.wirecqh.org/AboutUs.cfm:

EHR Challenges and Opportunities

Challenge	Opportunities	Potential Next Steps
EHR adoption rate among Idaho providers needs improvement overall, especially among smaller providers.	Opportunity for WIREC to continue outreach activities with additional funding. The Medicaid EHR Incentive Program provides incentives to provider for EHR adoption.	IHDE continues to connect providers to the statewide HIT infrastructure and offer its virtual health record (VHR).
Providers who do not use EHRs in their practice reported in focus group meetings that they perceive EHR adoption to be a significant business risk to their organization.	Opportunity for education and outreach by the IHC, WIREC, IHDE, and/or the State of Idaho.	IHDE will promote statewide interoperability by recruiting non-participating providers to its VHR. IHDE will provide connectivity for providers already participating in one of the State's established HIT structures through the building of hubs and connections allowing push and pull functionality.
Disparate EHR solutions.	Promote standardization or lingua franca for EHR data to enable the creation of data hubs, data sharing, analytics, and reporting. The IHC, WIREC, IHDE, and/or the State could provide value-added consulting to assist with EHR implementation and integration efforts.	The IHC will promote the adoption of standardized EHR protocols and facilitate committees that will explore necessary HIT infrastructure changes to promote statewide population health management.
Meaningful use requirements.	Opportunity for education, consulting, and other value-added activities to help providers meet meaningful use requirements.	Providers may need assistance in understanding how to configure their EHR systems, make changes to workflow, and perform other activities to meet meaningful use requirements.
Increased reporting and data output requirements. Different EHRs have different ways to capture and report data. Data extraction can take time/effort. Proper data output requires correct data input.	Opportunity for IHDE to help integrate EHR systems into data hub. Opportunity for the IHC, through subcontracting to aggregate data in readily available forms for purposes of population health management.	IHDE will promote connectivity among providers not already connected to one of the larger HIT infrastructures in the State.

Challenge	Opportunities	Potential Next Steps
Costs related to initial implementation or changing to a new EHR solution.	The State or other payers could consider giving financial assistance to providers with their EHR implementation efforts.	Providers seeking to become PCMHs will have access to start-up funding and a PMPM to cover the costs of continued advancements within the practice as well as lump sum payments to offset costs related to becoming a PCMH.

According to ONC data for Idaho,[43] in 2012, 58% of hospitals, 42% of physician offices, 51% of PCPs, and 33% of small practices had adopted basic EHRs. While significant work is still needed to resolve barriers and achieve greater penetration of EHR adoption across Idaho's primary care practices, the Medicaid Provider Incentive Program has established a critical foundation for the work ahead.

Health Information Exchange

Idaho's statewide Health Information Exchange (HIE) is maintained by the Idaho Health Data Exchange (IHDE), which was created as a result of the efforts of the HQPC. IHDE, a 501(c) (6) nonprofit corporation, was established to govern the development and implementation of a HIE in Idaho. IHDE is governed by a Board of Directors that includes representation from both the public and private healthcare sectors. Initial funding for IHDE was appropriated by Idaho's Legislature and ongoing funding comes from participants in the Exchange.[44] IHDE also received a grant from ONC to develop and advance the HIE. Currently, connections to the HIE consist of 10 hospitals, six laboratories, three payers, and over 1,200 provider-group users.[45] These connected providers receive clinical results and are also able to conduct e-prescribing through the system. IHDE also offers clinical messaging, or clinical results delivery, to connected providers and a clinical data repository (which consists of laboratory, radiology, and hospital transcription information) through a portal called the Virtual Health Record (VHR). Through the VHR, providers are able to view continuity of care documents for their patients.

The HIT workgroup identified the following challenges and opportunities related to HIE in Idaho:

HIE Challenges and Opportunities

Challenge	Opportunities	Potential Next Steps
HIE (IHDE) participation rate has been steadily growing, but will need improvement to support future growth if added functionality and services are considered.	Opportunity for more providers to participate in IHDE. Opportunity for State to incentivize provider organizations regarding participation.	Staffing plan and budget will be included in Idaho's MTP.

[43] ONC Health IT Dashboard at http://dashboard.healthit.gov/data/

[44] http://www.idahohde.org/dsite/node/9 and State Medicaid Health Information Technology Plan (SMHP) Version 1.2 April 1, 2013.

[45] Health Quality Planning Commission Annual Report, Creating a Healthy Idaho, July 2013.

Challenge	Opportunities	Potential Next Steps
Current HIE data sharing administrative agreements allow for sharing of data for treatment purposes only.	Opportunity to expand current scope of IHDE participant organization data sharing agreements to support SHIP activities.	A review of IHDE's existing policies to accommodate such opportunities will occur.
Current IHDE system is not adequate to perform all SHIP activities.	Opportunity for IHDE to expand capabilities and system architecture to support SHIP needs.	Additional review of IHDE's existing policies to accommodate such opportunities will occur.
Current IHDE staffing levels not sufficient to perform expanded role required by SHIP.	Opportunity for IHDE to increase organizational capacity.	A review of IHDE's existing policies to accommodate such opportunities will occur. Organizational expansion will occur through IHDE revenue generation and MTP grant funding.
Current HIE functionality is limited.	Opportunity to expand EHR data integration and other functionality.	Next steps mentioned in table above.
Limited reporting performed by IHDE today.	Opportunity to advance analytic and reporting capabilities and provide value-added data analytics and reporting services to participants, the IHC and RCs.	Review opportunity for growth in analytic capability and the integration of those analytic capabilities into the larger IHC led analytic efforts.

Telehealth

The Idaho Telehealth Taskforce (ITT) was established in March 2013 to explore resources and barriers related to healthcare delivery via telehealth in our State. Over 50 participants with broad representation of the healthcare system across the State are committed to this endeavor. Since its creation, the ITT has launched important initiatives, such as the Idaho Telehealth Collaborative Program, to expand telehealth throughout Idaho.

The Idaho Telehealth Collaborative Program was designed by the AHEC and members of the ITT to focus specifically on the delivery of behavioral health and substance use disorder treatment services. This project model has been reviewed by the taskforce and several key leaders in government and healthcare. The project has letters of support, including letters from the governor, the director of Health and Welfare, the Idaho Association of Counties, and the IMHC. In August 2013, ITT requested funding for the Idaho Telehealth Collaborative Program through Round Two CMS Innovation Grant funding. The grant application asks for $2,299,531 for three years. The Idaho Telehealth Collaborative Program will address the identified barriers to telehealth adoption by providing education, mentoring and support to encourage behavioral health providers in Idaho to engage in telehealth. Additionally, experienced telehealth providers in other states will be encouraged to become licensed in Idaho. A specific model of "readiness for change" will be implemented that will provide customized plans to teams at critical access hospitals and other facilities throughout the State to assist them in the development of telehealth programs. Outreach and education to rural communities will be conducted to make consumers aware of the availability of telehealth as a resource for accessing behavioral health services. In addition to the specific behavioral health project addressed by the Idaho Telehealth Collaborative Program, the ITT

supports expansion of telehealth for other health care services not currently available in rural/frontier regions.

While substantial investments have been made in both expanding broadband availability and in supplying teleconferencing equipment, use of telehealth technology has not been fully embraced in Idaho to date. Key barriers to the development of a robust, coordinated system of telehealth technology that can serve all regions of the State include a lack of provider champions, discomfort with change from traditional methods of service delivery, and the lack of parity in reimbursement for telehealth from both public and private payers.

Stakeholders repeatedly noted that expanded utilization of telehealth could be a solution to address access barriers in geographically isolated areas. It was suggested that IDHW consider expanding its Medicaid telehealth policy to other specialty areas beyond mental health services, such as emergency department consultation in physician shortage areas. The State's telehealth policy could be expanded to allow for reimbursement of these services through the Medicaid program, and commercial payers should also reimburse for telehealth and non-traditional visits. In addition, telehealth programs (e.g., New Mexico Project ECHO) may offer a means to care for more intensive services on site rather than have patients drive miles for specialty care.

Idaho's new PCMH model will incorporate these recommendations to maximize the use of telehealth technologies to achieve the goals of the model. Notably, Idaho will use telehealth as a means to train CHWs and community EMS workers in rural and underserved areas of the state to increase access to coordinated primary care services through the virtual PCMH. To support telehealth initiatives for behavioral health services, the IHC will work with IDHW and other payers to explore maximizing reimbursable telehealth services.

Stakeholder deliberations regarding HIT

The HIT work group was responsible for evaluating current HIT assets and barriers in Idaho, and developing a framework that will support information exchange between stakeholders and facilitate processes for timely data collection and analysis in the future PCMH model. The HIT work group was comprised of a wide range of stakeholders, including public entities (i.e., local public health districts and Medicaid), federal entities (VA and IHS) as well as FQHCs and a diverse set of stakeholders from the private sector including healthcare providers and payers. The HIT work group had broad consensus on the recommendations listed below.

The HIT work group considered three general options related to the development of HIT to support the new PCMH model.

1. Leverage existing tools, technologies, and methodologies instead of expanding the infrastructure and capacity. This option was immediately rejected as Idaho does not have basic foundational HIT components needed to advance SHIP objectives such as adequate EHR market penetration among providers, a statewide multi-payer database, an HIE environment that allows for the sharing of data/information for non-treatment only purposes, or adequate HIE participation amongst providers.

2. Utilize disparate and siloed third-party vendors or other products to attempt a "distributed" approach to data aggregation, integration, and reporting. This option was rejected for the same reasons as item 1 above and because no controlling entity exists to (or has shown success with) coordinating HIT data in the State of Idaho.

3. Build integrated system capacity for the collection and dissemination of data and information.

The HIT work group recommended pursuing the third option because, given the current state of HIT in Idaho, the work group felt that a centralized approach would facilitate a faster and potentially more successful process of connecting providers, payers, and healthcare consumers via technology to support the goals of the SHIP. The work group also noted that laying the foundation of a data hub would not preclude future contributions by third-parties, consulting organizations, data vendors/aggregators, etc. and, in fact, would likely support these potential future-state activities.

Stakeholders noted that IDHW's Medicaid Provider Incentive Program has laid the groundwork for expansion of EHR adoption and establishment of quality measures for meaningful use. The quality measures are in alignment with National Quality Forum and Physician Quality Reporting Initiative definitions. Additionally, the Medicaid Provider Incentive Program has established a process to assure that EHRs adopted by providers requesting Medicaid incentive payments are certified EHR products. The HIT work group recommended that the IHC and IHDE work closely with IDHW to leverage resources and incentives of the Medicaid Provider Incentive Program to support further expansion of adoption and meaningful use of EHRs.

Highlights of the HIT work group's key recommendations, including major components of the new HIT model, are described below.

The future of HIT in Idaho

The future state of the HIT system will see IHDE enlarging its capabilities to reach out to more providers and connect more systems in the State. To accomplish this, IHDE will continue to build interoperability with data hubs in other parts of the Idaho HIT infrastructure. Sources of data required for reporting and analytics may include broad categories such as payer data (e.g., claims and payment information), clinical data (e.g., from EHRs and other clinical sources), and patient data (e.g., patient portal data, personal health records, social media, and biometrics). Robust analytic and reporting capabilities will likely also require integration of other data sources such as public health, Medicare, and Medicaid. The analytic and reporting platform will need to be flexible in order to support differing needs of the various participants throughout the system. To that end, IHDE is in a unique position to leverage its current efforts and increase partnerships to continue to grow as an important part of the overall State HIT solution. This is a significant area of innovation given the relatively undeveloped HIT infrastructure in Idaho compared to other states.

Connecting statewide data hubs that contain payer, clinical, and patient data is a critical precursor to developing a reporting architecture that is capable of integrating these disparate data sources. In the beginning years of the transformation, the statewide aggregation of data will occur via a quality vendor contracting with the IHC to establish statewide baselines and enable whole population health management. As the model matures, IHDE and other already established HIT infrastructures will provide aggregation and analytic support to the IHC to facilitate its population health management functions.

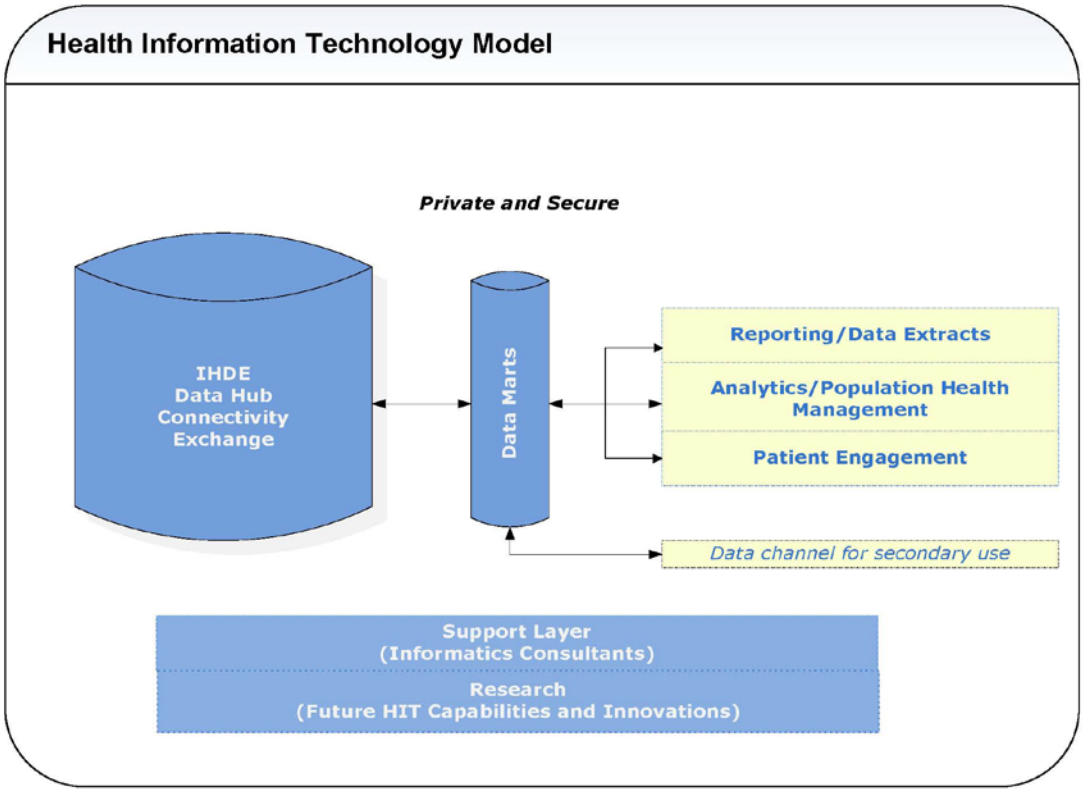
Access to the information outputs from IHDE will be segmented by need and other factors utilizing role-based security and other methodologies. Privacy and security protocols will be established and monitored to ensure protection of personal health information and other sensitive data in compliance with HIPPA requirements. Levels of reporting and access to data will need to be flexible and extensible in order to meet the various needs of PCMH providers and other system actors (e.g. the IHC or RCs). This flexibility and extensibility will likely require the ability to provide analytic and reporting capabilities and other services to connected organizations.

Provider participation rates will be increased through technical outreach, financial support through incentives, and possible policy changes. IHDE is a member-based organization and participant attraction and retention are key components of IHDE's mission.

In addition to providing data for use by providers, IHDE will develop the capability for the data to be used by other entities such as local public health districts for community health activities and other public health activities. The IHC will help facilitate the collaboration between IHDE and public health as this information will be important for the assessment of regional health needs.

Idaho recognizes that significant challenges may be encountered around infrastructure costs, the development of data sharing and use agreements, and ensuring connectivity for participating organizations. As such, federally supported internet broadband initiatives are underway to address connectivity issues in Idaho, e.g., www.linkIdaho.org. Expansion of the HIE functionality in Idaho is actively being managed by this group, and thus is not addressed further in this SHIP.

The following illustrates the HIT model described above.



As shown in the model above, IHDE will serve as a hub of connectivity for the State. Each of the otherwise not interoperable HIT Infrastructures (e.g. payer and hospital HIT systems) are represented here as “data marts.” The already matured HIT infrastructures around the State will not be feeding data directly to the IHDE hub, but will instead be connected to allow end-users access to share EHR-specific information to better coordinate care. Initially, aggregation of data will occur via a quality vendor with the IHC; however, as IHDE and the interoperability of the system mature, the IHC may transfer some of these functions to IHDE.

Increasing patient engagement through HIT

Patient engagement improves patients’ understanding of their health and healthcare conditions, enabling them to assume a more active role in their healthcare. This is a key element to the Triple Aim, healthcare innovation, EHR meaningful use requirements, and other aspects of healthcare delivery. IHDE can play a critical role in engaging patients and sharing broader population health information. This may include having a patient portal that different providers could use and the use of social media. The site could also include links to health initiatives, statistics, data, etc. Patient engagement activities could also include collecting biometric data from devices. Collaboration between IHDE and the IHC will direct how advances are made in the IHDE system to promote patient engagement.

Providing a mechanism for care coordination and collaboration

The current HIT Infrastructure in Idaho has several advanced HIT systems that are utilized exclusively by the payers and hospitals. The solution proposed here seeks to connect those

independent systems in a way that promotes care transition, coordination, management, and collaboration. In addition, IHDE, through increasing its participating provider footprint, will fill the gaps left by the independently constructed HIT Infrastructures around the State. Several enabling technologies are available today within the IHDE system that will improve care transitions across providers, making them safer, improving quality, and avoiding costly and unnecessary hospital readmissions.

Ensuring patient data privacy and security

Privacy and security are a main concern for patients, payers, and providers. A policy framework, physical and electronic security measures, and other privacy and security-related organizational and infrastructure items will need to be constructed to support the future state vision. Policies and procedures that govern privacy and a secure technical solution will need to be developed in tandem to ensure data is protected, and at the same time accessible to those that require it. As the system matures, Idaho may consider regulatory changes to further support data privacy and security, especially as the State considers inclusion of data related to behavioral health, substance use, and developmental disabilities.

Expanding reporting and analytic capabilities

Enhancements to current reporting capabilities will be implemented in phases. Initial reporting enhancements will be part of the expansion of the IHDE infrastructure and will include operational reports related to data handling, error routines, and balancing activities. Later phases will enhance analytics and end-user reporting through a variety of internally developed and possibly vendor-provided products providing both “drill down” and “slice and dice” capabilities through web interfaces with role-based and context-based security protocols.

Increasing the analytic and reporting capabilities of IHDE will ensure that otherwise unconnected participating providers are connected to a main HIT Infrastructure in Idaho. Because IHDE is available statewide and to any provider practice, this represents a critical innovation in the SHIP.

Coordinating with other statewide HIT initiatives to accelerate HIT adoption

Idaho has several other statewide HIT-related initiatives underway that support the activities outlined in the SHIP. Coordination between these various initiatives is essential for Idaho to maximize collaboration opportunities and value across the various initiatives. The IHC will have responsibility for advancing the success of the statewide HIT-related initiatives.

The HIT work group identified the following existing HIT initiatives, which will be leveraged in the new model:

The Idaho Telehealth Taskforce, which was discussed previously in this section.

- The Idaho HIT work group is focused on bringing players from all the facets of HIT in Idaho to the table and sharing ideas, challenges, and solutions. Members include providers, payers, technology companies, State government, federal government, and legislators. Recommendations from this work group were considered during the SHIP design process, and outputs from the work group will continue to be collected and considered during implementation of the SHIP. Cross-team sharing will occur as often as possible.

- The Time Sensitive Emergency (TSE) work group is tasked with presenting to the legislature a proposed TSE legislative bill to develop a statewide trauma, stroke, and heart attack system.

Members include providers, payers, State government, and legislators. Any resulting passed law will be incorporated into the SHIP.

- LINK Idaho is part of the Telehealth Taskforce, TSE, and HIT work groups and focuses on broadband access in Idaho. The IHC will consider how to leverage any technologies and agreements that are championed by LINK Idaho to further the efficient sharing of data, especially in rural communities.

- The WIREC has driven acceleration of HIT in the State. The WIREC's successes to-date on accelerating EHR adoption among hospitals, primary care providers, and other physicians, including small practices, has driven high EHR adoption. Section 3 provides additional information on WIREC and its success to-date facilitating EHR adoption by providers.

Provider engagement in adopting EHR technologies is critical to achievement of Idaho's healthcare delivery system transformation. The IHC and IDHW, through the Medicaid Provider Incentive Program, will partner with the above initiatives. Direct support of the PCMHs will ensure that providers are engaged in transition and continuity of care, data collection and dissemination, and patient engagement, which will serve to increase the wave of EHR adoption currently under way.

Reaching providers in rural areas, small practices, and behavioral health providers

The use of HIT and HIE technologies in the new model will have a statewide impact, including providers in rural areas, small practices, and behavioral health providers. The activities of the IHC and RCs, as outlined in Section 2, will ensure that HIT support will reach all providers, not just urban providers, large providers, or those providing primary care services.

As identified, one of the biggest barriers to adopting HIT among providers in rural areas and small practices is the cost associated with these systems. To help overcome this barrier, practices will be eligible for transition start-up payments provided through the IHC that can be used towards the purchase or upgrade of HIT systems and data registries. Technical assistance for practices in rural areas and small practices will also be available through the IHC and its RCs. The planned web-enabled reporting capability will allow the exchange of data between providers, IHDE, and the IHC, and back to providers regardless of location. Web-enabled reporting capability will provide easier access to provider reporting activities, and is thus especially attractive to rural and small providers that can afford "low-end" investments in their HIT infrastructure.

Cost allocation plan or methodology for any planned IT system solutions/builds funded In part by CMS or any other federal agency

The model in Idaho will rely on sustainability in a stand-alone capacity once start-up costs have been covered. Model Testing Proposal grant funds will be used to create infrastructure and cover startup costs related to connectivity, interoperability with other systems, and initial hardware purchases. Such investments will not likely use cost allocation plans, as in other information hubs or exchanges, as the initial costs will be grant funded through the Model Testing Proposal award.

Once the system is operational, practices will pay for use of the systems through fees based on costs and levels of services. These operating costs and fees will not be dependent on federal grants but instead on user contributions for the services they access. As such, no cost allocation plan would be required.

Impact on the Medicaid Management Information System

Medicaid and its Medicaid Management Information System (MMIS) will be a full and active partner in the project. IDHW will meet with all three vendors that comprise the Idaho MMIS to discuss how current functionality can support the future environment and also what additional enhancements each of their companies can offer (individually and collectively) that would assist Idaho in meeting the needs of the future as provided by the SHIP.

The Idaho MMIS is fully able to meet a tiered PMPM payment structure. This system configuration was completed in 2011 to meet the needs of the PCCM and updated in 2013 to meet the requirements of the health home initiative. It is anticipated that there will at minimum be a need for the Idaho MMIS to pass and receive data to/from other systems at the regional and State level. Data that could potentially be used includes claims, recipient, and provider data, in consideration of HIPAA and other regulations. The Medicaid Decision Support System aggregates claims and pharmacy data and may feed the proposed ‘data hub’ through a variety of mechanisms (flat file, web services, etc.). Required changes/modifications to the Decision Support System could include data filtering, data-specific aggregation, and transmission.

The planning and implementation timelines for changes to the MMIS are largely unknown until requirements have been developed and required changes are defined and prioritized. Any changes to the MMIS or related systems will likely require time/effort and possibly new resources as current IDHW resources are constrained by ongoing, non-SHIP related system changes, enhancements, and other activities, especially considering the priorities of the ACA and other initiatives.

6

Coordination with Existing State and National Health Programs and Healthcare Initiatives

Idaho's model of healthcare delivery and payment reform both builds off existing state and national healthcare initiatives and partners with those efforts to elevate their impact on the population. Below are key programs in Idaho that will be coordinated with the SHIP.

Coordination with Aging and Long Term Services and Supports

Community services for individuals with developmental disabilities, as well as elder care, community health, and home- and community-based services (HCBS) are available throughout Idaho, but often poorly coordinated. The Idaho Medicaid program currently has four Section 1915(c) waivers to provide HCBS to individuals who would otherwise require care in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID). These waiver programs are:

Act Early waiver	• For children age three to six who meet ICF/ID level of care and have an autism spectrum diagnosis and/or maladaptive behaviors
Children's Developmental Disabilities waiver	• Offers various HCBS to children up to age 17 who meet ICF/ID level of care and have autism, intellectual disabilities, and/or a developmental disability
Developmental Disabilities waiver	• Offers HCBS to individuals age 18 or older who meet ICF/ID level of care and have autism, intellectual disability, cerebral palsy and/or a seizure disorder
Aged and Disabled waiver	• Offers services to individuals who meet nursing facility level of care, and are either age 65 or older, or age 18 to 64 and have a disabling condition

The Administration on Community Living's Aging and Disability Resource Centers (ADRCs) and CMS' Money Follows the Person Program (MFP) are active in the State of Idaho. Idaho does not have an approved application for the Balancing Incentives Payment Program. The Idaho MFP Demonstration is known as Idaho Home Choice. The goal of the program is to help people transition from an institution (skilled nursing facility, intermediate care facilities or psychiatric facilities) to community living in an apartment, private home, or community setting such as a certified family home or residential assisted living facility. As of July 2013, the Idaho Home Choice program has helped 104 individuals transition from an institution back to the community.[46] There are six Area Agencies on Aging (AAAs) in Idaho, one in each of the State's Planning Service Areas,

[46] http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/IHCNewlsetter.pdf

that provide ADRC services to seniors in their service area, including options counseling to assist seniors in identifying community resources and supports to help meet their needs. The activities of the ADRCs are coordinated and governed by the Idaho Commission on Aging.

Patients with the highest need and patients at the highest risk of adverse health outcomes are often eligible for these public programs that provide case management, care coordination, and other resources to help ensure that the patient receives the right care in the right setting. However, poor coordination among those programs and with the patient's primary care team leads to the potential for these functions to be duplicated. At the same time, because these programs only serve those with the highest need, many patients who would benefit from case management and care coordination do not receive these needed services.

The Network work group considered the integration of institutional and community-based services for the aged and disabled populations in the PCMH model. The work group addressed the following questions:

1. Will the new model require any changes in the role of the HCBW waiver, MFP and ADRC programs? If so, what will their new role be?

2. What are the roles of each player (i.e., HCBS provider, MFP, ADRC, PCMH, and other agencies who provide LTC) in terms of case management and care coordination? How can we ensure that functions are not duplicated?

3. How will the model ensure coordination with facilities or home-based providers if the PCMH is not the primary deliverer of care (meaning the patient sees the provider who comes to them rather than choosing a PCP to go to see)?

4. How should end of life care be integrated into the system?

5. What role should the PCMH have in helping with transitions out of facilities in order to reduce readmissions?

Network and CQI work group members agreed that the PCMH model must include a strong element of coordination with long term care services that focuses on patient-centeredness and quality of care. The facilities and community-based organizations that serve the aging and long term care populations will be integrated into the new model to form a cooperative network of providers that work together to address the needs of the patient across his or her lifespan. These providers include: PCP, pharmacist, hospital, nursing home, residential assisted living facilities, home health/community care, physical therapist, occupational therapist, mental health provider, hospice, rehabilitation, substance use disorder provider, adult day care center, developmental disability center, social worker, and the community groups or facilities that provide meals either on site or home delivered. Stakeholders agreed that one of the goals of the new model should be to reduce facility readmissions, which can be achieved through greater care transition coordination among the facilities that participate in a patient's care. A key strategy for reducing facility readmissions is improving notifications of hospital/facility admissions (such as through EHR alerts) and careful care transition planning. Care transition will address critical components of effective care at home prior to the patient's discharge, including assistance with obtaining medicines, scheduled follow-up appointments, and at-home checks as needed.

The Multi-Payer work group recommended integrating complex cases into the new payment models through a value-based payment structure where payers will negotiate expanded PMPM payments to practices for the coordination of complex cases.

Restructuring Medicaid Supplemental Payment Programs

The Steering Committee also considered whether changes to Idaho's Medicaid supplemental payment programs will be necessary to support the new model. The supplemental payment program in Idaho is associated with hospital services. The proposed PCMH model focuses on creating a medical home, and the proposed payment strategies do not include inpatient or outpatient hospital services at this time. However, the longer range goal is to move toward total cost of care models with shared savings. At that point, the State might reexamine how the supplemental payment program could be utilized to aid in these strategies.

Coordination with Oral Health Services

The holistic approach developed by stakeholders recognizes the importance of oral health, in particular children's dental care, in attaining improved health status for Idahoans. Availability of dental care is a concern as there are 63 dental care health professional shortage areas in Idaho.[47] Workgroup members recommended that the RCs identify all dentists and organizations, e.g., public health, within the medical neighborhood providing dental care and work with them to establish formal mechanisms for communication and referrals.

Coordination with Idaho Community-based Quality Initiatives

Idaho is proud of its history of community initiatives supported at the local level by faith-based organizations, civic groups, local public health districts and nonprofit organizations, all of which will be harnessed in the new model to improve the health status of Idahoans across the State. Idaho's model builds off the experience and success of these local initiatives and supports the advancement of existing programs by partnering with these efforts to enhance and expand quality care. The IHC and its RCs will facilitate partnerships with local community-based initiatives to deploy evidence-based community health improvement strategies either developed locally or modeled from successful strategies used in other parts of the State or country. Community-based initiatives will vary by region to reflect local needs as identified through community needs assessments and align with performance measures.

Community initiatives listed here are examples of existing Idaho programs that share a common goal with the IHC and its RCs to respond to community health needs and improve the health of all Idahoans.

- Activate Treasure Valley is a multi-faceted healthy living initiative sponsored by the YMCA that encourages people to adopt healthier lifestyles. The initiative brings together health and wellness partners from across the region with the vision of making the Treasure Valley a model for active living and healthy eating in America.[48]

- The Cancer Awareness and Prevention Coalition of North Central Idaho planned and implemented a strategic plan to increase cancer screening rates and decrease cancer incidence

[47] *Idaho: Providers and Service Use*. The Henry J. Kaiser Family Foundation. http://kff.org/state-category/providers-service-use/?state=ID

[48] Treasure Valley YMCA, Activate Treasure Valley Website viewable at http://www.ymcatvidaho.org/programs/healthy-communities/activate-america

in the area. Their initiatives include the No Sun for Baby program that partners with local hospitals to educate new parents about the importance of protecting babies from the sun.[49]

- Let's Move Boise! is a community wide initiative to combat childhood obesity by increasing access to healthy food and physical activity. This initiative works in collaboration with the National League of Cities' Healthy Communities for a Healthy Future to impact child nutrition by educating child-care providers, raising awareness about nutrition programs, growing fruits and vegetables, and providing neighborhood based activities for kids and adults.[50]

- In the south central part of the State,[51] the local public health districts support a number of community health initiatives including the "Ask Me" program, a community-based education program utilizing volunteer partners to promote breast cancer screening with the goal of increasing the number of women receiving mammograms.

- Several grant funded programs are promoting dental health for children by providing fluoride varnish to children in Early Head Start in Twin Falls, Jerome, and Rupert. The local public health district also provides fluoride varnish to children in Migrant Seasonal Head Start and the Refugee Center.

- To help improve physical activity and nutrition, HEAL IDAHO and the local public health district have offered mini-grants to two elementary schools in Minidoka County to help increase access to nutritious foods or promote physical activity. These grants require schools to create and implement policy and/or environmental changes that will demonstrate how their project is sustainable.

- The Eastern Idaho Chronic Disease Partnership is a group of healthcare professionals who focus on reducing the burden of chronic diseases on individuals, families, and the community. The partnership meets every month and sponsors both professional development and community-based events.[52]

Coordination with National Campaigns and Health Promotion Programs

Many of the performance measures recommended by the CQI work group align closely with the tenets of a number of national campaigns and health promotion programs. Alignment of State efforts with national programs such as Healthy People 2020, the Million Hearts Campaign, the National Prevention Strategy, and the National Quality Strategy will allow the IHC and RCs to leverage large national health campaigns, in combination with localized efforts, to address some of the most important issues facing the health of Idahoans. Adoption of national campaigns can also be used as a first step to initiating programs and supports while recognizing resource limitations in some regions that might be a barrier to local initiative development. The IHC and RCs can leverage the outreach efforts of national campaigns such as Healthy People 2020 and the Million Hearts Campaign, while honing in on State and region-specific issues that pose the most significant concerns for individual regions. The combined efforts of national campaigns with State and regional engagement will amplify the effectiveness of outreach efforts at every level.

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[49] North Central Idaho Public Health District, Community Health Programs webpage, viewable at http://www.idahopublichealth.com/78-community-health/

[50] Let's Move Boise! Website viewable at http://www.letsmoveboise.com/

[51] South Central Idaho Public Health District, Community Health webpage viewable at http://www.phd5.idaho.gov/

[52] Eastern Idaho Public Health District web page viewable at http://www.phd7.idaho.gov/Health%20Promotion/Diabetes/diabetesmain.html

The Million Hearts campaign represents an opportunity for the IHC, RCs, public health districts, and the provider community to address a number of health concerns that contribute to some of the most significant causes of morbidity and mortality in Idaho. Through partnership and collaboration, the Idaho will be better able to achieve the goals of its Strategic Plan which align with the tenets of the Million Hearts Campaign, such as reduction in the use of tobacco products, promotion of healthy eating habits, and high rates of screening/management of cholesterol and blood pressure among Idahoans.[53] The adoption and reporting of a subset of these clinical quality measures, as well as data sharing with stakeholders also provides an opportunity for Idaho to align its SHIP with the Million Hearts Campaign and its goals.[54] Many of these goals and priorities also line up with goals established by the Healthy People 2020 program, which contains health-related goals spanning a wide range of specific criteria.

The alignment of goals, priorities, targets, and performance measures between IDHW, the IHC, RCs, local public health districts, and these national campaigns serves as an opportunity for cooperative efforts, meaningful dialogue, and information sharing. Many of the quality performance measures that will be collected, evaluated and reported as part of Idaho's SHIP align well with the targets and performance measures established by these and other national health campaigns. As such, Idaho has an opportunity to monitor the effectiveness of its targeted measures and programs as they pertain to specific health concerns and risk factors, as well as the opportunity to gauge Idaho's performance against a national benchmark. Idaho's participation in the data collection and discourse surrounding these national campaigns provides an opportunity to both improve the quality of health information gathered, as well as the care and service efficacy represented by those measures through the SHIP.

IDHW's efforts to promote health and quality healthcare and reduce costs also align with goals outlined by the Division of Medicaid's State Medicaid Health Information Technology Plan (SMHP) and the HQPC. Among the priorities of the SMHP is improving access to collaborative care, which is achieved through information sharing via the IHDE.[55] The SMHP specifically identifies program outreach and incentivized expansion of EHR utilization and connectivity. Furthermore, the SMHP establishes the IHDE as having a prominent role in the collection and reporting of meaningful use data, specifically clinical quality measures. Many of these measures, as described above, align with goals established in the SHIP, as well as the tenets of national campaigns such Healthy People 2020 and the National Quality Strategy.

Coordinating with Nonprofit Hospitals' Community Benefits/Community Building Plans

Stakeholders identified that the interaction between State and regional health efforts with community nonprofit hospitals represents a significant opportunity to assess and subsequently address some of the major health concerns in Idaho's regions. The ACA added new requirements for nonprofit hospitals, including the requirement to conduct a community health needs assessment and adopt an implementation strategy every three years. This is in addition to the community benefits analyses they were already required to perform pursuant to IRS regulations and Idaho's requirement that nonprofit hospitals with at least 150 beds report community benefits.

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[53] Idaho Department of Health and Welfare FY2013 – FY2017 DHW Strategic Plan. July 1, 2012. http://www.healthandwelfare.idaho.gov/Portals/0/Users/246/46/246/DHW%20Strategic%20Plan%20SFY%202013%20%20Final%20(2).pdf

[54] Wall, Hilary K. and Taylor, Erica. *Idaho Statewide Healthcare Innovation Plan Webinar Series for Model Design States – Aligning with Million Hearts.* Webinar presented July 25, 2013.

[55] Idaho Department of Health and Welfare Division of Medicaid. *State Medicaid Health Information Technology Plan*. April 1, 2013. http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/WebVersionSMHP.pdf

These assessments and analyses provide a valuable opportunity for nonprofit hospitals, which are integral components of the medical neighborhood, to cooperate with regulatory and health promotional agencies at the State and regional level in order to evaluate and address issues facing the health of Idaho's communities.[56]

Local public health districts have conducted community needs assessments similar to the requirements placed upon nonprofit hospitals, and the IRS has released an announcement that allows nonprofit hospitals and health departments to join efforts in conducting the community health needs assessments required by the ACA. Furthermore, the IRS allows nonprofit hospitals to work with outside agencies such as local, regional, and State health departments to develop implementation strategies for the community health needs assessments. The CQI work group discussed the challenge of integrating community assessment information from multiple sources. It was recommended that the IHC and RCs partner with local public health districts to conduct the community health assessments rather than duplicate the efforts. The work group noted that the IHC should also use the findings of these assessments to identify commonalities and differences among communities which have conducted assessments. The findings will educate the IHC, allowing it to create and administer programs that target the issues found to be common across Idaho communities.

The development of a standard approach to and follow-up from community assessments will be a process that involves the IHC, RCs, local public health districts, and other stakeholders in the Idaho healthcare delivery system. This standardization allows for benchmarking across regions and the identification of strengths and weaknesses of the healthcare delivery system both regionally and in the State as a whole. Furthermore, RCs can collaborate with nearby hospitals to identify further key measures that can be collected in addition to the Performance measure Catalog measures in order to shed light on region-specific concerns.

Although the collection of data for community health needs assessments will fall primarily on nonprofit hospitals and public health departments, PCMHs within the State will also benefit from this collaborative process. Several of the core PCMH measures should be in line with the measures being reported by hospital systems and local public health districts, so PCMHs can both provide data to and use data from community needs assessments to improve their patients' health status. For example, hospital readmission rates can serve as an indicator for poor discharge planning and/or coordination of care, providing PCMHs with data that can be used to improve their impact on community health. Also, PCMHs can refer their patients to health and wellness programs, health education classes and other benefits being provided by hospitals, local public health districts, and community agencies.

Integrating Early Childhood and Adolescent Health Prevention Strategies with the Primary and Secondary Educational System

Currently, early childhood and adolescent health prevention strategies are the shared responsibility of Idaho's Department of Education and IDHW. The Department of Education operates several programs—with federal and State funds—that are geared towards promoting health literacy and healthy behaviors as well as ensuring a healthy school environment for students. The Coordinated School Health program includes health education, physical education, school nurse services, nutrition services, school counseling, psychological and social services, programs to promote a healthy school environment, and school-site health promotion for school staff. Section 204 of Public Law 108-265 mandates that all school districts have a wellness policy that includes goals for

[56] *New Requirements for Non-profit Hospitals Provide Opportunities for Health Department Collaboration*. The Network for Public Health Law. Last Updated October 2011. http://www.networkforphl.org/_asset/fqmqxr/CHNAFINAL.pdf

nutrition promotion, nutrition education, and physical activity, as well as guidelines for foods available on school campuses.[57] A 2009-2010 evaluation of school wellness policies revealed high compliance with this requirement.[58]

IDHW also plays a vital role in early childhood and adolescent health prevention strategies through federal and State-funded public health programs as well as direct prevention services provided through the seven local public health districts.

There was significant discussion within the Network work group regarding how PCMH practices should be integrated with existing school services and the primary and secondary educational system. The work group addressed the following questions:

- How will the new model integrate with existing programs/services for early childhood and adolescent health?

- How should school-based providers be connected into a medical home to create a better, more complete medical/behavioral health treatment model and to educate each other on the child's welfare? In the future, could a school-based wellness center become part of a PCMH?

- How much of the information-sharing capacity with schools currently exists versus what would need to be built? What information can be shared under HIPAA provisions? Who would have access to the child's record at the school?

There were areas of consensus and disagreement in the discussion of these issues. Work group members agreed that schools are in a unique position to observe behavioral and development issues that may not be apparent to a provider. Schools should be involved in conducting ongoing behavioral and developmental assessments. When issues are identified by such assessments, those need to be incorporated into the child's treatment plan, with treatment options explored by the PCMH, and the school providing treatment services where such services are available. As such, the new model should promote information sharing and coordination of care between the school and the child's PCMH. The PCMH's electronic medical record should contain information received from the school in order to coordinate those aspects of a child's care, particularly as they relate to behavioral and developmental issues in which the school is involved.

Currently, Idaho schools do not provide comprehensive preventive and primary healthcare services. In the event that these types of school-based wellness centers (SBWCs) develop in the future, the work group addressed how their services would be integrated with the PCMH model. Some work group members felt that the PCMH needs to be the principal service-delivery team and that SBWC services have the potential of fragmenting care and weakening coordination. However, a majority of work group members felt that as long as good communication exists and data is shared between the two entities, there is a role for the PCMH and SBWCs to work together. The PCMH would be responsible for developing a treatment plan, and assuring the coordination of care. The SBWC would have a role in providing care as an extension of the PCMH.

Coordinating with Health Insurance Marketplace Activities

Since the three largest commercial payers have agreed to follow the payment model and attribute membership to PCMHs for all individual and group policies, including policies sold through the

[57] http://www.sde.idaho.gov/site/cnp/wellness/docs/Section204ofPublicLaw.pdf

[58] http://www.sde.idaho.gov/site/cnp/wellness/docs/StatewideResults.pdf

Health Insurance Marketplace, the work groups did not discuss additional options for coordinating with marketplace activities. These decisions will be made during the model testing phase.

7

Policy Considerations

While several states have used executive, legislative or regulatory authority as tools for implementing new healthcare delivery models, Idaho stakeholders rejected the idea of policy changes that mandate adoption of the model or any of its components. Work group members and focus group participants across the board stated that incentives should be used to garner the cooperation of practices to transform their practices to the PCMH model and participate in performance reporting. Likewise, stakeholders rejected the idea of changes to the law impacting payer payment methods or data collection and reporting. Stakeholders were clear in stating that mandates and penalties do not work in Idaho, but that real change could occur through the cooperation of payers, providers, and patients.

Stakeholders recognized that, in some instances, legislation and executive orders have helped advance the quality of Idaho's healthcare delivery system. However, as a general rule, stakeholders felt that not only were policy levers unnecessary to achieve change when there is collective support across providers, payers and patients but could, in fact, back-fire if appearing to be a mandate. As such, there was minimal discussion of potential policy levers to aid in model implementation. Policy considerations that were discussed in work groups are noted below.

Relevant Idaho Healthcare Policy Levers

In recent years, several key pieces of legislation and action by the Governor through executive order have supported the development of a model that provides quality, patient-centered care. For example, the Idaho Health Planning Act states:

> "It is the intent of the legislature to provide to all of Idaho residents a quality healthcare system for a reasonable cost and to prevent the deterioration of such system by the duplication of services or the introduction of new categories of services that are not necessary to their health. It is further the intent of the legislature to promote cooperation among healthcare providers in health planning activities and to provide access to necessary care for all who require it. It is hereby declared that it is in the public interest of the state, to provide for the relief from penalties of state and federal law, cooperative planning in healthcare that is likely to benefit the residents of the state."[59]

Other important enacted legislation includes HB 260, passed by Idaho's legislature in 2011. This legislation directed IDHW to develop a plan for Medicaid managed care with a focus on high-cost populations. Specifically noted in the legislation was that the Department consider ways to improve coordination of care through patient centered medical homes. IMHC, created by Governor Otter through Executive Order 2010-10, embodies the purpose and policy set forth in the State's Health Planning Act and carries out legislative direction established through HB 260. As noted previously, the IMHC was tasked with making recommendations to the Governor and the Department of Insurance (DOI) regarding policies and activities necessary to transform Idaho's healthcare delivery system to a PCMH model. On November 21, 2012, CMS approved a Section 2703 health home

[59] Idaho Code §39-4901

State plan amendment (SPA) for Medicaid participants with chronic conditions. The SPA enables the Idaho Medicaid program to participate in the IMHC. Stakeholders across the four work groups and the Steering Committee agreed that the model proposed through the Health Planning Act and embodied in the IMHC's PCMHs should serve as the foundation for the future healthcare delivery system.

Idaho is one of several states with an "any willing provider law." Enacted in 1994, Idaho's law requires insurers and managed care organizations to accept in their provider network any qualified provider willing to accept the terms and conditions of the contract.[60] Stakeholders noted that this law may bolster the availability of providers participating in the model and increase patient choice.

Idaho's Individual Health Insurance Availability Act[61] sets forth critical provisions regarding health insurer requirements, including rate review provisions. The law establishes that rate filing is required for increases above 10%. Insurers must file new and proposed rate changes with the Idaho DOI (for increases are above 10%), but do not need to receive formal approval before they can implement the rate or rate change. Stakeholders did not feel that the statute or other DOI requirements imposed any barriers on implementation of the proposed PCMH delivery and payment model.

The Steering Committee considered how the new model will align with State regulatory authorities. Through the gaps analysis process, stakeholders identified that at this time Idaho does not have a certificate of need program and an alternative program was not recommended during the stakeholder input process.

State Plan Amendment to Implement the PCMH Model for Medicaid and CHIP

In order to implement the PCMH model described in this SHIP for Medicaid and CHIP, Idaho will submit an Integrated Care Model (ICM) Medicaid State plan amendment. Idaho's ICM SPA will be developed in accordance with CMS' guidance regarding ICMs, including State Medicaid Director letters #12-002 and #13-005 and will include changes to both Attachment 3.1-A and Attachment 4.19-B. In addition to the ICM SPA, Idaho will submit any necessary conforming changes to its Title XIX (Medicaid) and Title XXI (CHIP) State plans. Idaho will begin preparing these SPAs upon notice of award of a Model Testing Grant. Idaho will also revise its administrative rules, provider manuals, etc. as needed to implement the PCMH model within six months of award.

Additional policy levers considered include the following:

- Stakeholders discussed the importance of EHR adoption and other HIT tools to support care coordination, patient engagement and performance reporting. However, stakeholders did not support using mandates, such as the Massachusetts approach of requiring EHR adoption by a specified deadline as a requirement of obtaining a medical license in the State. Instead, stakeholders recommended that it is important to understand existing and perceived barriers, and implement supports and incentives to help providers overcome barriers.

- Stakeholders felt that potential legislation that might be supported is a change to the law that would allow information from the Idaho Immunization Reminder Information System (IRIS), to become part of a centralized electronic health record for the patient. IRIS is the statewide

[60] Idaho Code §41-3927 and §41-2872

[61] Idaho Code §41-5206

population based information system that tracks vaccines by patient and provides patient specific reminders to help providers monitor their patient's vaccination schedule. Current Idaho law[62] allows IRIS to receive data from other systems but does not permit the system to transmit immunization data back to those systems, including electronic health records systems.

- Stakeholders considered whether legislation should be enacted to require providers to accept patients from all insurers but rejected this idea. There was concern that providers would be disadvantaged if forced to accept all forms of insurance.

- Stakeholders considered the policies of Maryland's PCMH program that require the State's major carriers of fully insured health benefits to participate in the program. Stakeholders rejected this approach, noting that it was important to work collaboratively with payers to form partnerships as legislation that would mandate their participation in the model would not succeed in Idaho.

- Anti-trust legislation was considered but was determined to be unnecessary to implement the model.

As the IHC takes form and collaboration in implementation of the model continues across payers, providers, communities and individuals, stakeholders may eventually identify legislative, executive and/or regulatory authorities that would benefit and advance transformation of Idaho's healthcare delivery system. At this time, however, no such authorities are recommended as Idaho is confident that the model can be implemented through the commitment of healthcare system stakeholders and be advanced by incentives to transform to a patient-centered, population health approach.

[62] Idaho Code §39-4803

8

Self-Evaluation Plan

Plans for Continued Improvement and Evaluation

Through the SHIP model design process, Idaho has created an initial evaluation plan that will be expanded and developed by the IHC in the first phase of model implementation. The final evaluation plan, as developed by the IHC in coordination with external evaluation consultants, is intended to provide Idaho with a process for tracking progress in implementing the SHIP and in achieving the aims of the SHIP. The evaluation plan will help Idaho monitor an overall picture of implementation activities, as shown in the driver diagram at the end of this section, so that areas of need can be quickly identified in order to make changes to activities and resources. The plan is a fluid document that will change and expand over time based on work plan objectives, accomplishments, and expectations.

Idaho will provide access to data to enable CMS to evaluate the extent to which Idaho's health system transformation plan was implemented and the results of the model. This will include but not be limited to providing performance measure baselines and results and sharing community needs assessments and initiatives implemented by the IHC and RCs. In addition, IDHW, the IHC, and the RCs will identify key stakeholders for CMS to interview and facilitate contact as needed.

Idaho's Self Evaluation Plan

The self-evaluation plan is intended to provide a process for tracking the State's progress in implementing and achieving the aims of Idaho's SHIP. The evaluation plan will also provide a roadmap of evaluation activities so that required staff time and resources can be identified. Details of the plan may change and expand over time based on work plan objectives, accomplishments, and expectations.

The evaluation plan is based on the stated objectives of Idaho's SHIP, and includes performance and process measures that reflect the key elements of a successful system transformation. Most measures were identified because they are currently collected by different providers, and thus, available to support evaluation early in the model testing period. Source identification did not reveal any overly burdensome collection processes.

The evaluation measures identified during the SHIP model design phase indicate key milestones and outcomes of the model, all of which are targeted to achieving the Triple Aim of improved health outcomes, improved quality and patient experience of care, and reducing overall healthcare costs. Idaho's evaluation plan focuses on 4 key areas: outcomes, costs, structure and care experience.

The Performance Measure Catalog, presented below and described in Section 2, identifies the outcome measures that Idaho will evaluate. Information regarding the requirements and timeframes for data collection and reporting on these measures is also found in Section 2.

Idaho's Initial Performance Measure Catalog

Measure Name (and Source)	Measure Description	Rationale for the Measure
Screening for clinical depression.	Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow up plan documented.	In Idaho, 22.5% of persons aged 18 or older had a mental illness and 5.8% had SMI in 2008–2009 while 7.5% of persons aged 18 or older had a major depressive episode (MDE). During the period 2005–2009, 9% of persons aged 12-17 had a past MDE. Suicide is the second leading cause of death for Idahoans aged 15–34 and for males aged 10–14. This measure aligns with Healthy People 2020.
Measure pair: (a.) Tobacco use assessment.	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.	In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.
(b.) Tobacco cessation intervention (SIM)	Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	
Asthma ED visits.	Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	While asthma prevalence (those with current asthma) in Idaho was 8.8% in 2010, reduction of emergency treatment for uncontrolled asthma is a reflection of high quality patient care and patient engagement.
Acute care hospitalization (risk-adjusted).	Percentage of patients who had to be admitted to the hospital.	While Idaho has one of the country's lowest hospital admission rates (81/1000 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.
Readmission rate within 30 days.	Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	Data currently unavailable. Metric will be used to establish baseline.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of a hospital ED.	While Idaho has one of the country's lowest hospital ED utilization rates (327/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of emergency services, as well as a reflection of quality and patient engagement in primary care related to avoidable treatment.
Elective delivery.	Rate of babies electively delivered before full-term.	Data currently unavailable. Metric will be used to establish baseline.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Low birth weight rate (PQI 9).	This measure is used to assess the number of low birth weight infants per 100 births.	While Idaho's percentage of low birth weight babies is low compared to the national average, the opportunity to improve prenatal care across settings is an indicator of system quality. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia (HEDIS).	The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Idaho has a 100% shortage of mental health providers statewide. Without these critical providers, there is little or no support for patient engagement and medication adherence. Improved adherence may be a reflection of improved access to care and patient engagement.
Weight assessment and counseling for children and adolescents (SIM).	Percentage of children, two through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.	In 2011, 13.4% of children were overweight as defined by being above the 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th percentile for BMI by age and sex.
Comprehensive diabetes care (SIM).	The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.	Adult diabetes prevalence in 2010 was 8.0%. Overall, this represented one in 12 people in Idaho had diabetes.
Access to care.	Percentage of members who report adequate and timely access to PCPs, BEHAVIORAL HEALTH, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes access to the appropriate level of care.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Childhood immunization status.	Percentage of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	While there have been significant improvements in immunization rates, Idaho ranks 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.
Non-malignant opioid use.	Percent of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.

The table below identifies the cost measures that Idaho will evaluate. These measures were identified by the Multi-Payer work group, as described in Section 3. The timeframes to achieve cost targets can also be found in Section 3.

Idaho's Cost Measures

Issue	Target	Target Phases	Mechanism to Reach Target
Appropriate Generic Drug Use	Generic fill rate of 85%	25% of target in Year 1 one, 50% in Year 2 and 25% in Year 3	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%-1.0% in Medicaid and 2%–3% in commercial payer)
Re-hospitalizations	5%–10% reduction	10% of target in Year 1, 20% in Year 2 and 70% in Year 3	20% of all hospitalizations are preventable re-hospitalizations

Issue	Target	Target Phases	Mechanism to Reach Target
Acute Care Hospitalizations	1%–5% reduction in total hospitalizations	0% of target in Year 1, 25% in Year 2 and 75% in Year 3	PCMHs reduce acute hospitalizations with IMPACT and IOCP training
Non-Emergent ED use	5%–10% reduction in total ED use	25% of target in Year 1, 50% in Year 2 and 25% in Year 3	10%–30% of ED visits are non-emergent (best in class commercial rates are 120-150/1000)
Early Deliveries (in weeks 37–39 of gestation)	20% improvement over baseline or all hospital report <5% 37-39 weeks	50% of target in Year 1, 50% in Year 2	1%–4% of total NICU admissions ($40-$70K/admit) are preventable with later deliveries

Idaho will also evaluate model structure and patient experience of care measures. These measures, and their data sources, are presented in the table below.

Model Structure and Patient Experience of Care Measures

Evaluation Area	Performance Measure	Data Source	Performance Targets
Model Structure			
Establish PCMHs statewide.	Percent of practices that achieve PCMH designation and accreditation tier requirements in required amount of time.	IHC tracking.	• 300 PCMHs are established over five year project period (60 new PCMHs per year of model testing).
Patient enrollment in PCMHs.	Percent of Idahoans who enroll in PCMHs.	IHC tracking.	• 80% of Idahoans will be enrolled in a PCMH by Year 5 – Year 1: 10% – Year 2: 20% – Year 3: 50% – Year 4: 75% – Year 5: 100%.
Establish regional support for practice transformation through the establishment of RCs.	Percent of primary care practices desiring to transform to a PCMH that can receive assistance through an RC.	IHC tracking.	100% of primary care practices desiring to transform to a PCMH will be able to receive assistance through an RC.
Establish PCMH care coordination.	Percent of PCMHs who have established protocols for referrals and follow up communications with providers in their medical neighborhood.	RC tracking.	100% of PCMHs will have instituted referral and follow up communication protocols with providers in their medical neighborhood.
Establish Virtual PCMHS.	Percent of rural communities establishing a virtual PCMH following assessment of need.	IHC tracking.	TBD by IHC.

Evaluation Area	Performance Measure	Data Source	Performance Targets
Training of lay community health workers.	Number of new community emergency medicine personnel and community health workers trained.	IHC or its designee.	TBD by IHC.
Establish payment incentives.	Percent of payers who adopt total cost of care shared savings reimbursement models.	Payers and IHC tracking.	By Year 3 of model implementation, Idaho's major payers (public and private) participate in total cost of care shared savings reimbursement models.
PCMH integration of certified EHRs.	Percent of PCMH participants with active her.	PCMH registry.	TBD by IHC after consultation with IDHW's Medicaid Provider Incentive Program.
Care Experience			
Regional Health Needs Assessments.	Percent of PCMHs who receive results of community health needs assessments that can be used to guide development of quality initiatives within their practice.	IHC, RC and Public Health tracking tool.	75% of PCMHs will receive information from their regional community health needs assessments Year 1 – 5% Year 2 – 20% Year 3 – 40% Year 4 – 60% Year 5 – 75%.
Patient Engagement.	Percent of enrolled PCMH patients who report they are an active participant in their healthcare.	Patient satisfaction survey.	TBD by IHC.
Stakeholder Engagement.	Number of stakeholder forums occurring to inform, refine and improve delivery system model.	SHIP Steering Committee and later the IHC.	At least two stakeholder events, (e.g., townhalls, focus groups, online survey) will be held quarterly to assess patient and provider satisfaction with model implementation.

The Idaho evaluation plan measures, as identified in the tables above, will be used to monitor model implementation over time. The IHC will be responsible for the collection and analysis of measurement outcomes data, while relying on a combination of internal staff and vendors to perform these activities. In the implementation phase, the IHC and RCs will work with the State evaluator (chosen by the IHC and approved by CMMI) to develop a detailed work plan to launch the evaluation.

Idaho has several well suited entities in State that would be able to work through cooperative agreements to assist in program evaluation. These include the Idaho Rural Health Association, which is administered through the Idaho State University's Institute of Rural Health and the Center for Health Policy at Boise State University. The Center for Health Policy conducts health policy research and works with stakeholders around the State to develop innovative health policy. Another qualified entity that could provide program evaluation services is Qualis Health. Qualis Health is a nonprofit healthcare consulting organization that has worked with Idaho entities in monitoring and improving healthcare delivery and outcomes. The State evaluator will be selected during the implementation phase so that the evaluation plan can be initiated upon commencement of Year 1 model testing.

Idaho's Driver Diagram

TRIPLE AIM ← **PRIMARY DRIVERS** ← **SECONDARY DRIVERS**

By 2019, Idaho will:

1. **Improve health outcomes**
2. **Improve quality and patient experience of care**
3. **Reduce healthcare costs by $70 million.**

Specifically, Idaho will:

Increase appropriate generic fill rate
Decrease re-hospitalizations
Decrease acute care hospitalizations
Decrease non-emergent ER use
Decrease early term deliveries
Increase tobacco use assessments and tobacco cessation interventions (SIM measure)
Increase weight assessments for kids and adolescents (SIM measure)
Increase rates of comprehensive diabetic care (SIM measure)

IHC will identify additional measures after Year 1 among the following:

Increase screening rates for clinical depression
Increase adult BMI assessment
Patient satisfaction
Decrease asthma ED rates
Decrease ER visits
Decrease low birth weight babies
Increase adherence to antipsychotics among patients with schizophrenia
Increase childhood immunization rates
Decrease non-malignant opioid use

PRIMARY DRIVERS → **SECONDARY DRIVERS**

- **80% of Idahoans** access primary care via an **accredited PCMH.**
  - Primary care practices become PCMHs, some rural practices become **virtual PCMHs**.
  - **State/regional support** for practice transformation.
- PCMH reimbursements **incent quality of care**.
  - Payers adopt **total cost of care shared savings** reimbursement models.
  - PCMHs develop **sustainable pricing models**.
- Health care is **patient-centered**.
  - PCMHs engage patients throuch **comprehensive assessments, wellness activities and technology**.
  - PCMHs coordinate care with all providers in the patient's **medical neighborhood**.
- Adequate team-based **primary care workforce**.
  - Expand the primary care workforce.
  - Train lay healthcare professionals (**community health workers and community paramedics**).
- **State and regional population health focus**
  - Link data and services with **other federal, state and tribal agencies**
  - Adopt and track core **statewide** measures plus **regional** measures.
  - **Regional health needs assessments**.

9

Road Map for Health System Transformation

Milestones for Health System Transformation

Year 1 Milestones

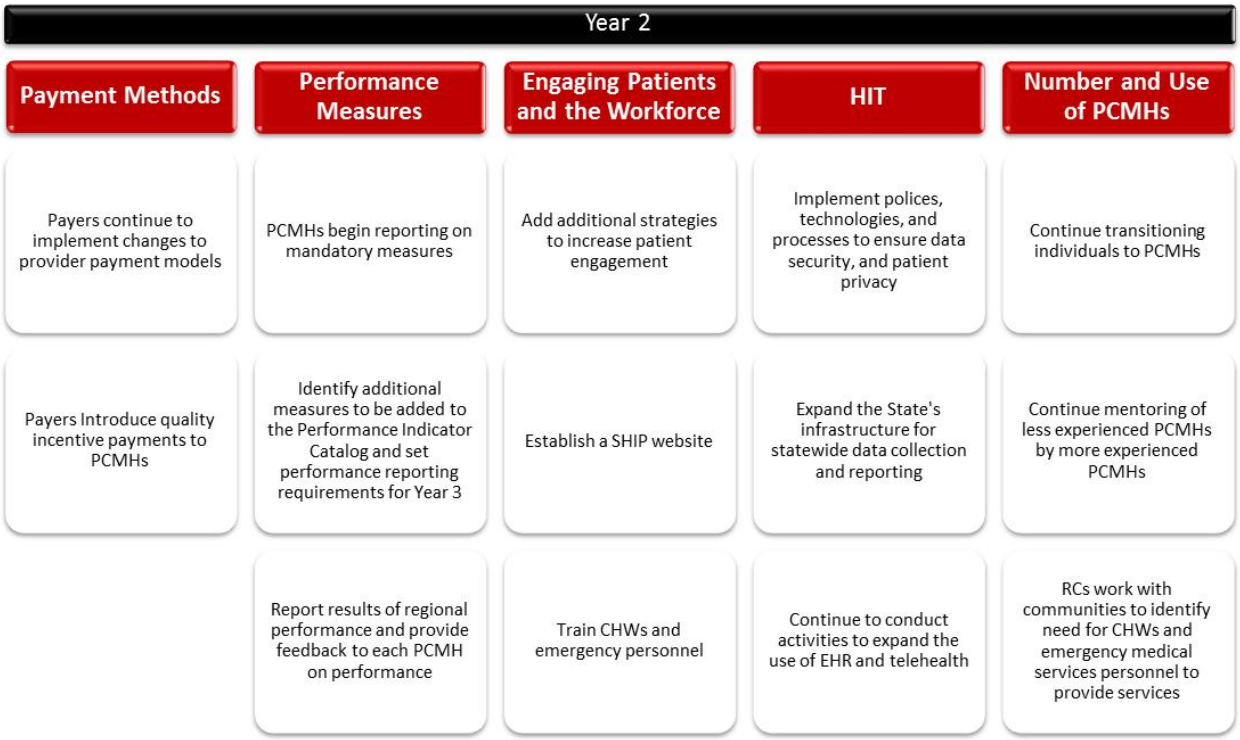
- IHC is fully operational and provides resources and supports for primary care practices to transform to the PCMH model. Support is also provided to established PCMHs to further expand their capacity as a PCMH.
- RCs are established and are providing supports to PCMHs within their regions.
- Funds to assist practices with start-up costs for transformation are distributed by the IHC based on results of readiness reviews completed by practices. Practices receiving funds must meet requirements and milestones established by the IHC.
- Funds to assist established PCMHs in enhancement of the model within their practice are distributed by the IHC based on an assessment of need and established goals. Practices receiving funds must meet requirements and milestones established by the IHC.
- The IHC designates practices as PCMHs following determination that the practice has met core mandatory requirements of the PCMH, as established by the IHC. The IHC provides supports and guidance to PCMHs as they work toward accreditation from a nationally accrediting body.
- Begin PCMH mentoring program to assist practices through the transformation process.
- Begin to implement changes to provider payment models (provide start-up costs and a PMPM payment for ongoing PCMH activities as noted above) and continue to engage the participation and cooperation of payers.
- Collect baseline data on all measures in the Performance measure Catalog.
- Educate providers about data collection techniques and the Performance measure Catalog.
- Develop training program for CHWs and community emergency services personnel to increase opportunities for coordinated primary care in rural and underserved areas.
- Conduct outreach, education, and other supports needed to increase EHR adoption and expansion of telehealth use.
- Develop policies and technology for data sharing and reporting.
- IHC reviews baseline data, establishes reporting requirements for Year 2 by identifying mandatory measures from the Performance measure Catalog, and sets performance targets.

Year 1					
Structure	**Payment Methods**	**Performance Measures**	**Engaging Patients and the Workforce**	**Health Information Technology (HIT)**	**Number and Use of PCMHs**
Establish the Alliance and begin to provide resources and support for primary care practices to transform to the PCMH model	Begin to implement changes to provider payment models and continue to engage the participation and cooperation of payers	Collect baseline data on all measures in the Performance Indicator Catalog	Develop and implement strategies to increase patient engagement	Develop policies and technology for data sharing and reporting	IMHC pilot PCMHs begin to transition "healthy" individuals to their PCMH practice
Establish regional collaboratives (RCs) and begin to support PCMHs within their regions	Distribute funds to assist practices with start-up costs for transformation	Educate providers about data collection techniques and the Performance Indicator Catalog	The Alliance and RCs develop educational campaigns and community initiatives	Conduct outreach, education and other supports needed to increase EHR adoption and expansion of telehealth use	Begin PCMH mentoring program to assist practices through the transformation process
Establish PCMHs and provide support to established PCMHs to further expand their capacity as a PCMH	Distribute funds to assist established PCMHs in enhancement of the model	Alliance reviews baseline data, establishes reporting requirements for Year 2, and sets performance targets	Support the Governor's health council efforts to expand the workfoce	Expand reporting and analytics capabilities	Continue to expand the number of PCMH and the members in PCMHs

Year 2 Milestones

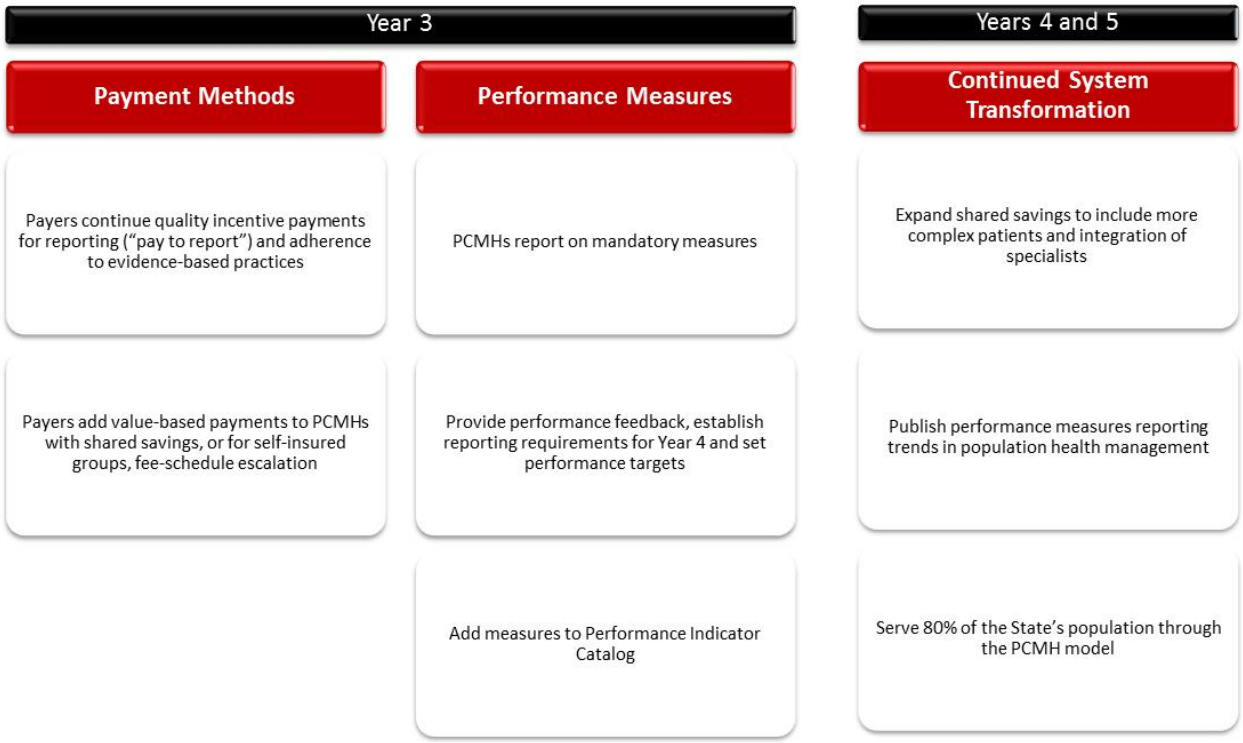
- Designation of PCMHs continues, with the IHC and RCs providing guidance to assistance practices through the transformation process.
- Assistance and supports are also provided to new and existing PCMHs to help them attain higher levels of accreditation and enhance their capacity as a PCMH.
- Continue to implement changes to provider payment models and introduce quality incentive payments to PCMHs.
- PCMHs begin reporting on four measures chosen by the IHC from the Performance measure Catalog for statewide performance reporting.
- Establish a SHIP website and use it as a mechanism to share information with consumers and providers regarding prevention, wellness, and other statewide campaigns.
- RCs and public health collaborate to assess community health needs.
- Implement quality initiatives to address areas in need of improvement.
- RCs work with rural, medically under-resourced communities to identify need for CHWs and EMS personnel to provide services.
- Continue to conduct activities to expand the use of EHR and telehealth.
- Determine regional results of regional performance and provide feedback to each PCMH on its performance.

- Implement quality initiatives to address areas in need of improvement.
- Identify additional measures to be added to the Performance Measure Catalog based on performance results, community health assessment findings and other clinical data.
- Identify performance reporting requirements for Year 3.



Year 3 Milestones

- IHC and RCs continue to provide support to practices in the transformation to PCMHs and to new and existing PCMHs.
- Add value-based payments to PCMHs.
- PCMHs report on statewide measures in the Performance Measure Catalog as identified by the IHC for Year 3 reporting.
- PCMHs report on regional specific measures as identified by the IHC and RCs based on regional performance, community health assessments and other regional clinical data.
- The IHC provides performance feedback to regions and PCMHs, establishes reporting requirements for Year 4, and set performance targets.
- Implement quality initiatives to address areas in need of improvement.
- Determine additional measures to be included in the Performance Measure Catalog.
- Use of EHR adoption and telehealth has increased.



Years 4 and 5 Milestones

- Expand shared savings to include more complex patients and integration of specialists.
- Continue to encourage and support increased levels of quality as demonstrated through higher levels of accreditation.
- Continue to expand evidence-based practices and patient engagement activities and tools to improve the patient's experience of care.
- Serve 80% of the State's population through the PCMH model.
- Conduct population health management through the evaluation of statewide data and continue to adjust performance targets and improve population health.

Appendix A

Key Terms

Agency for Healthcare Research and Quality (AHRQ) – An agency within the U.S. Department of Health and Human Services that funds research and development of reports, practical tools, and other resources to make care safer and better for people across the country. Audiences for AHRQ's resources and information typically include clinicians and other healthcare providers, consumers, policy makers at all levels of government, purchasers, and payers.

Area Health Education Center (AHEC) – Established by Congress in 1971, the network of AHEC organizations across the country was created to improve the distribution, diversity, and supply of the primary care health professions workforce who serve in rural and underserved areas. Idaho AHEC is a program of Mountain States Group Inc., a multi-service non-profit organization located in Boise. It is affiliated with the University of Washington Medical School WWAMI Program, which is a five state collaboration for medical education that takes its name from the first letter of each of the states who partner together: Washington, Wyoming, Alaska, Montana, and Idaho.

Attribution Methodology – The assignment of members to a PCHM to be held accountable for quality (and cost) of healthcare services to those members. These assignments are often based on data-driven factors and can employ a number of methodological approaches including patient-based attribution, episode-based attribution, single and multiple attributions, as well as prospective and retrospective attributions.

Behavioral Health – Mental health and substance use services.

Centers for Medicare & Medicaid Services (CMS) – An agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare, Medicaid and CHIP.

Center for Medicare & Medicaid Innovation (CMMI) – A component of CMS that supports the development and testing of innovative healthcare payment and service delivery models including the State Innovation Models initiative.

Children's Health Insurance Program (CHIP) – The joint federal/State program of medical assistance for uninsured children established by Title XXI of the Social Security Act, which in Idaho is administered by IDHW.

Commercial Insurance – Private health insurance including individual, small group, large group, and self-insured plans. Does not include public insurance programs such as Medicare or Medicaid/CHIP.

Data Hub – A platform for collaborating on gathering, sharing and using data.

Dual Eligible – An individual who is enrolled in both Medicare and Idaho Medicaid. Also referred to as a Medicare-Medicaid enrollee.

Electronic Health Record (EHR) – A record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test

results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Federally Qualified Health Center (FQHC) – An entity that is receiving a grant under Section 330 of the Public Health Service Act; is an FQHC "look-alike" (i.e., the HRSA has notified it that it meets the requirements for receiving a Section 330 grant, even though it is not actually receiving such a grant); or is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Healthcare Improvement Act.

Fee-for-Service (FFS) – A reimbursement model in which medical services are billed and paid individually as they are administered.

Health Professional Shortage Areas (HPSAs) – A geographical area, specific population or medical facility which has been identified by the U.S. Department of Health and Human Services as having a shortage of healthcare professionals. Identified shortage categories include Primary Care, Dental Care, and Mental Healthcare.

Health Quality Planning Commission (HQPC) – A committee established by Idaho legislation tasked with improving care quality and health outcomes through the use of health information technology and patient safety initiatives.

Healthy Connections (HC) – A PCCM program for Medicaid beneficiaries that establishes a PCP as coordinator for all services, including referrals to services not provided by the PCP. Providers in the HC program receive additional payments on a PMPM basis for the patients they serve.

Health Information Exchange (HIE) – The sharing of healthcare information among various entities and stakeholders within the healthcare delivery system. Information sharing generally occurs electronically through the integration of HIT.

Health Information Technology (HIT) – Any technology service or system used to house, distribute, or analyze health data.

Idaho Department of Health and Welfare (IDHW) – Idaho State agency responsible for the administration of various services pertaining to healthcare and social, and economic issues. Responsible for administering, among other programs, the State Medicaid and CHIP programs

Idaho Health Data Exchange (IHDE) – A nonprofit corporation established to develop and oversee the implementation of HIE in Idaho.

Idaho Medical Home Collaborative (IMHC) – Collaboration of various healthcare stakeholders to promote the development and implementation of a PCMH model of care statewide in Idaho.

Medicaid – The joint federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 USC 1396 et seq., which in Idaho is administered by IDHW.

Medicare – Federal health insurance program for people who are 65 or older and certain younger people with disabilities

Medicare Advantage (MA) Plan – A health plan administered by a private company contracting with Medicare to provide Medicare benefits to beneficiaries.

Medical Neighborhood – The larger healthcare infrastructure in which a PCHM operates. The medical neighborhood includes the PCMS itself, along with the range of other healthcare providers, as well as State and local public health agencies and social service organizations.

National Committee for Quality Assurance (NCQA) – A private, nonprofit organization dedicated to improving healthcare quality.

Patient-Centered Medical Home (PCMH) – A model of care that emphasizes care coordination and communication to transform primary care and focuses on the core attributes and functions of comprehensive care, patient-centeredness, coordinated care, accessible services, and quality and safety.

Primary Care Provider (PCP) – A medical doctor or doctor of osteopathy or other licensed medical practitioner who, within the scope of practice, is responsible for providing primary care services to patients. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, and nurse practitioners provided that the practitioner is able and willing to provide primary care services in accordance with licensure requirements.

Regional Collaborative (RC) – The proposed entities across Idaho that will serve as the administrative hub of healthcare services in each defined planning and service area. Primary responsibilities will be ensuring community health needs are identified through assessments, and working with PCMHs to ensure individual and community health needs are met. This will occur through the dissemination of best and evidence based practice models, collection, and dissemination of performance metrics, and collaboration with providers to access needed community health services for residents when needed.

Rural Health Clinic (RHC) – Family medicine clinics that provide outpatient primary care health services, including diagnostic and laboratory services, and employ mid-level practitioners 50% of the time the clinic is open. To be certified as an RHC by IDHW, a clinic must be located in a non-urban area *and* a medically-underserved area or serve a designated population group or geographic health professional shortage area.

Shared Savings – A payment strategy that offers incentives for providers to reduce healthcare spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts. A shared savings methodology typically comprises four important concepts: a total cost of care benchmark, provider payment incentives to improve care quality and lower total cost of care, a performance period that tests the changes, and an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality. In Idaho's model, the specifics of the arrangements will be negotiated between the payers and the PCMHs through their regular contracting process

State – When capitalized, refers to the State of Idaho.

Statewide Health IHC (IHC) – A section 501(c) (3) organization that is responsible for supporting and overseeing a coordinated system of implementation and management of the PCMH model statewide, including activities of the RCs, assets and gaps of practices in all states of PCMH development, enabling integration with other healthcare services, assuring consistency and accountability for statewide metrics, and collection and distribution of performance measure results.

Triple Aim – A framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance based on the premise that new designs must be developed to simultaneously improve the health of the population, enhance the patient experience of care (including quality, access, and reliability) and reduce or at least control, the per capita cost of care. Adopted by CMMI to: aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our healthcare system.

Washington & Idaho Regional Extension Center (WIREC) – Funded by the Office of the National Coordinator for Health Information Technology (ONC), WIREC, led by Qualis Health, provides vendor neutral health information technology consulting services related to the successful adoption, implementation, and utilization of EHRs for the purpose of improving care.

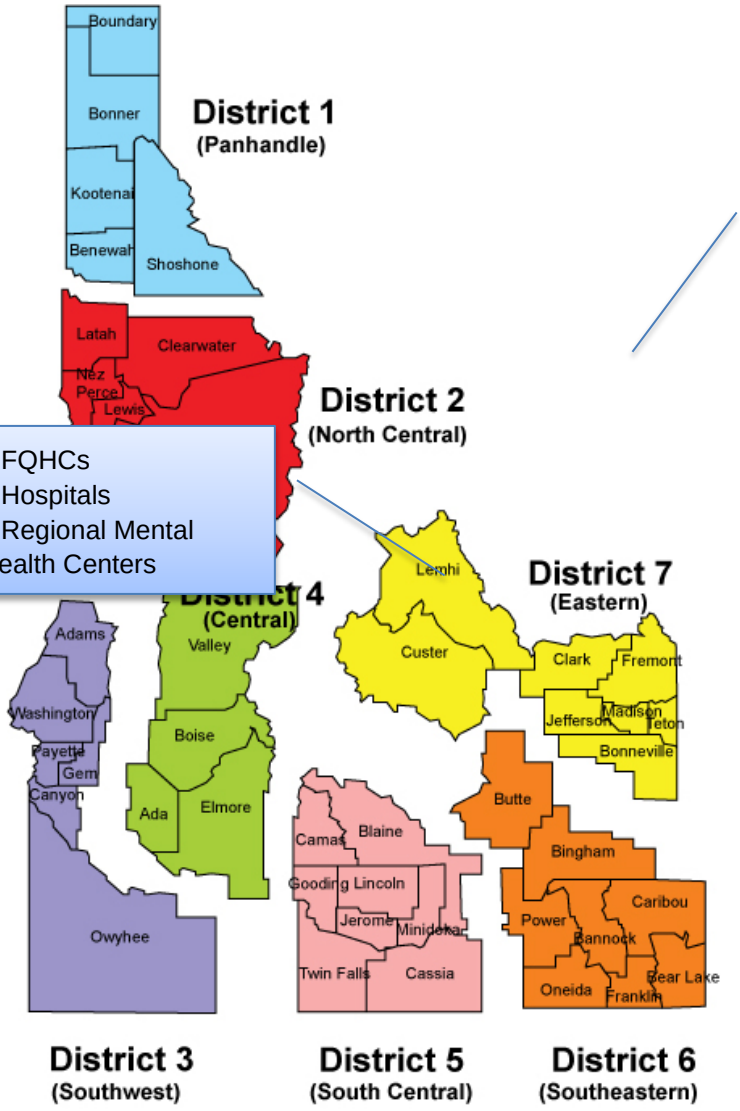
Acronyms

AAA	Area Agency on Aging
ACA	Affordable Care Act
ACO	Accountable Care Organization
ADRC	The Administration on Community Living's Aging and Disability Resource Centers
AHEC	Area Health Education Center
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CQI	Clinical Quality Improvement
DOI	Department of Insurance
D-SNP	Duals – Special Needs Plan
ECHO	New Mexico's Project ECHO (Extension for Community Healthcare Outcomes)
EHR	Electronic Health Record
EMS	Emergency Medical Services
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HB	House Bill
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HMO	Health Management Organization
HQPC	Health Quality Planning Commission
HRSA	Health Resources and Services Administration
ICM	Integrated Care Model

IDHW	Idaho Department of Health and Welfare
IMHC	Idaho Medical Homes Collaborative
IOCP	Intensive Outpatient Care Program
IRIS	Immunization Reminder Information System
LDL	Low-density lipoprotein
MA	Medicare Advantage
MFP	Money Follows the Person Program
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NIHN	North Idaho Health Network
NP	Nurse Practitioner
NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PCCM	Primary Care Case Management
PCMH	Patient Centered Medical Home
PCP	Primary Care Physician
PFFS	Private Fee for Service
PHMG	Primary Health Medical Group
PMPM	Per Member Per Month
PPO	Preferred Provider Organization
PRATS	Pregnancy Risk Assessment Tracking System
RC	Regional Collaborative
RHC	Rural Health Center
RHCAP	Idaho's Rural Health Care Access Program
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBWC	School Based Wellness Center
SED	Serious Emotional Disturbance
SHIP	Statewide Healthcare Innovation Plan
SIM	Statewide Innovation Model
SMHP	Idaho Division of Medicaid's State Medicaid Health Information Technology Plan
SPA	State Plan Amendment
SPMI	Severe and Persistent Mental Illness
TRUST	University of Washington's Targeted Rural and Underserved Track (TRUST) program
TSE	Time Sensitive Emergency
VA	Veterans Affairs
VHR	Virtual Health Record
WIREC	Washington and Idaho Regional Extension Center

Appendix B

Map of Idaho's Local Health Districts and Counties



- 2 FQHCs
- 5 Hospitals
- 3 Regional Mental Health Centers
- 2 Tribal Facilities

- 3 FQHCs
- 5 Hospitals
- 4 Regional Mental Health Centers

- 5 FQHCs
- 7 Hospitals
- 2 Regional Mental Health Centers

- 7 FQHCs
- 7 Hospitals
- 3 Regional Mental Health Centers
- 2 Tribal Facilities

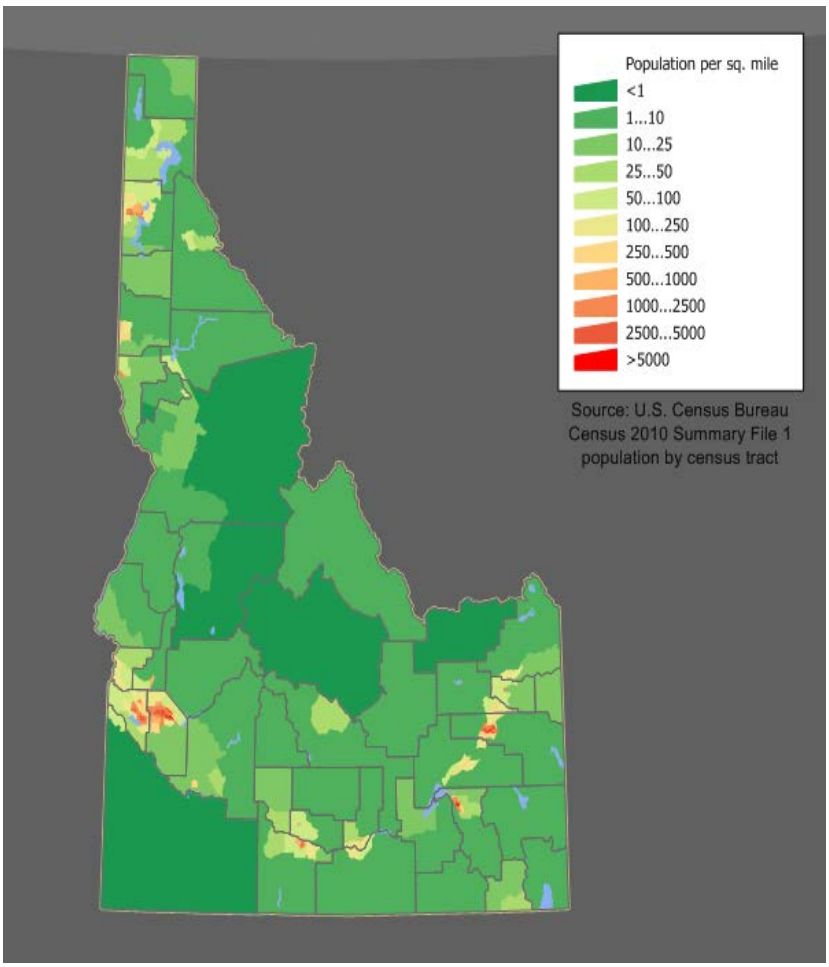
- 12 FQHCs
- 3 Hospitals
- 3 Regional Mental Health Centers

- 6 FQHCs
- 6 Hospitals
- 2 Regional Mental Health Centers

Appendix C

Idaho Population Information

Map of Idaho's Population per Sq. Mile



Idaho Demographics

- Total population of just over 1.5 million
- Idaho's population is approximately half male and half female
- Children under five years old represent 7.3% of the population, while those under 18 represent 26.7%. Persons 65 years and older represent 13.3% of the population
- The median household income was $46,890, which was nearly 9% below the national average
- Approximately half of all Idahoans obtain health insurance through their employer or the military
- Approximately a quarter of the State's residents rely on government-sponsored healthcare (Medicaid/CHIP, 14.8%; and Medicare, 15%),
- More than 18% of Idahoans are uninsured

Appendix D

Current Healthcare Delivery System Models

As noted in the SHIP, Idaho's current healthcare system includes a wide spectrum of model designs, ranging from private multi-facility integrated healthcare systems, to solo physician practices, to publicly funded healthcare systems both large and small and local public health districts. This appendix provides additional information on Idaho's current healthcare delivery system models.

Private Health System Models

Large private healthcare systems in Idaho, such as the Saint Luke's and Saint Alphonsus health systems, are becoming an increasingly prevalent system model in the State. These systems group together networks of hospital facilities and outpatient clinics located around the State. However, many Idahoans still receive care at smaller physician practices and solo practices, which are more common in rural parts of the State. Practice and referral patterns among Idaho's healthcare providers reflect the geographic characteristics of the State. In many communities, Idaho's mountainous areas serve as natural divisions that define regional networks of care as the area where patients can reasonably access services by car or other forms of transportation. In rural communities that border Washington, Oregon, Nevada, Utah, Wyoming, and Montana, providers often refer patients to facilities located in adjacent states; mostly for acute and specialty care. This practice has created patient retention challenges for providers, as patients who are referred to specialists or facilities outside the community sometimes do not return to primary care providers because, under the current FFS model, specialists have a financial incentive to continue seeing the patient for all services.

Public Health System Models

Like in many rural states, publicly-funded health systems are a foundational component of the current health model in Idaho, offering critical safety-net services to under-insured and uninsured Idahoans. Chief among these systems are Idaho's 13 non-profit community health centers, which provide outpatient health services to Idahoans at locations in 37 communities throughout the State. These 13 community health centers include 12 FQHCs and one FQHC "look-alike".[63] In 2012, the 12 FQHCs served 130,399 patients, half of whom were uninsured. The FQHCs provided medical services to 106,981 individuals, dental services to 30,193 individuals, mental health services to 7,488, substance abuse services to 427, and enabling services to 9,583 people.

The Veteran's Affairs (VA) health system also has a strong presence in Idaho, providing both inpatient and outpatients services to Idaho's active service members and veterans. The VA operates a large inpatient medical center in Boise, as well as ten outpatient clinics located throughout the state[64].

Idaho's public health programs and local public health districts are also important system components in the State, as they are responsible for coordinating initiatives that assess State and community health needs and respond to these needs by providing information, resources, linkages, and funding to support services that promote the health and wellness of all Idahoans. The agencies that comprise the IDHW provide a range of health and social services aimed at promoting and protecting the health and safety of Idahoans. At the State level, IDHW sets the vision and strategic

[63] http://www.idahopca.org/community-health-centers/about-community-health-centers

[64] http://www1.va.gov/directory/guide/state.asp?State=ID&dnum=ALL

plan for the public health system in Idaho and monitors progress towards goals. IDHW's total budget in State FY 2013 is $2.366 billion, which includes $610.16 million in State general fund appropriations, $1.5 billion in federal funds, $83.9 million in State-dedicated funds, and $164.4 million in receipts for direct services.[65]

Federal funding to IDHW comes primarily in the form of Medicaid match and grants through the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and other federal partners to implement health programs across the State. Many of these programs are implemented at the local level through contractual relationships between IDHW and the seven local health districts described below.

Statewide health initiatives are aimed at addressing the risk factors for chronic disease, increasing health literacy, and promoting healthy lifestyles. While coordinated and monitored at the State level, local implementation occurs through the seven health districts. These programs help communities address local barriers to health, help individuals make healthy decisions, and receive support and clinical care when they need it. A few program highlights include:

- The Healthy Eating, Active Living program brings together a voluntary network of organizations, agencies, businesses, and individuals to share information and resources to create an environment where all Idahoans value and have access to healthy food options and places to be physically active in their communities.

- The Idaho Prenatal Smoking Cessation program, targeted to pregnant women enrolled in the Women, Infants and Children (WIC) program, operates the Idaho QuitNow line, a free telephone counseling and internet service that uses evidence-based interventions including telephone counselors and online support to help women quit smoking. Free nicotine replacement products are also available to those who enroll in the QuitNow program.

- In response to the growing burden of diabetes in the State, IDHW has funded the Idaho Diabetes Prevention and Control Program, which encourages linkages and the development of coalitions and partnerships to promote clinical standards of care, reach patients in disparate populations, and provide professional education and training to reduce the risk of diabetes and the complications it causes. This program has been extremely successful in generating local, sustainable coalitions of community partners.

- The Adolescent Pregnancy Prevention Program uses an evidence-based curriculum to provide sexual health and risk avoidance education and activities to youth and their families and caregivers to reinforce healthy choices and development.

- To connect residents with care providers, the IDHW operates the 2-1-1 Idaho CareLine, a free statewide community information and referral service that provides callers with information about where to go to obtain free or low cost health and human services, including medical assistance, as well as social services.[66] In SFY 2012, the Idaho CareLine received 162,587 calls.

Local Public Health Districts

[65] Facts, Figures and Trends: 2012-2013. A publication of the Idaho Department of Health and Welfare. http://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2012-2013LR.pdf

[66] http://www.idahocareline.org/

The public health infrastructure in Idaho includes seven local public health districts that operate independently of, but in close collaboration with, IDHW. The seven local public health districts are defined as: Panhandle, North Central, Southwest, Central, South Central, Southeastern, and Eastern. Each local public health district has a board of health appointed by county commissioners within that district. The local public health districts perform traditional public health functions such as environmental health and disease reporting, but also provide direct clinical care and public health services to their residents, playing a critical role as a service provider in the communities they serve.

Direct services offered by the local public health districts range from community health nursing and home health nursing to dental hygiene and nutrition. Many services are provided through contracts with IDHW, and are available for the community, including the uninsured, free of charge or for a nominal fee. All local public health districts provide immunizations, sexually transmitted disease counseling and services, family planning services, reproductive health and women's health services, child oral health services, a tuberculosis clinic, and services through the WIC program. Some local public health districts provide additional services such as school health services on a FFS basis, refugee health services, and cholesterol and heart risk screenings.

In 2011–2012, the public health districts used the CDC's Community Health Assessment and Group Evaluation tool to assess policies and practices in their communities that support healthy people and healthy communities. The districts are using the results of these assessments to make sustainable changes that will have a lasting impact on chronic disease in Idaho. One of the major focus areas to emerge from the assessment was addressing the underlying risk factors for chronic disease, including tobacco use, physical inactivity, and unhealthy eating. For example, health districts collaborated with IDHW and local partners to foster workforce wellness programs and school-based health education interventions.

Services Provided by Local Public Health Districts (FY2012)

- 8,761 communicable disease reports and investigations
- Reproductive health services to 22,306 individuals
- Tobacco use cessation education to 1,503 individuals
- Fluoride mouth rinse to 30,647 individuals
- Vaccines to 44,867 adults and 72,159 children

The health districts and the communities they serve are also local innovators in implementing community-based wellness programs that build on existing local resources, engage local partners, and respond to the particular needs of their local communities. These local programs are a vital part of the health infrastructure in Idaho, as they bring needed services and support to local communities throughout the State. A few examples of initiatives that are occurring at the local level are:

- Bonner County Emergency Medical Services has recently launched a community emergency medical service (EMS)/paramedicine program that leverages the free time that trained EMS personnel have between emergency calls to engage with patients before they need emergency services. The program sends EMS personnel to proactively visit the homes of patients who have been identified by their physician as being at high risk for a medical emergency.

- The North Central district operates the Cancer Awareness and Prevention Coalition, which assists in planning and implementing a strategic plan to increase cancer screening rates and decrease cancer incidence in the area. To prevent skin cancer in babies, the North Central district has partnered

with local hospitals to educate new parents about the importance of protecting their babies from the sun through a program called No Sun for Baby that gives new parents a sun hat for their infant and sun safety information. The North Central District also promotes a community garden to foster a culture of health for individuals and communities, improve food security, encourage healthy eating practices, and assist families and communities in becoming more resilient to disasters.

- The Panhandle district has implemented a Moving Minutes Challenge aimed at helping its residents maximize daily physical activity. The program encourages participants to make a daily log of the time spent each day doing physical activity, and the district awards prizes for those who submit their logs. Schools and employers are encouraged to enter as groups to motivate as many people as possible to join the initiative.

- The Central District provides cholesterol screening and cardiac risk assessments for a nominal fee to identify at-risk individuals and promote resource referrals.

The collaboration that would be fostered under Idaho's new PCMH model would encourage the sharing of ideas and promote adapting and replicating programs such as these.

Services for American Indians

The Indian Health Service (IHS) (an operating division of the U.S. Department of Health and Human Services) is the federal agency charged with the responsibility to provide healthcare to all enrolled members of Idaho Tribes. The Indian health system is very unique and is governed by a complex set of federal laws and regulations.

The IHS Portland Area Office oversees funding provided for tribal health programs in Idaho: the Shoshone-Bannock, the Northwest Branch of the Shoshone, the Nez Perce, the Coeur d'Alene, and the Kootenai tribes. Four tribes manage their own health programs under the Indian Self-Determination and Education Assistance Act (ISDEAA, P.L. 93-638) through contracts or compacts with the IHS. Ft. Hall Service Unit, which provides services to the Shoshone-Bannock tribe, is managed by an IHS. The Benewah Medical Center also receives HRSA funding through Section 330 of the Public Service Act. As such, the Benewah Health Center provides services to both American Indian and non-American Indian individuals. Tribally-operated health programs operated under the ISDEAA have also been statutorily designated as FQHCs under the Social Security Act.[67]

These IHS and Tribally-operated health programs provide basic ambulatory primary care services, limited pharmacy and laboratory services, traditional healing practices, dental care, eye care, and behavioral health programs. Some of the programs may offer physical therapy, ophthalmology, audiology, optometry, home health nurses, diabetes education, tobacco cessation education, registered dieticians, community health outreach, and youth programs.

[67] Social Security Act §1905(l)(2)(A)(iv).

Appendix E

Profiles of Larger Commercial Payers

General

Current commercial payer offerings include individual, small group, large group, and self-insured products. There are currently eight companies licensed by the Idaho Department of Insurance to offer individual health benefit plans. Regence BlueShield of Idaho is the dominant insurer with 41.5% of the market in 2011. The other seven companies are Blue Cross of Idaho Health Service Inc., Coventry Health & Life Insurance Co., John Alden Life Insurance Co., Mega Life and Health Insurance Co., PacificSource Health Plans, SelectHealth Inc., and Time Life Insurance Co.[68]

There are currently 13 companies licensed by the Idaho Department of Insurance to offer small employer health benefit plans,[69] with Regence BlueShield of Idaho covering 46.3% of the market in 2011.[70] The other 12 companies are Altius Health Plan, Best Life and Health Insurance Co., Blue Cross of Idaho Health Services Inc., John Alden Life Insurance Co., Madison National Life Insurance Co., PacificSource Health Plans, SelectHealth Inc., Sterling Life Insurance Co., Time Insurance Co., Trustmark Life Insurance Co., United Healthcare Insurance Co., and WMI Mutual Insurance Co.

In 2011, there were 14 large group carriers, with Blue Cross of Idaho being the largest carrier in this market.[71] There are currently 12 self-funded health plans licensed by the Idaho Department of Insurance. They are A-Plus Benefits Inc., Employee Benefit Trust of Idaho, Boise Fire & Police Trust, City of Boise Employee Healthcare Plan Trust, City of Caldwell Employee Benefit Trust, City of Nampa Employee Welfare Benefit Trust, Government Employees Medical Plan, Idaho AGC Self-Funded Benefit Trust, Idaho Interdependent Intergovernmental Authority, Independent School District of Boise City, Employee Dental Benefit Plan Trust, Snake River Sugar Company Member Benefit Plan, Timber Products Manufacturers Trust, and the University of Idaho Health Benefits Trust.[72]

In 2011, 40% of employers were self-insured. Firms consisting of 49 or fewer employees only composed 11.2% of the total, while those with 50 or more represented 66.7%. Nearly three in every five workers (59.6%) were in self-insured plans in 2011 with only 8.6% being employed by firms with 49 or less employees and 73% with those having 50 or more.

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[68] Idaho Department of Insurance, List of Individual Health Benefit Companies Referenced August 7, 2013 viewable at http://www.doi.idaho.gov/health/individual_list.aspx

[69] Idaho Department of Insurance, List of Small Employer Health Benefit Companies Referenced August 7, 2013 viewable at http://www.doi.idaho.gov/health/smempl_list.aspx

All information relating to the Idaho Patient Centered Medical Home Collaborative sourced from http://imhc.idaho.gov/MinimumRequirements.aspx

[70] December 2012 Report from the State Health Access Data Assistance Center (SHADAC) under contract with NORC. Funded by CMS & CMMI.

[71] December 2012 Report from the State Health Access Data Assistance Center (SHADAC) under contract with NORC. Funded by CMS & CMMI.

[72] Idaho Department of Insurance, Insurer by type page: http://www.doi.idaho.gov/insurance/TypeList.aspx?Type=SF

Blue Cross of Idaho

Blue Cross of Idaho had more than 708,000 members in 2011 and includes as network partners every hospital in the State and 96% of all physicians. The company reports an administrative cost ratio of 6.9%.[73]

Regence BlueShield of Idaho

Regence BlueShield of Idaho (Regence) is a nonprofit mutual insurance company and an independent licensee of the Blue Cross and Blue Shield Association that serves more than 150,000 Idaho residents. It processed approximately 2.4 million claims and paid out 79% of every premium dollar collected (medical loss ratio) in 2012.[74] In 2012, Regence began collaboration with St. Luke's Health System called the Healthy U CoPartner Program. In this innovative delivery model, physicians and nurses work closely with Regence patients who have multiple health conditions to increase patient engagement in their treatment plans and promote lifestyle adjustments. This highly personalized and coordinated care aims to avoid unnecessary duplication of services, reduce costs, and improve members' overall health.[75]

PacificSource Health Plans

PacificSource is a not-for-profit community health plan offering individual and group health insurance.[76] PacificSource participates in the IMHC by supporting participating clinics with a $22.50 PMPM for members who meet eligibility criteria, including diagnosis of SPMI/SED, diabetes and asthma, diabetes and a co-morbidity or specified risk factor, or asthma and a co-morbidity or specified risk factor.

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[73] Blue Cross of Idaho Annual Report for 2011 viewable at https://www.bcidaho.com/_assets/2011-Annual-Report.pdf

[74] The Year in Review: 2012 Regence BlueShield of Idaho viewable at http://www.regence.com/docs/overviews/overview-2012-id.pdf

[75] Id.

[76] PacificSource Health Plans: Idaho plan summaries web page. Referenced on August 2, 2013 viewable at http://www.pacificsource.com/agent/idaho/plan-summaries.aspx

Appendix F

Current Performance Measurement Data Sources and Idaho's National Health Care Quality Report Results

Idaho Department of Health and Welfare Data Sources

As noted in the SHIP, IDHW is a main source of healthcare data used for performance measurement in Idaho. The main State sources of healthcare performance data are the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Tracking System (PRATS), Vital Records, and community health surveys conducted by Idaho's providers and public health districts using the CDC's Community Health Assessment and Group Evaluation tool. What follows is a description of these data sources.

Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Tracking System (PRATS), and Vital Records

The BRFSS is a public health surveillance program developed and partially funded by the CDC.[77] It is designed to estimate the prevalence of risk factors for the major causes of morbidity and mortality in the United States. The survey provides State-specific estimates of the proportion of adults aged 18 and over with selected health risk behaviors. Questions on the BRFSS survey address numerous topics, including but not limited to, general health status, number of healthy days, healthcare access, sleep, exercise, diabetes, oral health, cardiovascular disease, asthma, disability, tobacco use, alcohol consumption, immunizations, falls, women's health, cancer screening, HIV/AIDS, emotional support and life satisfaction, public health issues, heart attack and stroke, and drug use. In addition to the standard static report, Idaho provides InstantAtlas dynamic reports.[78] The crude data reports provide risk factor prevalence estimates for the Idaho adult population in a given survey year. These data are useful for determining the number or proportion of a population affected by various health risk factors. The age-adjusted data reports present prevalence estimates that are age-adjusted using the 2000 US Standard Population. Age-adjustment removes the impact of age variations across years and geographical regions. These data are useful for providing a consistent basis for evaluating the impact of health interventions across several years of data.

Beginning in 1997, Idaho's seven public health districts partnered with IDHW to develop health district-level estimates from the BRFSS.[79] The districts' participation enabled IDHW to increase sample size and produce district-level health behavior estimates. Additionally, IDHW provided health districts the opportunity to add questions to the BRFSS addressing their specific data needs. In 2009 and 2010, five district sponsored questions were added to the BRFSS survey. Two questions concerned required immunizations for children, two concerned health and safety inspections of commercial food establishments, and one concerned the amount of children's school-time physical activity. The results for these five questions are included in a separate report.

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[77] *Idaho Behavioral Risk Factors: Results from the 2010 Behavioral Risk Factor Surveillance System*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx

[78] http://www.healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx#dynamic

[79] *Idaho Behavioral Risk Factor Surveillance System. Public Health District Sponsored Questions: Results, 2010*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Portals/0/Health/Statistics/BRFSS%20Reports/BRFSS_Health_District_Report_2010.pdf

The PRATS is an annual survey of new mothers in Idaho regarding maternal experiences and health behaviors surrounding pregnancy.[80] It provides information on a variety of perinatal health topics, including unintended pregnancy, prenatal care, substance use, breastfeeding patterns, postpartum depression, and immunizations.

IDHW's Bureau of Vital Records and Health Statistics collects information regarding births, deaths, stillbirths, etc. The Vital Statistics Annual Report includes information on Idaho's population, including census, race, age, and sex; live births, including method of delivery (vaginal or Cesarean) and low birth weight live births; mortality, including leading causes of death, and infant deaths.

Community Health Surveys

Several public and private providers, including health districts and hospitals have conducted community health surveys, which are aimed at collecting data pertaining to the health of specific communities within the State. The surveys include questions pertaining to the identification of serious health concerns and risky behaviors in the community, as well as access to quality care and healthcare coverage status.[81]

Medicare Data Sources

The Medicare program is also a source of data used to assess current system performance. CMS measures and publicly reports on the quality of care provided at hospitals, nursing facilities, dialysis facilities, and home health agencies that participate in Medicare. CMS also publishes star ratings for MA plans that assess MA plan performance on more than 50 measures grouped into five categories: staying healthy (screenings, tests, and vaccines), managing chronic conditions, member experience, member complaints and issue resolution, and health plan customer service.[82] Star ratings are assigned by measures, category, and by an overall summary rating that summarizes all category measures into a single rating. The star ratings range from one star (worst) to five stars (best), and are intended to be used as a guideline for Medicare beneficiaries to select the MA plan that provides the best value. Two of the three major commercial insurers (BlueCross of Idaho and PacificSource) have one or more MA plans with a star rating of four, and Regence's MA plans have a star rating of three and a half.

Idaho's 2011 National Health Care Quality Report Results

Compared to other states, Idaho's quality of care measurement scores as reported by the 2011 NHQR for Idaho are considered to be average in most areas. But as of 2011, there was a noted trend of decreased quality of care scores in most areas. For instance, acute and hospital quality of care measures scored in the very strong range in 2010 (baseline year), but both were scored as only strong the following year. More importantly, the areas of preventive measures, maternal and child health and respiratory disease quality of care measure scores that were considered strong or average in 2010 were scored as weak in 2011. The following are Idaho results of the 2011 NHRQ. Note that there is missing baseline data for diabetes and ambulatory care[83]:

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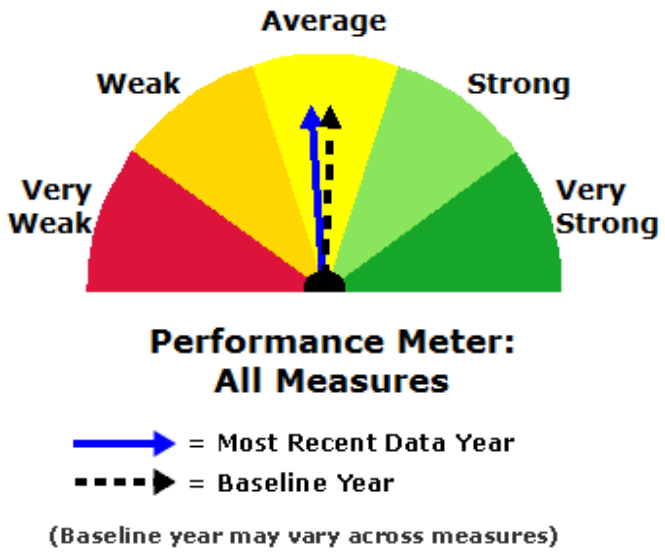
[80] http://www.healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/PregnancyRiskAssessmentTrackingSystem/tabid/915/Default.aspx

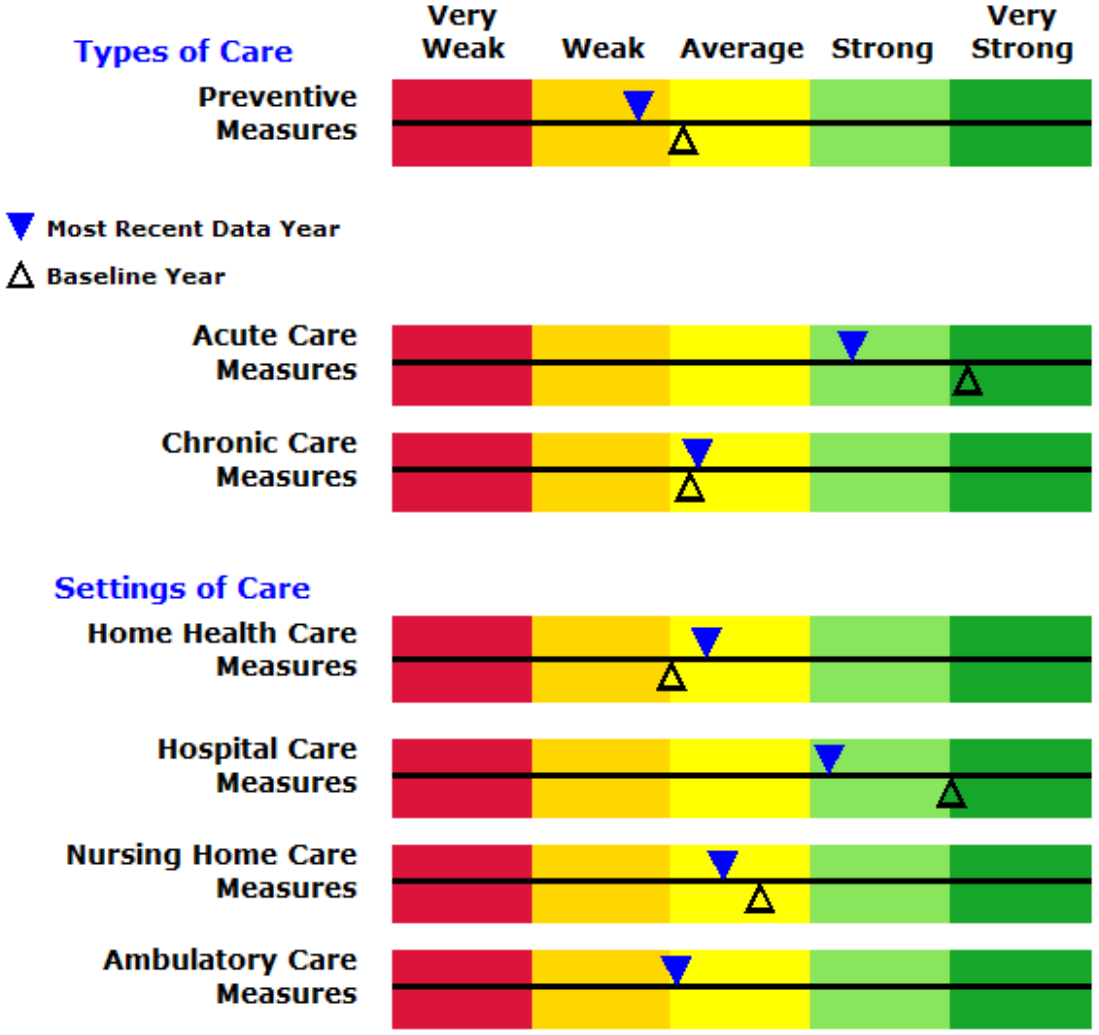
[81] See, e.g., Bonner County Community Health Survey Results 2012. Idaho Panhandle Health District. http://www.phd1.idaho.gov/home/documents/BonnerCoCombinedResults.pdf

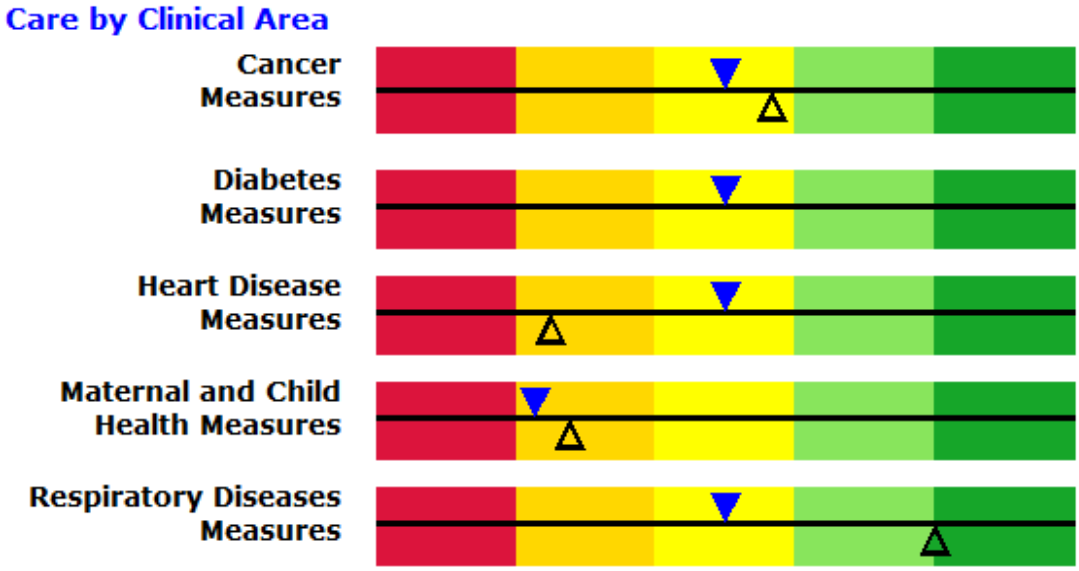
[82] Medicare Advantage 5 Star Enrollment. Updated July 2013. http://www.medicare.gov/Publications/Pubs/pdf/11226.pdf; http://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/five-star-enrollment/5-star-enrollment-period.html



Source: National Healthcare Quality Report (NHQR) for Idaho, 2011

Current State 2011:





Source: National Healthcare Quality Report (NHQR) for Idaho, 2011.

[83] A missing arrow or triangle means there were insufficient data to create the summary measure. http://statesnapshots.ahrq.gov/snaps11/dashboard.jsp?menuId=4&state=ID&level=0

Appendix G

Additional Information Regarding Idaho's Current Healthcare Workforce

This appendix provides information regarding other classes of healthcare professionals and facilities not mentioned in the SHIP document.

Ancillary Providers

There are 27 outpatient physical therapy/occupational therapy/speech therapy (PT/OT/ST) centers distributed throughout the State. These centers are unevenly distributed around the State, with a higher concentration of 13 PT/OT/ST centers located in the Boise Region (Region 4) as compared to an average of two to three in the other regions.[83]

There are 26 dialysis centers, which are evenly distributed throughout the State.[84]

There are 85 home health agencies.[85]

Facilities

There are 51 hospitals in Idaho with a total of 3603 beds. This includes 27 critical access hospitals and six BEHAVIORAL HEALTH facilities (including inpatient drug/alcohol abuse centers and psychiatric hospitals). The table below[86] shows the distribution of hospitals and beds by region.

Region	Number of Hospital Facilities	Number of Beds
1	7	417
2	6	294
3	4	343
4	11	1328
5	7	313
6	10	459
7	6	449
TOTAL	**51**	**3603**

There are also 50 ambulatory surgical centers (47 of which are certified by Medicare) and 78 long term care/skilled nursing facilities (LTC/SNFs) in Idaho. The table below[87] shows the distribution of LTC/SNFs by region.

Region	Number of LTC/SNF	Number of Beds
1	11	958

[83] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/ROPT.pdf

[84] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RESRD.pdf

[85] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RHHA.pdf

[86] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RHospital.pdf

[87] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RLTC.pdf

Region	Number of LTC/SNF	Number of Beds
2	9	720
3	12	937
4	15	1345
5	11	797
6	12	645
7	8	558
TOTAL	72	5819

Idaho has 67 facilities with 508 beds for people with intellectual disabilities.[88] Like most specialty inpatient care facilities, these community homes, group homes, and treatment centers are clustered in the Boise Region (Region 4).

[88] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RICF.pdf

Appendix H

Crosswalk of SHIP Standard and Special Terms & Conditions

SHIP Standard and Special Terms & Conditions		SHIP Section
A – State Goals		
1.	Vision Statement for health system transformation.	2
2.	Description of health system models in “current as is” and “future to be” conditions, including the level of integration of behavioral health substance abuse, developmental disabilities, elder care, community health, and home and community-based support services.	1, 2, Appendix D
3.	Description of delivery system payment methods both “current as is” and “future to be” payment methods.	2, Appendix E
4.	Description of health care delivery system performance “current as is” and “future to be” performance measures.	2, Appendix F
B – Description of State Health Care Environment		
1.	Description of population demographics and profiles of major payers in the state including number of residents covered by commercial insurers, Medicare, Medicaid and CHIP.	2, Appendix C, Appendix E
2.	Description of population health status and issues or barriers that need to be addressed.	2, Appendix F
3.	Report on opportunities or challenges to adoption of Health Information Exchanges (HIE) and meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT.	2, 5
4.	Description of the current health care cost performance trends and factors affecting cost trends (including commercial insurance premiums, Medicaid and CHIP information, Medicare information, etc.).	3
5.	Description of the current quality performance by key indicators (for each payer type) and factors affecting quality performance.	2, Appendix F
6.	Description of population health status measures, social/economic determinants impacting health status, high risk communities, and current health status outcomes and the other factors impacting population health.	2, Appendix F
7.	Description of specific special needs populations (for each payer type) and factors impacting care, health, and cost.	2, 6, Appendix D
8.	Description of current federally-support program initiatives under way in the state, including those supported by but not limited to CDC, CMMI, CMCS, ONC, HRSA, and SAMHSA.	6
9.	Description of existing demonstration and waivers granted to the state by CMS.	6
C – Report on Design Process Deliberations		

SHIP Standard and Special Terms & Conditions	SHIP Section
1. The Plan shall contain a report on the State's deliberations and its consideration of each of the levers and strategies enumerated in items (a) through (n) of the preceding section, "Scope of Model Design Project." This part of the plan should describe the options considered during the review of each item, evidence of stakeholder engagement, and any consensus reached, or disagreement that remained at the close of deliberations of each item.	Sections 2-7 include stakeholder deliberations by topic
D – Health System Design and Performance Objectives	
1. Description of delivery system cost quality and population health performance targets that will be the focus of delivery system transformation.	1, 2, 7
2. State's goals for improving care, population health and reducing health care cost.	1, 2
C – Proposed Payment and Delivery System Models	
1. The plan shall set forth the state's proposed payment and service delivery models including strategies that involve multiple payers that will move the preponderance of care in the state from fee for service to value-based payment systems. The plan should aim to move 80% of the state's total population to value-based payment and service delivery models within 5 years.	2
2. The plan will identify how the state proposes to use the executive, regulatory and legislative authorities to align multiple payers (including commercial) and providers for health delivery system transformation and, specifically, identify how the state will use levers in incentivizing stakeholders to engage in health care transformation, including but not limited to: • Academic medical centers. • Certificate of need (or, if not applicable, voluntary health capacity planning). • Practitioner licensing and scope of practice. • Purchasing of health care. • Health insurance regulation. • The Health Insurance marketplace. • Graduate medical education. • Medicaid supplemental payment programs. • Survey and certification of acute and post-acute health care facilities.	7
F – Health Information Technology	
1. How activities under the plan will coordinate with other statewide HIT initiatives to accelerate adoption of health information technology among providers.	5
2. How activities under the Plan will reach providers in rural areas, small practices and behavioral health providers.	4, 5
3. Cost allocation plan or methodology for any planned IT system solutions/builds funded in part by CMS or any other federal agency.	5
4. Any impact this project will have on the MMIS, and how the MMIS will be used to support the project, including whether there will be a need to add any new system functionality or enhancements to existing system functionality to support the effort. Please describe all MMIS claims, recipient, provider or other MMIS data and the specific MMIS business processes the state will utilize in support of this effort.	5
5. Estimated planning and implementation timelines for the needed changes to MMIS and how these timelines will dovetail with the SIM project.	5
G – Workforce Development	

SHIP Standard and Special Terms & Conditions	SHIP Section
1. The Plan should set forth a strategy to develop innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through policies regarding training, professional licensure, and expanding scope of practice statutes, including strategies to enhance primary care capacity, and to better integrate community health care manpower needs with graduate medical education, training of allied health professionals, and training of direct service workers; and move toward a less expensive workface that makes greater use of community health workers when practicable.	4
H – Financial Analysis	
1. The Plan should contain a financial analysis describing (i) the populations being addressed and their respective total medical and other services costs as per member per month and population total, (ii) estimated cost of investments necessary to implement the Plan, including ongoing costs to providers, infrastructure costs including personnel and vendors, (iii) anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population, (iv) expected total cost savings and return on investment during the project period for the overall state model and basis for expected savings (previous studies, experience, etc., and (v) a plan for sustaining the overall model over time.	3
I – Evaluation Plans	
1. Plans to provide access to data and stakeholders to enable CMS to evaluate the extent to which the state's delivery system reform plan was implemented, its effect on health care spending, and its impact on health care quality.	8
2. Identification of potential sources of data including provider surveys, Medicare administrative claims, state Medicaid and CHIP program information, beneficiary experience surveys, site visits with practices, and focus groups with beneficiaries and their families and caregivers, practice staff, direct support workers, and others (e.g. payers), for program evaluation.	8
3. Plans to play an active role in continuous improvement and evaluation, particularly in regard to Medicaid and CHIP benefits. Each state is encouraged to identify a research group, preferably within the state, that could assist in the CMS evaluation and develop in-state evaluation efforts continue after the model funding has ended.	8
J – Road map for Health System Transformation	
1. Provide a timeline for transformation.	9
2. Review milestones and opportunities.	9
3. Describe policy, regulatory and/or legislative changes necessary to achieve the State's vision for a transformed health care delivery system.	9
4. Describe any federal waiver or State plan amendment requirements and their timing to enable key strategies for transformation, including changes or additions required to position the Medicaid and CHIP program to take advantage of broad health care delivery system transformation.	9

1. The Health Care System and Integration

Idaho Response:

Idaho has established the State Healthcare Innovation Plan (SHIP) to develop a statewide process for evolving Idaho's health care system. The goal of SHIP is to redesign Idaho's healthcare system, evolving from a fee–for-service, volume-based system to a value-based system of care that rewards improved health outcomes.

In December 2014 The Idaho Department of Health and Welfare received a state innovation model grant for $39,683,813.The grant, from the Center for Medicare and Medicaid Innovation, will fund a four-year model test that begins on Feb. 1, 2015, to implement the Idaho State Healthcare Innovation Plan (SHIP). During the grant period, Idaho will demonstrate that the state's entire healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care, and the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services.

Work on the SHIP began in 2013 when Idaho stakeholders came together to study Idaho's current healthcare system and develop a plan for transformation. The 6-month planning process involved hundreds of Idahoans from across the state working together to develop a new model of care. In early 2014 Governor Otter established the Idaho Healthcare Coalition (IHC) which 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, healthcare associations and community representatives.

The IHC has established seven goals, the goals and anticipated challenges are listed below.

Goal 1: Transform primary care practices across the state into patient-centered medical homes (PCMHs): Idaho will test the effective integration of PCMHs into the larger healthcare delivery system by establishing them as the vehicle for delivery of primary care services and the foundation of the state's healthcare system. The PCMH will focus on preventive care, keeping patients healthy and keeping patients with chronic conditions stable.

Challenge: Access to Behavioral Health and SUD services and PCP for individuals with SMI/SPMI. This goal will increase access and capacity to services, screening, identification and referral.

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood: Idaho's proposal includes significant investment in connecting PCMHs to the Idaho Health Data Exchange (IHDE) and enhancing care coordination through improved sharing of patient information.

Challenge: Access to data and determination of outcomes. This goal seeks to improve communication between providers to include mental and SUD services.

Goal 3: Establish seven regional collaboratives to support the integration of each PCMH with the broader medical neighborhood: At the local level, Idaho's seven public health districts will serve as regional collaboratives that will support provider practices as they transform to PCMHs.

Challenge: Access to services and prevention services. This goal seeks to build a greater network of support for individuals receiving services through a PCMH.

Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs: This goal includes training community health workers and integrating telehealth services into rural and frontier practices. The virtual PCMH model is a unique approach to developing PCMHs in rural, medically underserved communities.

Challenge: Access to services and prevention services in rural communities. This goal seeks to build a greater network of support for individuals receiving services through a PCMH in rural areas and provides additional service options through the use of CHW and CHEMS.

Goal 5: Build a statewide data analytics system: Grant funds will support development of a state-wide data analytics system to track, analyze and report feedback to providers and regional collaboratives. At the state level, data analysis will inform policy development and program monitoring for the entire healthcare system transformation.

Challenge: Access to data and determination of outcomes. This goal seeks to improve data sharing and outcome based payments for improved healthcare.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value: Idaho's three largest commercial insurers, Blue Cross of Idaho, Regence and PacificSource, along with Medicaid will participate in the model test. Payers have agreed to evolve their payment model from paying for volume of services to paying for improved health outcomes.

Challenge: Payment for Behavioral Health and SUD services. This goal sees to realign payment from a fee for services to a PMPM which will ultimately enhance access to Behavioral Health and SUD service.

Goal 7: Reduce healthcare costs: Financial analysis conducted by outside actuaries indicates that Idaho's healthcare system costs will be reduced by $89 million over three years through new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care and outcomes rather than volume of service. Idaho projects a return on investment for all populations of 197 percent over five years.

Challenge: High cost of Mental Health and SUD services. Receiving services through a PCMH, identification and prevention will ultimately increase access and decrease costs.

More information about Idaho's Health Care System redesign and integration, can be found in the Idaho State Healthcare Innovation Plan also attached to this section.

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PROFESSIONAL REIMBURSEMENT SCHEDULE

		UBH/OPTUM					
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		PROFESSIONAL REIMBURSEMENT SCHEDULE					
CPT Code	**Modifier**	**Description**	**Unit**	**Fee: MD**	**Fee: PHD**	**Fee: Master's Level**	**Fee: APRN or other prescribing nurse practitioner**
90791		Psychiatric Diagnostic Evaluation; used for diagnostic assessment or reassessment, if required. This code should not be used in conjuction with 99201-99215. This code does not include psychotherapeutic services. When appropriate, report with interactive complexity add on code 90785. Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	$140.00	$99.00	$99.00	$99.00
90791	**GT**	Psychiatric Diagnostic Evaluation; used for diagnostic assessment or reassessment, if required. This code should not be used in conjuction with 99201-99215. This code does not include psychotherapeutic services. When appropriate, report with interactive complexity add on code 90785. Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	$140.00	Not Valid	Not Valid	$99.00
90792		Psychiatric Diagnostic Evaluation with Medical Services; when appropriate may report with interactive complexity add on code 90785. (Do not report in conjunction with 99201 - 99215); Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	$108.55	Not Valid	Not Valid	Not Valid
90792	**GT**	Psychiatric Diagnostic Evaluation with Medical Services; when appropriate may report with interactive complexity add on code 90785. (Do not report in conjunction with 99201 - 99215); Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	$108.55	Not Valid	Not Valid	Not Valid
90832		Psychotherapy, 30 minutes with patient and/or family member; when appropriate may report with interactive complexity add-on code 90785; do not report psychotherapy of less than 16 minutes duration.	Unit	$53.98	$40.39	$40.39	$40.39
90833		Psychotherapy, 30 minutes with patient and/or family member, with an evaluation and management service; when appropriate may report with interactive complexity add-on code 90785; do not report psychotherapy of less than 16 minutes duration.	Unit	$36.23	Not Valid	Not Valid	Not Valid
90833	**GT**	Psychotherapy, 30 minutes with patient and/or family member, with an evaluation and management service; when appropriate may report with interactive complexity add-on code 90785; do not report psychotherapy of less than 16 minutes duration.	Unit	$36.23	Not Valid	Not Valid	Not Valid
90834		Psychotherapy, 45 minutes with patient and/or family member; when appropriate may report with interactive complexity add-on code 90785	Unit	$70.39	$60.60	$60.60	$60.60
90836		Psychotherapy, 45 minutes with patient and/or family member with an evaluation and management service; when appropriate may report with interactive complexity add-on code 90785; use in conjunction with 99201-99215	Unit	$58.86	Not Valid	Not Valid	Not Valid
90837		Psychotherapy, 60 minutes with patient and/or family member ; when appropriate may report with interactive complexity add-on code 90785	Unit	$103.19	$82.77	$82.77	$82.77
90846		Family Psychotherapy, without patient present (1 unit = 1 visit)	Unit	$95.00	$77.00	$77.00	$77.00
90847		Family Psychotherapy, (conjoint psychotherapy) with patient present (1 unit = 1 visit)	Unit	$95.00	$77.00	$77.00	$77.00
90853		Group Psychotherapy, other than multiple-family group; when appropriate may report with interactive complexity add-on code 90785 (1 unit = 1 visit)	Unit	$35.00	$21.00	$21.00	$21.00
96101		Psych Testing: per hour, Interpreting and preparing report (1 unit = 1 hour)	Per hour	Not Valid	$72.81	Not Valid	Not Valid
96102		Psych Testing: per hour, administered by tech (1 unit = 1 hour)	Per hour	Not Valid	$57.05	Not Valid	Not Valid
96103		Psych Testing: per hour, administered by computer. Interpretation and report (1 unit = 1 hour)	Per hour	Not Valid	$48.13	Not Valid	Not Valid
96118		Neuropsychological Testing Battery, per hour	Per hour	Not Valid	$84.92	Not Valid	Not Valid
96119		Neuropsychological Testing Battery, per hour, administered by tech	Per hour	Not Valid	$60.53	Not Valid	Not Valid
96120		Neuropsychological Testing Battery, per hour, administered by computer. Interpretation and report	Per hour	Not Valid	$70.34	Not Valid	Not Valid
99201		Office Outpatient New Patient; 10 minutes	Unit	$34.15	Not Valid	Not Valid	$29.03
99201	**GT**	Office Outpatient New Patient; 10 minutes	Unit	$34.15	Not Valid	Not Valid	$29.03
99202		Office Outpatient New Patient; 20 minutes	Unit	$59.02	Not Valid	Not Valid	$50.17

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CPT Code	Modifier	Description	Unit	Fee: MD	Fee: PHD	Fee: Master's Level	Fee: APRN or other prescribing nurse practitioner
99202	**GT**	Office Outpatient New Patient; 20 minutes	Unit	$59.02	Not Valid	Not Valid	$50.17
99203		Office Outpatient New Patient; 30 minutes	Unit	$86.54	Not Valid	Not Valid	$73.56
99203	**GT**	Office Outpatient New Patient; 30 minutes	Unit	$86.54	Not Valid	Not Valid	$73.56
99204		Office Outpatient New Patient; 45 minutes	Unit	$133.19	Not Valid	Not Valid	$113.21
99204	**GT**	Office Outpatient New Patient; 45 minutes	Unit	$133.19	Not Valid	Not Valid	$113.21
99205		Office Outpatient New Patient; 60 minutes	Unit	$167.67	Not Valid	Not Valid	$142.52
99205	**GT**	Office Outpatient New Patient; 60 minutes	Unit	$167.67	Not Valid	Not Valid	$142.52
99211		Office Outpatient Established Patient; 5 minutes	Unit	$18.25	Not Valid	Not Valid	$15.51
99211	**GT**	Office Outpatient Established Patient; 5 minutes	Unit	$18.25	Not Valid	Not Valid	$15.51
99212		Office Outpatient Established Patient; 10 minutes	Unit	$35.18	Not Valid	Not Valid	$29.90
99212	**GT**	Office Outpatient Established Patient; 10 minutes	Unit	$35.18	Not Valid	Not Valid	$29.90
99213		Office Outpatient Established Patient; 15 minutes	Unit	$57.45	Not Valid	Not Valid	$48.83
99213	**GT**	Office Outpatient Established Patient; 15 minutes	Unit	$57.45	Not Valid	Not Valid	$48.83
99214		Office Outpatient Established Patient; 25 minutes	Unit	$86.45	Not Valid	Not Valid	$73.48
99214	**GT**	Office Outpatient Established Patient; 25 minutes	Unit	$86.45	Not Valid	Not Valid	$73.48
99215		Office Outpatient Established Patient; 40 minutes	Unit	$117.01	Not Valid	Not Valid	$99.46
99215	**GT**	Office Outpatient Established Patient; 40 minutes	Unit	$117.01	Not Valid	Not Valid	$99.46
96372		Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular. (1 injection = 1 unit)	Unit	$19.79	Not Valid	Not Valid	$19.79
H0031		BH Assessment by certified paraprofessional for peer support, family support or CBRS	Per 15 minutes	$12.09	$12.09	$12.09	$12.09
H0032		Individualized BH Treatment Plan by certified paraprofessional for peer support, familly support or CBRS	Per 15 minutes	$11.35	$11.35	$11.35	$11.35
H0038		Peer Support by certified Peer Support Specialist - **Value Add**	Per 15 minutes	$13.63	$13.63	$13.63	$13.63
H0046		Family Support by certified Family Support Specialist - **Value Add**	Per 15 minutes	$13.63	$13.63	$13.63	$13.63
H2014		Skills Training and Development (15 minutes)	Per 15 minutes	$2.24	$2.24	$2.24	$2.24
H2015		Community Transition Support Services by licensed and a certified Peer Support Specialist (requested by ICM or other licensed Optum Idaho clinician) - **Value Add**	Per 15 minutes	$15.00	$15.00	$15.00	$15.00
H2011		Community Crisis Intervention	Per 15 minutes	$11.04	$11.04	$11.04	$11.04
H2017		Community Based Rehabilitation Services	Per 15 minutes	$11.35	$11.35	$11.35	$11.35
H0001		Individual Assessment - Substance Abuse	Per 15 minutes	$12.25	$12.25	$12.25	$12.25
H0003		Drug/Alcohol Testing (1 Unit = 1 Test)	Unit	$13.50	$13.50	$13.50	$13.50
H0004		Individual Counseling - Substance Abuse	Per 15 minutes	$11.25	$11.25	$11.25	$11.25
H0005		Group Counseling - Substance Abuse	Per 15 minutes	$6.63	$6.63	$6.63	$6.63
H0006		Case Management - Substance Abuse	Per 15 minutes	$11.25	$11.25	$11.25	$11.25
T1013		Language Interpretation Services (sign language or oral interpretation) (1 unit = 15 minutes)	Per 15 minutes	$10.00	$10.00	$10.00	$10.00
T1014	**GT**	Telehealth transmission, per minute, professional services bill separately	Unit	$20.00	Not Valid	Not Valid	$20.00

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CPT Code	Modifier	Description	Unit	Fee: MD	Fee: PHD	Fee: Master's Level	Fee: APRN or other prescribing nurse practitioner
T1017		BH Targeted Case Management	Per 15 minutes	$12.09	$12.09	$12.09	$12.09
Q3014	**GT**	Telehealth Originating Site Facility Fee	Unit	$20.00	Not Valid	Not Valid	$20.00
Add-On Codes:							
90785		Interactive complexity - Use only in conjunction with 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, and 90853	Unit	$4.10	$4.10	$4.10	$4.10
90838		Psychotherapy, 60 minutes with patient and/or family member, with an evaluation and management service; when appropriate may report with interactive complexity add-on code 90785; use in conjunction with 99201-99215	Unit	$95.02	Not Valid	Not Valid	Not Valid

1) The listing of a service or CPT code above does not guarantee that it will be covered under every account-specific plan. To be reimbursable, a service provided to a beneficiary must be a covered benefit under the beneficiary's benefit plan. All reimbursements are less patient responsibility and represent the total allowable reimbursement, including patient responsibility, for all pre-authorized services only. Patient responsibility represents the applicable co-payment, coinsurance, and/or deductible, and is determined by type of insurance and/or benefit plan.

2) **Telehealth Services**: Claim must include the "GT" modifier appended to the procedure code; reimbursement is not available for telephone conversation, electronic mail message (email), or facsimile transmission (fax) between provider and a participant; Services will not be reimbursed when provided via skype, a videophone or webcam.

Reimbursement: There will be reimbursement for the transmission fee at the originating site + MH services provided based upon rates above. There will be no facility fee reimbursement for the distant site.

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ID Medicaid Fee Schedule
Version 9/1/13 (IDMD - 1/1/13)

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures 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, and people living with HIV/AIDS or other chronic diseases/impairments) 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 standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the 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 top Secretarial priority in the Action Plan is to "[a]ssess 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."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] 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.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population 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 being served or 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, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

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

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C: Environmental Factors and Plan

2. Health Disparities

Page 45 of the application Guidance

Narrative Question: In the block grant application, states define the population 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 being served or 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, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

Data on access or enrollment in services, types of services and outcomes by race, ethnicity, gender, age and LGBTQ are tracked in several ways. The Division of Behavioral Health utilizes the Web Infrastructure for Treatment Services (WITS) electronic health record for data tracking and reporting. The system has the capability to track by race, ethnicity, gender, and age. LGBT is tracked as an optional field. WITS tracks data for services provided through the State Mental Health Authority (SMHA) Regional Behavioral Health Centers (RBHC) and substance use disorder services provided through the Substance Use Disorder (SUD) Treatment Management Services contractor. Data is collected through applications, comprehensive intakes and assessments. Individuals receiving Medicaid services are tracked by the Medicaid Managed Care organization. Access to substance abuse prevention services are tracked through demographic data on individuals participating in recurring services and through funding applications identifying specific populations to be served in single service activities.

Race	State Population	SUD Treatment Clients	SMI and SED Clients
White	93.7%	94.6%	80%
Black	1.5%	0.8%	1.71%
Asian	1.4%	0.3%	0.6%
Native American	1.7%	0.0%	1.9%
2 or More Races	2.2%	2.5%	2.1%

Ethnicity	State Population	SUD Treatment Clients	SMI and SED Clients
Not Hispanic	89.4%	88.2%	79.4%
Hispanic	10.6%	11.8%	9.7%

Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above populations.

Efforts to address and eventually reduce disparities in access, service use and outcomes for the above disparity vulnerable subpopulations will be addressed through collaboration between several agencies. The Division of Behavioral Health's RBHCs offer services and materials in English and Spanish, and also offer translator services in other languages. Regions have access to Telecommunications Devices for the Deaf (TDD) technology to help communicate with those who are deaf or hard of hearing, and some regions have staff who sign. While the major second language in Idaho is Spanish, Idaho is also home to many refugees who speak other languages. Collaboration with refugee agencies and resources will be key to providing good services to these individuals. The SUD Treatment Management Services Contractor will be responsible to track client demographics and to work with enrolled providers to provide appropriate services to each individual. The Medicaid Managed Care organization will be responsible to do the same for enrolled Medicaid participants. Idaho will continue to address language needs for individuals in substance abuse prevention services using two processes. Annual review of language needs will enable the substance abuse prevention system to identify new needs and additional resources.

Are linguistic disparities/language barriers identified, monitored, and addressed?

The Division of Behavioral Health's (DBH) WITS data system tracks demographic data to all who receive adult and children's behavioral health services through DBH Regional Mental Health Centers. By SFY 2014, all SUD Treatment providers were required to enter data into the WITS system as well. For substance abuse prevention services, the Division continues to collect language needs as a part of funding applications as well as through tracking participant requests for language assistance including sign language. Individuals receiving Medicaid services are tracked by the Medicaid Managed Care organization. Language needs for individuals in substance abuse prevention services are tracked through two processes. The funding applications must identify the population(s) to be served and the language in which services will be delivered. In addition, substance abuse prevention providers are required to notify the contract manager if they have a client with special language needs which includes not only speaking languages other than English, but also need for sign language.

Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

The Division of Behavioral Health's RBHCs offer services and materials in English and Spanish, and also offer translator services in other languages. Regions have access to Telecommunications Devices for the Deaf (TDD) technology to help communicate with those who are deaf or hard of hearing, and some regions have staff who sign. While the major second language in Idaho is Spanish, Idaho is also home to many refugees who speak other languages. Collaboration with refugee agencies and resources is key to providing good services to these individuals. The Regional Behavioral Health Centers have several available options for seeking interpreter services including over the phone interpretation services from contracted providers, coordinating on call or in person contracted providers including sign language, and accessing other Department employees identified as interpreter/communication resources. The Department also providers document translation services.

Is there state support for cultural and linguistic competency training for providers?

The Division of Behavioral Health continues to prioritize the need to address cultural and linguistic competence for providers of mental health and substance use services. The Division finalized and approved a new Division Cultural Competency and Linguistics policy effective 5/1/2015. The policy

requires completion through the Department's online Knowledge and Learning Center (KLC) of the Cultural Diversity course and the Cultural Issues in Mental Health Treatment course within the first month of hire and then again a minimum of once every three years after that. The Division also developed a new online training; Working with People Who Are Deaf or Hard of Hearing which is intended to build the competency and knowledge needed to improve customer service and communication with participants who are deaf or hard of hearing. The Division also completed the standard, Cultural Diversity and Respectfulness and is in the process of finalizing several Special Populations standards specifically addressing LGBTQ, Tribes, Older Adults and Vulnerable Youth.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse 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 Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] 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."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. 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 Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and 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 mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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[59] Ibid, 47, p. 41

[60] 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

[61] 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.

[62] 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.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Evidence-based Practices and Programs Audit: Overview and FY16 Plan

The Provider Oversight Committee, made up of representatives from Idaho Department of Correction, Idaho Department of Juvenile Corrections, Idaho Department of Health and Welfare, Idaho Supreme Court, Advocates for Addiction Counseling and Treatment (AACT) Idaho and Business Psychology Associates, developed and implemented an Evidence-based Practices and Programs Audit Process. The purpose of this audit process is to: 1) evaluate current treatment programs; 2) create a database of modalities utilized by the network; and 3) move towards the ultimate goal of ensuring all treatment provided by Idaho's state-funded provider network is evidence-based.

The Provider Oversight Committee has adopted the following definitions for evidence based practices and programs.

> "Evidence-based *practices* are skills, techniques, and strategies that can be used by a practitioner. Examples of evidence based practices include cognitive behavior therapy, cognitive mapping, good behavior game, systematic desensitization, token economy motivation systems and social skills teaching strategies, and a variety of clinical practice guidelines. Such practices describe core intervention components that have been shown to reliably produce desirable effects and can be used individually or in combination to form more complex procedures or programs."

> "Evidence-based programs consist of collections of practices that are done within known parameters (philosophy, values, service delivery structure, and treatment components) and with accountability to the consumers and funders of those practices. Evidence-based programs represent a way to translate the conceptual, goal-oriented needs of program funders and agency directors into the specific methods necessary for effective treatment, management, and quality control. Examples of evidence-based programs include Assertive Community Treatment, Functional Family Therapy, Multi-systemic Therapy, and Supported Employment." (Fixsen, D. et al. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231)

An Evidence-based Practices and Programs Audit was conducted by BPA for each treatment provider in conjunction with their annual clinical audits in FY 2015. A standardized tool was developed with four sections: 1) Written Descriptions; 2) Clinician Interview; 3) Client Interview and 4) Group Observation. The following report summarizes a review of the results of 116 providers completed with modifications to the process to enhance the results in the coming year.

Written Description

The Regional Coordinators contacted the providers in advance of the audit and requested descriptions of their Evidence-based Practices and Programs utilized for clients. Though this is a baseline year, BPA reviewed the results internally to identify those programs that are on the NREPP site (National Registry of 349 Evidence-based Programs and Practices) or have some other evidence-based foundation. In total, 116 reported using 80 programs and practices. Over 80% report using 4 or more programs or practices to treat their clients. The following tables summarize the findings to date:

Programs / Practices utilized by 10 or more providers	# of Providers
Matrix Model (NREPP)	85
Moral Reconation Therapy (NREPP)	79
Dialectical Behavioral Therapy (NREPP)	46
Relapse Prevention Therapy (NREPP)	45
Cognitive Self Change-Idaho Model (IDOC)	43
Seeking Safety (NREPP)	40
Living in Balance (NREPP)	32
Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual (SAMHSA)	31
Motivational Interviewing (NREPP)	23
Motivational Enhancement Therapy (NREPP)	12
Cognitive Behavioral Therapy (NREPP)	16
Co-Ocurring Disorders Program (Hazelden)	14
The Change Company Journals	13
Trauma-Focused Cognitive Behavioral Therapy-TF-CBT (NREPP)	11
Helping Women Recover and Beyond Trauma (NREPP)	10
Total Providers using these programs	**110**

Programs / Practices utilized by 4 or more providers	# of Providers
Trauma Recovery Empowerment (TREM)	7
Twelve Step Facilitation Therapy	7
Anger Management Workbooks (Various)	6
Thinking for a Change TFAC (NICIC)	6
TCU Mapping: Enhanced Counseling Manual (NREPP)	6
Dual Diagnosis Therapy using Coping with Dual Diagnosis	6
Women in Recovery (Dr Stephanie Covington)	6

Early Recovery (Mark Gornik)	6
Eye Movement Desensitization and Reprocessing EMDR	5
Stages of Change: Group Treatment for Substance Abuse Manual	5
Mindfulness-based Stress Reduction MBSR	4
Dual Diagnosis Workbook	4
Total Providers using one of these programs	**61**

Note: A list of programs and practices utilized by 3 or fewer providers are attached.

Future Vision for EBPP in the Provider Network: After reviewing the information gathered, the committee agreed the focus for the coming years will be to ensure that programs are evidence-based, balanced with the importance of individualized care and the limitations on treatment episodes due to funding constraints.

Priority approval will be given to those programs listed on the following sites:

SAMHSA National Registry (NREPP)
National Institute of Corrections (NICIC)

The committee will consider the best approach to encourage providers to move from non-listed programs to programs that are listed on an evidence-based registry.

FY 2016 Plan:

Create a database and tool to allow referral sources to search by EBPP: A tool will show what EBPPs are used by each provider. State Agencies and Branches of Government that require specific EBPPs such as MRT or CSC can utilize those providers exclusively for high-risk offenders. Partner agencies have varying expectations with regard to evidence-based practices and programs. The results of the EBPP Audit allow for agencies to use providers that meet their expectations.

Monitor new providers upon entry to the network to ensure EBPP: The EBPPs documented for current providers has established a baseline of information for the network. As providers apply to join the network, BPA will request information on EBPPs and ensure these planned programs meet expectations. Those that are not on an approved list will be reviewed quarterly by the Provider Oversight Committee. If they are not approved by the committee, the provider will be advised that they cannot be used for state-funded clients. New providers will have to demonstrate that they provide one or more approved programs and practices to join the BPA Network.

Integrate review of EBBP into clinical chart audit: Regional Coordinators will begin the process of providing technical assistance to integrate the EBPPs into the treatment plan and notes, identifying the EBPP utilized for the client and reviewing evidence of the utilization in the treatment planning and service notes during the clinical chart audit. The interview and observation will be scheduled at the same time to allow a full understanding of the integration of the EBPP. A recommendation that providers that score 90 or above will be placed on a 2 year audit schedule will be made to the Governance Council for consideration.

Clinician and Client Interview

The Regional Coordinators schedule time with up to three clinicians and clients to ask a standard set of questions. The Committee agreed that the Regional Coordinators should continue to conduct the interviews as a means to understand further and confirm the use of Evidence-based Practices and Programs. The interviews should be connected to the files reviewed for best results. No quantitative results will be developed from this process and qualitative results will be reviewed and reported. The interview summaries will be maintained in BPA electronic files and accessible upon partners' request. A survey will be developed to aggregate quantitative results and trends.

Group Observation

The Regional Coordinators schedule Group Observation at each agency. The group observation, though disruptive, can provide some basic information about the clinician's adherence to a plan and the group's engagement. The Committee requested that the Group Observation piece continue. The members recognized that there are limitations to the process but agreed that it is a strong component to have some observation of the agency's work. The tool will be utilized. No quantitative results will be developed but completed tools will be maintained in the electronic provider files.

Monitoring Outcomes

Implementing the use of a Provider Dashboard to gauge referrals, length of stay and discharge results will be a new element added with the publication of quarterly dashboards to each provider. The draft of the Provider Dashboard will begin to be circulated in Q1 of FY 2016. This information will be a critical component to the review of EBPP and outcomes.

Reporting to the Provider Oversight Committee:

On a quarterly basis, BPA will provide the following results to the committee:

1) Clinical Chart Audit Scores;
2) List of new Providers and EBPPs utilized;
3) Any concerns with documentation that may include interview and group observation results;
4) Provider Dashboard Summaries.

Attachment

Other Programs and Practices Listed by Three or fewer providers

NREPP List:
Chestnut Health Systems-Bloomington Adolescent Outpatient (OP) and Intensive Outpatient (IOP) Treatment Model
The Seven Challenges
A Woman's Path to Recovery (Based on a Woman's Addiction Workbook)
Interactive Journaling
Nurturing Programs for Families in Substance Abuse Treatment and Recovery (Nurturing Parenting Programs)
Solution Focused Group Therapy
Strengthening Families Program
Trauma Recovery and Empowerment Model for Men M-TREM
Brief Strengths-Based Case Management for Substance Abuse
Family Support Network (FSN)
Healing from Trauma and Abuse (WRAP)
PRIME for Life
Trans-theoretical Model (TTM)
Acceptance and Commitment (ACT)

Hazelden Programs:
Coping with Stress: A CBT Program for Teens with Trauma
Family Matrix
Inside Out
Living Skills: Refusal Skills
Reducing Anger in Adolescents: An REBT Approach
Youth Life Skills: Decision Making
Youth Life Skills: Conflict Resolution
A New Direction: Men in Recovery
Shame-Resilience Curriculum
Dual Recovery Socialization
Bully Prevention Program
Socialization
Connections: a 12-session psychoeducational

Other EB Programs:
Helping Men Recover (Dr. Stephanie Covington)
Parenting (ISU-Mark Roberts and Love & Logic)

Time Out for Men (Based on TCU Mapping)

Programs to be Reviewed by the Provider Oversight Committee:
Weeks & Vietri: Advanced Relapse Prevention, Anger Management
Bell Counseling: Aftercare (SAMHSA), Upper, Downers and All-Arounders (Idaho RADAR)
Community Services Counseling: Boundaries with Kids
Mental Wellness Centers: Dual Diagnosis Workbook
A Fresh Start Recovery: Dual Diagnosis Treatment/Therapy (University of S. Florida)
Benewah Medical Centers: TIP Substance Abuse Treatment: Group Therapy (SAMHSA):
Recovery 4 Life: Sober Living Straight Ahead
Easter Seals Goodwill Behavioral Health: Social Supports
Camas Professional Counseling, Ascent Behavioral Health, Preferred Child & Family Services: Stages of Change Therapy Model:
Preferred Child & Family Services: Thinking Matters (Abe French)
Lifestyle Changes Counseling: Staying Quit: A Cognitive Behavioral Approach to Relapse Prevention Workbook (Correctional Counseling)
Community Outreach Counseling, Ada County Juvenile Court Services: The Basics: A Co-occurring Curriculum (Rhonda McKillip)
Integrated Family & Community Services: Thinking for Good- Pre MRT
Road to Recovery: Yoga of 12-Step Recovery Y12SR

14a Response

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The Idaho Office of Drug Policy (ODP) assumed oversight of the delivery of substance abuse prevention services in Idaho effective July 1, 2013. At that time, ODP introduced the *Strategic Prevention Framework* (SPF) principles as the foundation for substance abuse prevention strategies and programs across the state. The SPF model is data-driven. The process of establishing priorities, identifying gaps in resources, and choosing evidence-based practices to address specific needs are all based on available data and local conditions.

ODP, with the assistance of numerous partners, utilized data on substance use consumption patterns, consequences of use, and risk and protective factors to compile an annual substance abuse prevention needs assessment. This completed assessment serves as the basis for the identification of primary prevention services that are needed. The *Idaho State Epidemiological Outcomes Workgroup* (SEOW) implemented a four step process to determine appropriate indicators to inform prevention efforts:

> Step 1: Review Data Indicators. An examination of existing information was conducted, establishing a comprehensive list of over 150 possible state-wide indicators grouped by substance and construct type. From this initial list, statewide priorities were identified.
>
> Step 2: Incorporate Criterion. Driven by the interest of requiring data sources that would reflect a statewide scope, the workgroup assigned 6 criterion to refine the above mentioned list to 40 indicators.
>
> Step 3: Identify Relevance and Record Type. Using a scale of one to three, with 1 being *Very Relevant* and 3 being *Not Relevant*, all indicators were scored by SEOW members and classified based on the data source, administrative (A) or survey-based (S).
>
> Step 4: Score. A hybrid Delphi method was employed by the SEOW workgroup to further define indicators. The resulting indicator list is composed of 12 constructs and 38 indicators. The resulting trends from the remaining indicators were used to determine areas of need in the state.

In addition to the annual Needs Assessment, and with the support of the State Epidemiological Outcomes Workgroup staff, the Office of Drug Policy began an update of Idaho's Prevention and Treatment Research (PATR) website. Currently, the site focuses on substance abuse prevention data. The data is being transitioned to incorporate use and consumption information obtained through both the *Idaho Youth Risk Behavior Survey* (IYRBS) and the *Behavior and Risk Factors Surveillance System* (BRFSS). The site also includes a variety of archival and survey data reported at the state and county level. The goal is to provide the resources and data that individual providers and community coalitions could use in community planning as well as grant applications. The PATR web address is: http://patr.idaho.gov/. Further expansion of the site is planned to include behavioral health data and information.

What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were

used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

All specific recurring primary prevention programs, practices and strategies funded with SABG prevention set-aside dollars must be on Idaho's approved list of evidence-based programs (this list can be found at: http://odp.idaho.gov/grants/sabg.html). Decisions to include an evidence-based program on the list are based on National Registry of Evidence- based Programs and Practices (NREPP) ratings and/or Idaho outcome data. National registry-listed programs that have shown positive outcomes with Idaho populations which do not meet NREPP ratings requirements may be provisionally funded in areas where the program has proven effective, if approved by the Evidence-Based Practices (EBP) Workgroup.

The EBP Workgroup was formed in 2014 to gain an understanding of the role of evidence-based programs in Alcohol and Other Drug prevention. The Workgroup is composed of research professionals from several state agencies. Idaho's EBP Workgroup is responsible for several related functions. This workgroup provides communities with information and technical assistance regarding effective programs, practices, and policies; how to implement these with fidelity; and how to evaluate their effectiveness.

More specifically the EBP Workgroup is tasked with:

1) Reviewing and approving/disapproving strategies proposed by sub-recipient communities based on whether or not they achieve a certain level of evidence;
2) Creating and disseminating an evidence-base practices guidance document;
3) Reviewing and approving a list of evidence-based programs, practices, and policies for use by funded coalitions;
4) Developing a process by which coalitions can submit for approval interventions not already listed; creating an evidence-based practices "Best Fit" form for coalitions to use when submitting their proposed strategies for review.

The identification of evidence-based environmental strategies has proven to be a bit more challenging, as few are listed on National Registry of Evidence-based Programs and Practices, and even fewer have comprehensive implementation materials that are comparable to the recurring education programs. Currently, Idaho funds media campaigns/media advocacy; community town hall meetings and awareness/education activities; youth projects related to substance abuse prevention or education; responsible server training; policy change initiatives; and, prescription drug take back events.

Idaho ensures that SABG dollars are used to purchase primary substance abuse prevention services by implementing a statewide partnership with multiple agencies. The Office of Drug Policy has established multiple workgroups to build a substance abuse prevention infrastructure in Idaho.

IV: Narrative Plan

F Use of Evidence in Purchasing Decisions

Page 70 of the application Guidance

Narrative Question: 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 mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

- 1) Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) How is information used regarding evidence–based or promising practices in your purchasing or policy decisions?
- 3) Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
- 4) Does the State use a rigorous evaluation process to assess emerging and promising practices?
- 5) Which value based purchasing strategies do you use in your state:
    - a. Leadership support, including investment of human and financial resources.
    - b. Use of available and credible data to identify better quality and monitored the u impact of quality improvement interventions.
    - c. Use of financial incentives to drive quality.
    - d. Provider involvement on planning value-based purchasing.
    - e. Gained consensus on the use of accurate and reliable measures of quality.
    - f. Quality measures focus on consumer outcomes rather than care processes.
    - g. Development of strategies to educate consumers and empower them to select quality services.
    - h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
    - i. The state has an evaluation plan to assess the impact of its purchasing decisions.

The Division of Behavioral Health (DBH) encourages use of evidence based or promising practices. Several DBH staff are responsible to track and disseminate information regarding evidence-based or promising practices. The Department of Health and Welfare maintains an on-line learning system. The Knowledge Learning Center (KLC) provides a multitude of courses for Department staff, with many courses offering Continuing Education Units (CEU's). DBH staff have contributed to the development of several courses, including Motivational Interviewing, SAMHSA's Tip 42 and a unit on Gay, Lesbian, Bisexual, Transgender and Questioning (GLBTQ) awareness.

Specific evidence based or promising practices are available in Idaho. Regional Behavioral Health Centers (RBHC) provide Assertive Community Treatment (ACT) services. Each ACT team includes a Certified Peer Specialist who models recovery and resilience. Data on ACT services and outcomes is tracked through the DBH WITS data system and disseminated through state and federal reporting.

Projects for Assistance in Transition from Homelessness (PATH) programs use PATH Certified Peer Specialists to provide outreach, engagement and case management to adults with serious mental illness who

are either homeless or at risk of becoming homeless. Data on these services is tracked and reported through monthly service reports from the contractor (Mountain States Group's Office of Consumer and Family Affairs) and through the PATH Annual Report. The PATH supervisor at Mountain States Group also provides updates on PATH services to the State Planning Council.

The Idaho Home Outreach Program for Empowerment (ID-HOPE) provides the evidence based practice of Critical Time Intervention, with adaptations that include the use of a team with bachelors/masters staff and Certified Peer Specialists. This program also offers seven to fourteen day, community based crisis intervention to ID-HOPE participants as an alternative to hospitalization. Data on services provided, consumer satisfaction and outcomes is collected and reported monthly by the contractor (Human Supports of Idaho) to the Project Director at DBH. Human Supports also works closely with the ID-HOPE Advisory Board, and information on services and outcomes are provided at their quarterly meetings. Monthly reports are also available to Board members.

Parenting with Love and Limits (PLL) is in its seventh year of services through the Children's Mental Health Program and is available in all seven regions of the state. PLL is an evidence based treatment model for adolescents, aged 10-17, with extreme emotional and behavioral problems. PLL combines parenting management group therapy, family therapy, and wound work into one system of care to quickly engage resistant parents and the teenagers. PLL was implemented to address the following gaps in service delivery:

- Limited to No Parent or Family Involvement: Most programming focused on serving only the individual child, with little focus on serving the family;
- Lengthy Treatment Periods: The average length of stay for a youth in CMH is 12 months, while Community Based Rehabilitative Services (CBRS) averages 24 months in duration; in contrast, PLL is a brief treatment model with an average length of stay of two to three months;
- High Costs of Care: The average cost per child for CMH is approximately $3,5783, and $4,9404 for CBRS services; in contrast, the PLL cost of care is $1,360 per youth5; and
- Program Accountability: In the 2008 WICHE Report6, Idaho Senator Joe Stegner noted, "One of the biggest gaps involves oversight of local providers. We have a multitude of providers delivering services with varying degrees of competence and effectiveness."

The Idaho Youth Treatment Program (IYTP) is an evidence-based project based upon the Adolescent Community Reinforcement Approach (A-CRA) to treatment for Transitional Aged Youth (TAY), 18-25 y.o., with Substance Use Disorders (SUD) or co-occurring disorders- under a four year grant from SAMHSA- and with a focus on often-underserved populations: Hispanic, Tribal, African-American and LGBT. Business Psychology Associates was awarded the contract and local service providers were designated. In Region 2, the service provider will be Snake River Rehabilitation (Lewiston), and in Region 4 the provider will be Recovery4Life (Boise). Each provider employs three clinicians and one supervisor under the grant. All of the clinicians are trained and certified by Chestnut Health Systems in the A-CRA model, along with one supervisor per service provider for each region. Additionally the supervisors will receive further training in a "train-the-trainer" component so that sustainability and a pool of A-CRA qualified and certified staff are available in urban, rural or underserved areas across Idaho. In year two of the grant, Region III was added and in each subsequent year of the grant, one or two regions will be added through workforce development and expansion of the evidence-based treatment model until all seven H&W regions have clinicians trained and certified in the A-CRA model. The IYTP is a project of the Division of Behavioral Health and specifically the Policy Unit- with the support and involvement of the Operations Unit.

The treatment involves sessions for the TAY, sessions for the families/ caregivers and combined sessions with both together. Included in the treatment will be community-based, and other, pro-social activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. The program will recruit and develop TAY to serve on a "consumer-driven" advisory board, and will establish a multi-agency stakeholder advisory group also for each region. Data will be collected through the Global Appraisal of Individual Needs (GAIN) at intake and subsequently after treatment, as well as from service provider monthly reports and Web Infrastructure for Treatment Services (WITS) reports.

Information regarding evidence-based or promising practices has been used in purchasing or policy decisions. Historically, Certified Peer Specialists placed with RMHC ACT teams were hired and supervised through a contract with Mountain States Group's Office of Consumer and Family Affairs. RMHC programs found peers to be a useful addition to ACT teams, and these individuals were directly hired by the Department of Health and Welfare, effective November 19, 2012.

Information regarding evidence-based practices has been used in several ways. Evidence based program information is available to Department staff on the KLC. State Medicaid agencies have been educated on evidence based programs and the Optum Idaho utilizes evidence based practices as the foundation for the Idaho Behavioral Health Plan and their level of care guidelines. Regarding purchases, the DBH does use data on service outcomes to make decisions about purchases with funds that they control. Clear data on successful and cost effective service outcomes is increasingly important in a context of limited behavioral health funding. Services that demonstrate good outcomes and cost savings are more likely to be funded.

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4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Page 48-49 of the application Guidance

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

******It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.**

Please indicate areas of technical assistance needed related to this section

While there are no formal prevention efforts underway by the Division of Behavioral Health the Division supports the efforts of the Regional Behavioral Health Centers in their efforts to engage in outreach, education and prevention activities in their local communities. The Division recognizes tthat prevention efforts are historically more beneficial and more cost effective than more intense treatment services. In addition to being less stigmatizing, community based services are significantly less expensive than hospitalization, jail or residential options.

The Division contracts with the Office of Consumer and Family Affairs (OCAFA) to provide education on mental health issues. The Division provided education and awareness information during Mental Health month in May. The Regional Behavioral Health programs actively outreach to local schools to provide information and education on behavioral health issues as well as information on available services to facilitate early identification and referral to needed services. Several Regional programs participate in local fairs, community events and conferences by providing information booths and distributing information and education materials on behavioral health issues and services. All Regional programs participate in Children's Mental Health Awareness week local activities. Information on available behavioral health services is sent to pediatricians at the Regional level. Additionally, Parenting with Love and Limits (PLL) clinicians have the ability to accept PLL waiver cases which may include youth who would not otherwise qualify for CMH services. These youth are typically referred by a juvenile probation officer or another community partner. These efforts to accept and provide treatment to waiver families have developed a proactive approach to treatment by helping families before problems intensify and there is a need for a higher level of care in either the mental health system or juvenile justice systems.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Minimum Data Set

1. Participant Demographics

	Age Range	American Indian/Alaska Native		Asian		Black/ African American		Hawaiian/ Other Pacific Islander		White		More Than One Race		Race Not Available	
	18 – 20														
	21 – 24														
	25 – 44														
	45 – 64														
	65 – 74														
	75 +														
	Age not available														

2. Participant Ethnicity

	Age Range	Hispanic		Not Hispanic		Ethnicity Not Available	
	18 – 20						
	21 – 24						
	25 – 44						
	45 – 64						
	65 – 74						
	75 +						
	Age not available						

3. Expenditures by Service *(Note: upon selection of an evidence-based program, this list may change to more accurately reflect the services delivered.) Examples of the type of data, reported by number of participants, served, number of units delivered and cost of the service.*

	Service	# of Participants	# of Units Delivered	Cost
	Assessment			
	Case Management			
	Group Therapy			
	Medication Management			
	Peer Support			
	Crisis Care			
	Other – Please list.			

4. Profile of Participant Turnover

Participant Turnover
a. Number of participants are start of services
b. Number of participant admissions during the year
c. Number of participants discharged during the year
d. Patient length of Stay Chart (Length of stay data reported in number of days.)

	Length of Stay – Discharged participants only		Length of Stay for 1 year or less - All clients regardless of service completion status		Length of Stay for more than 1 year - All clients regardless of service completion status	
	Average (mean)	Median	Average (mean)	Median	Average (mean)	Median

5. Profile of Adults Receiving Specific Services

	Age	Receiving Family Psychoeducation	Receiving Illness Self Management	Receiving Medication Management
	18 – 20			
	21 – 64			
	65 – 74			
	75+			
	Not Available			
	Gender	**Receiving Family Psychoeducation**	**Receiving Illness Self Management**	**Receiving Medication Management**
	Female			
	Male			
	Not Available			
	Race	**Receiving Family Psychoeducation**	**Receiving Illness Self Management**	**Receiving Medication Management**
	American Indian/ Alaska Native			
	Asian			
	Black/African American			
	Hawaiian/Other Pacific Islander			
	White			
	More than one race			
	Race not available			
	Ethnicity	**Receiving Family Psychoeducation**	**Receiving Illness Self Management**	**Receiving Medication Management**
	Hispanic/Latino			
	Not Hispanic/Latino			
	Not Available			

6. Adult Clients by Employment Status

	Employment Status	18 - 20			24 - 64			65+			Not Available		
	Employed Full or Part Time												
	Unemployed												
	Not in Labor Force (Retired, Sheltered Workshop, etc.												
	Not Available												

7. Living Situation

	Age	Private Residence	Crisis Residence	Jail/ Correctional Facility	Homeless/ Shelter	Other	Not Available
	18 – 64						

	65+						
	Not Available						
	Gender	**Private Residence**	**Crisis Residence**	**Jail/ Correctional Facility**	**Homeless/ Shelter**	**Other**	**Not Available**
	Female						
	Male						
	Not Available						
	Race	**Private Residence**	**Crisis Residence**	**Jail/ Correctional Facility**	**Homeless/ Shelter**	**Other**	**Not Available**
	American Indian/Alaska Native						
	Asian						
	Black/African American						
	Hawaiian/ Pacific Islander						
	White/ Caucasian						
	More than One Race Reported						
	Race Not Available						
	Ethnicity	**Private Residence**	**Crisis Residence**	**Jail/ Correctional Facility**	**Homeless/ Shelter**	**Other**	**Not Available**
	Non-Hispanic or Latino Origin						
	Non-Hispanic or Latino Origin						
	Not Available						

8. Summary Profile of Participant Evaluation of Care

	Question	Number of Positive Responses	Total Responses
	1. Reporting Positively about Access		
	2. Reporting Positively about Quality and Appropriateness for adults		
	3. Reporting Positively about Outcomes		
	4. Adults Reporting on Participation in Treatment Planning		
	5. Adults Positively about General Satisfaction with Services		

9. Criminal Justice Involvement

Participants who began services during the past 12 months

	Adults 18 and over	12 Months prior to beginning services			Since Beginning Services			If arrested prior 12 months			If not arrested prior 12 months		
	Gender	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response	Arrested	Not Arrested	No Response

	Female												
	Male												
	Not Available												

Since starting to receive services, participant encounters with the police have:

	Gender	Reduced	Stayed the Same	Increased	Not Applicable	No Response
	Female					
	Male					
	Not Available					

10. Profile of Adults with Serious Mental Illness Receiving Specific Services

	Age	Receiving Supported Housing	Receiving Supported Employment	Receiving Assertive Community Treatment
	18 – 20			
	21 – 64			
	65 – 74			
	75+			
	Not Available			

	Gender	Receiving Supported Housing	Receiving Supported Employment	Receiving Assertive Community Treatment
	Female			
	Male			
	Not Available			

	Race	Receiving Supported Housing	Receiving Supported Employment	Receiving Assertive Community Treatment
	American Indian/Alaska Native			
	Asian			
	Black/African American			
	Hawaiian/ Pacific Islander			
	White/ Caucasian			
	More than One Race Reported			
	Race Not Available			

	Ethnicity	Receiving Supported Housing	Receiving Supported Employment	Receiving Assertive Community Treatment
	Hispanic/Latino			
	Non-Hispanic/Latino			
	Not Available			

5. Evidenced-Based Practices for Early Intervention (5 Percent)

Idaho Response

For this activity, Idaho's Community Mental Health Services block grant set-aside is $127.741. The Division of Behavioral Health began the process by conducting a needs assessment to evaluate the scope of the need and the issues involved. Once the assessment was completed and analyzed, a priority population and location was selected. The program was located in one of Idaho's less populated regions to fill the identified service gap. The population identified was individuals 18-25, experiencing first episode psychosis within the past 2 years. The RAISE evidence-based program was selected based on the priority population and their needs. The RAISE programs' coordination of specialty care was seen as an essential element in delivering comprehensive, participant-directed care. The implementation phase was initiated October 1, 2014 and completed on February 28, 2015.

The program was implemented in October of 2014 and became fully operational in March of 2015. Service agreements were established to facilitate the development of a multidisciplinary treatment team. Community resources were employed, based on the participant's assessment and preferences.

Integral to the development of the program was implementation of comprehensive, ongoing data collection. Attached to this response is the report from the contractor provide monthly updating the Division on the number and types of participants served. This data is collected on each participant. To date the program has served 5 individuals. For FFY 2014-2015, all set-aside funds were used to establish the program and initiate services. No additional funds were used for the implementation of this service.

The form used to collect participant data for the FFY 2014-2015 Community Mental Health Services (CMHS) block grant is included in the attachments to this response. Data was collected and aggregated on all participants. No participant has completed the program at this time, so no outcome data are available. It is anticipated that outcome data will be available for the FFY 15 CMHS report.

For FFY 2016 - 2017, the early intervention funds will be moved to the Division's Region VII Mental Health Program. This region located in eastern Idaho also has large frontier and rural areas. The Region also houses Idaho's first Crisis Center. Pairing the Early Intervention Program with the Crisis Center resources will enable the region to broaden the scope of available services. The Region VII Mental Health Program will offer the Strengths Through Active Recovery (STAR) program. This program follows the procedures and practices outlined in the Raise Coordinated Specialty Care for Frist Episode Psychosis manual and the manuals from the OnTrackNY/Connections Program for first episode psychosis. The Mental Health Program will use these modalities as with the additional set-aside funds.

a. TREATMENT CONCEPTS:
   i. Recovery
   ii. Shared Decision Making
   iii. Active and Focused Treatment

iv. Flexible and Consistent Treatment
v. Fostering Autonomy and remaining available
vi. In-depth Safety Planning
vii. Critical Time Interventions (CIT)

b. TEAM MEMBERS (Currently these range from about 0.05-0.15 FTEs per position or (1-3 hours/week):

i. Team Leader
ii. Primary Clinician
iii. Team Psychiatrist
iv. Team Nurse
v. Individual Placement Support (IPS) Specialist
vi. Recovery Coach

Idaho plans to track participant data using the Web Infrastructure for Treatment Services (WITS) data system. This data will be augmented with with hospitalization days, jail days, days in independent liver and employment/school attendance.

Idaho's set-aside amount of $127.741 will be added to the existing budget of $20,000. It is anticipated this budget will services a minimum of 10 additional clients per year. In addition to the cost of delivering the manualized-services, funding will be used to cover the cost of housing, medication and transportation for individuals and services not covered by health insurance or Medicaid.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

Idaho Response

Division of Behavioral Health employs multiple service delivery systems in the provision of behavioral health care. Individuals eligible for Medicaid receive behavioral health services managed by private intermediary, OPTUM. Actual services are delivered by private and non-profit providers throughout Idaho. Community Mental Health Services block grant-funded adult and children's care is delivered by Division of Behavioral Health Regional staff. These staff qualify participants for care, work with the client to develop a treatment plan and identified needed services. When adults and children need mental health services not funded delivered by Regional staff, services are delivered by a private provider under contract with the Department. In these cases, the Regional staff work with the participant, and if appropriate their family, to identify a mental health services provider.

The Division's Substance Use Disorders (SUD) services are also managed by an intermediary, Business Psychology Associates. The intermediary is responsible for conducting brief financial and clinical screening to determine qualification for care. Upon determination the participant qualifies for care, the intake staff work with the client providing information on the network treatment agencies available to deliver the level and type of service(s) indicated by the initial screenings, enabling participants to select the provider who best meets their needs. The client is free to choose any provider in the network. While it is discouraged for clinical reasons, the client may transfer to another provider at any time during the treatment episode.

Idaho does not currently have the statutory foundation required to implement a voucher system for publicly-funded behavioral health services. At this time, Idaho has no plans to implement a voucher system.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 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 USC § 300x– 55, 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 to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible 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 abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. 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 mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required 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 consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

State of Idaho Behavioral Health Best Practice Standards

Updated December 2014

DBH Policy Unit

December 2014 Edition

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INTRODUCTION

The Division of Behavioral Health has begun an ongoing process of developing best practice standards, which are anticipated to improve behavioral health services provided in the state of Idaho. The standards carry the intention of serving as a consistent base for the provision of high quality behavioral health care in Idaho, by providing increased awareness, understanding and utilization of best-practice service and treatment modalities.

The first release of standards (known presently as the "Core 18") includes principles that are intended to apply to all behavioral health treatment and recovery support service providers in Idaho. Additional standards will be developed according to priority and system need, and may apply to only those entities that offer the services or serve the populations identified in the standards.

Throughout the development process, careful consideration has been paid to: a) evidence-based behavioral health practices; b) widely accepted standards of behavioral health care; c) Idaho Administrative Rule (program specific); d) State contractual requirements; e) current practice; f) need throughout the state; and g) input from community providers, consumers, and stakeholders. Using the following guiding principles, a research team from Division of Behavioral Health has developed best practice standards for implementation by behavioral health providers across the state of Idaho.

Guiding Principles:
As an effort to produce standards that are unique to Idaho's behavioral health infrastructure, 11 guiding principles were established as the foundation for standards development and decision-making. These guiding principles define the qualities that are essential to the improvement of behavioral health service delivery in Idaho.

- ✓ Provide effective direction for the state of Idaho's evolving behavioral health system.
- ✓ Practice responsible management of finances and resources.
- ✓ Place a heavy emphasis on providing exceptional customer service to participants and their families, providers and stakeholders, by modeling professional and ethical behavior.
- ✓ Demonstrate respect for and encouragement of diversity and cultural awareness.
- ✓ Strive for continuous enhancement of Idaho's Best Practice Standards.
- ✓ Foster recovery, resiliency and independence by providing strengths-based, person-centered and family-focused care.
- ✓ Endorse comprehensive and integrated healthcare whereby both mental health and substance use disorders care is coordinated with primary care.
- ✓ Provide guidance for programming that is innovative and evidence-based/best practices, through decision-making that is guided by research and data analysis.
- ✓ Promote ongoing quality improvement based on participation and collaboration in development of services, policy, and planning from providers, stakeholders and participants.
- ✓ Encourage preemptive and valuable staff training and education.
- ✓ Prevention and intervention services are outcomes-based, established to minimize risks and support recovery.

What is the main function of standards?
Serve as a guide for practitioners and agencies to provide best practice Behavioral Health and Recovery Support Service in Idaho. Contractors may use any portion(s) of this manual for auditing purposes.

How do I use this manual?
This manual is intended to serve as a user-friendly reference guide for providers, consumers, and stakeholders; it offers guidelines on the provision of behavioral health care in Idaho. It is fully searchable by simply using the keyword search box. The guidelines contained within these standards are to be interpreted as benchmarks rooted in up-to-date evidence for not only community providers, but funding contractors as well.

What are the expectations for implementation?
Currently, the basis for implementation of these standards is opt-in, but the Department will be integrating them into current practices, and suggests that partners and stakeholders begin to do so also.

Anatomy of a Standard:

7.0 Behavioral Health Crisis Intervention and Response

7.1. Agency Protocols for Behavioral Health Crisis Intervention and Response

Rationale: Effective interventions and responses to behavioral health crisis situations can substantially enhance participants' recovery experiences, improve their overall quality of life, and even result in fewer future crisis situations. Agency has protocols in place to help guide how to effectively intervene and respond to a wide range of crisis situations.

7.1.1. Agency develops and implements strategies for guidance of staff members in carrying out crisis response and intervention strategies.
7.1.2. Agency defines "crisis", as it applies to the services provided/population served.
7.1.3. Agency's scope as it relates to the ability to intervene or respond to crises is clearly documented.
7.1.4. Agency defines actions to be taken if it is not prepared or qualified to handle certain crisis situations.
7.1.5. Agency employs protocol for managing crises during, as well as, outside of business hours.
7.1.6. Interventions/responses foster recovery and empowerment of individual served.
7.1.7. Crisis interventions/responses are intended to stabilize participant as soon as possible so he/she may function at the same level as prior to the crisis.
7.1.8. Agency practices only within their scope of care, and provides referrals as necessary when it cannot provide required crisis services.
7.1.9. A protocol is developed and implemented for following up with participants after a crisis is experienced.

Special Considerations: For guidance on environmental disasters, reference Facility Safety section of manual.

For guidance on infection control, reference section on Reducing Risk of Spreading Infection.

References for Standard 7.0:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual*. Tucson: CARF International.
(pgs. 60-68, 71-72)

IDAPA Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs 16.07.20, §§ 390-392, 399 (2013).

- The sub-standards are short subtitles that introduce the key components of each standard.
- The "Rationale" describes the logical foundation for each sub-standard.
- Below the rationale section, you will see application guidelines that specifically discuss how the agency is to carry out or evidence compliance with standards.
- Sub-standards may include a category for Special Considerations. This category is designed to include any caveats that may apply to the sub-standard to which it is attached.
- References are located at the end of the respective standard.

►**Future Section:** After each standard, there is a Question/Answer section that is to be continuously updated with answers to questions asked by community providers, consumers and stakeholders regarding that specific standard.
The Question/Answer sections will be added after the initial public comment period, as questions pertaining to specific standards are submitted.

How will the manual be distributed?
For ease of access and to ensure the most recent copy available at all times, this manual will be published electronically. Please sign up on our website to receive email updates when changes to the eManual are made.

How often will the manual be updated?
This manual will be updated on an annual basis or more frequently, according to factors including: public comment, frequently asked questions addition/changes, behavioral health field and evidence base enhancement, implementation of new services, rule/statute changes, and other identified needs.

How can I provide input?
Public input is always welcome and solicited for a period of at least 30 days prior to publication of any new standards. Comments and feedback are collected via our website (mentalhealth.idaho.gov).
Please sign up on our website to receive email updates when comment periods open on proposed standards. If you have a specific comment or question, please email us at BHSurvey@dhw.idaho.gov.

CORE STANDARDS

1.0 General Agency Guidelines

1.1. Explanation of Provision of Services

Rationale: Providing documentation of services and scope of care delivers a clear message to prospective and active participants, their family members/advocates, partner agencies, referring agencies and other interested parties. The purpose of this information is to help participants and their advocates determine appropriateness to receive services from agency, and increase accountability for the agency to practice within its scope.

3.9.2. Agency prepares and implements a written plan for the provision of services that evidences appropriate resources and personnel to accomplish its goals.

3.9.3. This documentation includes: population(s) served, services provided, agency's beliefs regarding recovery, funding sources, partner agencies, hours and days of operation, and facility/service location(s).

3.9.4. Documents can be internal procedures and/or external marketing materials.

Special considerations: The explanation is offered in such a way that the intended audience can interpret and understand the material being presented. Accessibility needs are considered and barriers removed to ensure comprehension.

1.2. Scope of Care is Documented and Followed

Rationale: Defining and following a scope of care ensures that the agency practices only within its means, providing the best possible care for participants - by not attempting to deliver services without appropriate knowledge, skills, and training. Participants whom have needs outside the scope of the agency are offered a referral or information about more appropriate treatment options.

1.2.1. Agency will only practice within legal scope and provide care to only participants whose needs fall within their scope of practice.

1.2.2. Agency employs qualified personnel who have appropriate training, licensure, degree(s), and certifications.

1.2.3. Agency documents necessary benchmarks/criteria for admission, transition and discharge.

1.2.4. If the participant has needs in addition to those services provided by the agency, necessary referral(s) is/are made, or information is provided to participant as to where participant may receive the needed services.

1.2.5. If a referral is warranted, agency protocol is followed to ensure continuity and timeliness of care.

1.3. Participant Eligibility/Ineligibility

Rationale: It is necessary to determine participant needs and whether or not those needs are within the agency's scope of practice, at the time of first contact so as to limit the amount of time before the participant gets into a treatment facility that appropriately suits his/her needs. In the case that someone does not qualify for services offered, informing the participant why they do not meet criteria assists them in identifying what to look for as they explore other treatment program options.

1.3.1. Agencies have written eligibility requirements for care that align with their scope of care and make reasonable accommodations to provide participants with appropriate access to services.
1.3.2. Pre-screening for eligibility is completed at the time of initial contact. This includes identification of potential barriers to entrance of care and removal of those barriers when possible.
1.3.3. If a participant is found ineligible for services, they are advised as to why and referral or other information is provided to help link them to an agency that can meet the needs identified at pre-screening.
1.3.4. An appeal process is available and documented to address situations in which the participant does not agree with the (in)eligibility decision made by the agency. The process can include internal or external reviews and involves a neutral party.

1.4. Evidence-Based Practices (EBP)

Rationale: In order to provide the best care possible, modalities are used that have been tested and have scientific backing. Evidence-Based Practices are practices that have been proven successful through research and analysis, and they are accompanied by materials that enhance the treatment experience as well as ensure model fidelity.

1.4.1. EBP modalities are accepted in Behavioral Health and are backed by findings from credible studies.
1.4.2. Agency uses EBP's that are based on current research and data, and updates modalities used on an ongoing basis.
1.4.3. Outcomes are analyzed periodically throughout treatment stay to ensure adherence to EBP model and effectiveness for participant needs.

1.5. Ensure Cohesive, Timely Care

Rationale: Engagement in care occurs as soon as possible after determining eligibility because it results in better treatment outcomes. The window of time between the participant's first attempt at contacting the agency and the beginning of their care episode is crucial because the longer the participant has to wait to start care, the more opportunity they have to change their mind, experience decompensation of mental health, or participate in substance abuse. If a referral is required, it is completed as soon as possible in order to limit the amount of time it takes to get in contact and begin services with the appropriate agency.

1.5.1. Upon determining eligibility, participant engagement in care is facilitated by the agency in a timely manner. A preliminary plan for care may be prepared if necessary.
1.5.2. If participant is deemed ineligible for services, the agency makes appropriate referrals without undue delay.
1.5.3. If the agency employs a waiting list, reasonable efforts are made by the agency to ensure participant is not without services for an extended period of time.
1.5.4. For agencies that utilize waiting lists, policies and procedures are in place and followed to ensure consistent protocol.

1.6. Intentions of Care

Rationale: In order to ensure the best outcomes possible, it is essential to provide care that addresses participants' strengths, needs, preferences, and goals throughout the treatment

stay. Care provided is meant to improve participants' overall quality of life, to aim for long-term recovery, and to avoid future need for similar assistance.

1.6.1. The agency has documented mission, vision, and philosophy that align with services provided and target population(s).
1.6.2. Services provided promote independence, recovery, and well-being of the participant.
1.6.3. To the greatest extent possible, care is delivered in the least restrictive environment to facilitate community integration.
1.6.4. Referrals made to outside sources carry the purpose of improving participants' outcomes.

1.7. Agency Protocols Related to Provision of Care

Rationale: Establishing clear agency protocols regarding the provision of care provides consistency to support management decisions and guide provision of care. They provide a clear explanation of subjective issues, resulting in unbiased treatment of participants and employees.

1.7.1. The agency develops and enforces clear guidelines for the provision of care and provides clarity on subjective matters.
1.7.2. Protocols align with the documented scope of care.
1.7.3. Personnel are educated on and understand the application and implications of agency protocols.
1.7.4. Agency develops and implements practices that ensure compliance with legal and regulatory expectations related to fulfillment of organizational obligations, responses to various legal actions, and protection of participant information.

1.8. Loss Prevention

Rationale: Precautions are taken to reduce the risk of loss or harm to agency resources, employees, participants, reputation or aptitude. It is necessary to maintain appropriate resources needed in order to provide adequate care.

1.8.1. Agency recognizes potential risks and develops courses of action to address them.
1.8.2. Agency maintains sufficient insurance coverage to cover identified risks.
1.8.3. Potential risks are re-evaluated regularly and adjustments are made to accommodate any changes in applicability.

1.9. Outside Support Offered or Referrals Available

Rationale: When participant's needs change during their treatment stay, agency ensures that care aligns with participant strengths, needs, preferences, and goals. If referral to another agency is required in order to effectively address participant strengths, needs, preferences, and goals, it is completed by referring agency in addition to coordination with outside agencies or other necessary external supports. This ensures that the agency only practices within its scope, and that the participant receives care from an agency with the appropriate resources/capacity.

1.9.1. The need for outside supports and/or referrals is determined by the strengths, needs, preferences, and goals of the participant as well as the capacity of the agency.

1.9.2. Outside services and referrals are coordinated in a manner that is timely and results in all parties knowing what their roles and responsibilities are.
1.9.3. Referrals are made on behalf of participant as necessary and coordinated by agency to ensure continuity of care, and necessary participant information is exchanged with agency/agency accepting referral.
1.9.4. Participant is involved in the referral/coordination process and informed by the agency as to the purpose and goals of the referral/coordination.
1.9.5. Agency communicates with other agency (or agencies) with which participant is involved, and is aware of other outside supports participant is utilizing. The purpose of this communication is to discourage provision of duplicate services.

1.10. Services Rendered Align With Participant Strengths, Needs, Preferences, and Goals

Rationale: Participants' strengths, needs, preferences, and goals, as identified in the screening and assessment process, will create an outline for the Service Plan to ensure provision of individualized care. Throughout treatment stay, participant's strengths, needs, preferences, and goals are documented, addressed, and provide the foundation for care provided.

1.10.1. Delivery of care follows Service Plan.
1.10.2. Participant strengths, needs, preferences, and goals will be reviewed on a regular basis and the Participant-Centered Plan will be updated accordingly.
1.10.3. Provision of care related to the participants' strengths, needs, preferences, and goals will be evidenced throughout case documentation.
1.10.4. Referrals made will consider participant's strengths, needs, preferences, and goals.

1.11. Family Involvement Encouraged

Rationale: When possible and appropriate, the agency supports and encourages family involvement with participants' treatment process. Involvement of family is encouraged because the inclusion of those who are supportive of the participant's recovery results in better treatment outcomes. Additionally, family will likely remain supportive to the participant even after discharge from services.

1.11.1. Clear roles and responsibilities are defined for and understood by the participant, their family members, and staff member(s) providing services.
1.11.2. Participant file includes clear documentation of family involvement.
1.11.3. Consent for family involvement is to be obtained from adult participants. For minors or those participants who cannot offer their own consent, permission is obtained in adherence to legal requirements.

Special considerations: "Family" may include anyone the participant considers as supportive of their recovery. Situations that may result in the inability to involve family members include, but are not limited to: legal constraints, history of violence/safety concerns, lack of cooperation/participation, agency scope of care/staff licensure or certification, conflicting points-of-view, and the inability to pay for services.

1.12. Participants Work With Specified Staff Members

Rationale: In order to ensure a smooth process of care and reduce the likelihood of duplication of services, participants have designated staff members who work with them and

maintain contact with each other regarding the participant's care. This also ensures that the participant's needs are addressed.

1.12.1. Participants have specific staff member(s) who tends to their case for the duration of care stay. The participant file clearly documents staff member(s) responsible for assisting participant.

1.12.2. Participants are informed of which staff is/are assigned to their case and how to get in contact with said staff member(s).

Special considerations: If participant is involved with services that are provided by separate individuals due to credentialing standards, those individuals stay in contact as key parts of the participant's treatment team. Additionally, if a participant's care is transferred from one staff member to another, the transition is clearly documented and the case is staffed to ensure that the new staff member has all information necessary regarding the participant's case.

1.13. Supervision of Direct-Care Staff

Rationale: Providing the appropriate level of supervision for direct-care staff members ensures that staff members receive necessary support, which results in providing more effective and higher quality care to participants.

1.13.1. Personnel who provide direct care to participants have supervision on a regular basis as required by their credentials, as well as additional supervision if necessary according to their experience and performance.

1.13.2. Supervision goals and activities are clearly documented in personnel file and signed off on by both supervisor and supervisee.

1.13.3. Supervision includes verification that staff members practice only within the scope of their credentials.

1.13.4. Supervision consists of face-to-face meetings, observation and review of documentation.

1.13.5. Direct-care staff whose credentials require them, have the ability to earn continuing education units through access to training.

Special considerations: Refer to Human Resources section for additional guidance on staff supervision.

1.14. Organizational Readiness for Recovery-Oriented Services

Rationale: Recovery-oriented systems of care create positive outcomes for both the participants and for the agency. Agencies that are recovery-oriented enhance their participants' abilities to manage their own illness and recovery, as well as increase their participation in and quality of life. In order for an agency to implement this type of service, it needs to prepare staff, policies, procedures and the community.

1.14.1 Staff members are trained in Recovery-oriented principles, practices and services, and believe in and implement the idea of shared responsibility of recovery between the agency and the recovering community.

1.14.2 Agency provides a welcoming environment that reveals respect and dignity toward all who visit: clean, comfortable, positive and uplifting signage, and a friendly and respectful receptionist.

1.14.3 Recovery-minded staff: are friendly; build real relationships; are hopeful for each participant with a focus on individual strengths rather than diagnoses; have high expectations for themselves as well as for participants; are inspiring, empowering and encouraging; offer choices; and treat everyone with respect.

1.14.4 Recovery-oriented staff includes peer employees.
1.14.5 Documentation indicates that the participant and his/her support system are included in the treatment planning process. Documentation reveals the goal of self-determination and timelines are indicated for the accountability of goals to be reached. All materials and documentation are written in person-first, recovery-oriented language, including agency policies and procedures.

References for Standard 1.0:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 36, 51-52, 58-59, 97-100, 102-104, 106, 266)

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(CTS pgs. 5-6, 8-9, 40, 43, 47-48, 111, 113-114)

Daniels, A. S., Tunner, T. P., Bergeson, S., Ashenden, P., Fricks, L., Powell, I., (2013), Pillars of Peer Support Summit IV: Establishing Standards of Excellence, www.pillarsofpeersupport.org; January 2013.
(pgs. 50-53)

2.0 Entrance to Care

2.1. Waiting Lists

Rationale: In order to ensure that participants receive timely access to care, agency makes every effort possible to avoid employing a waiting list. In case a waiting list is inevitable, guidelines are developed and implemented to direct the utilization of the waiting list, and ensure that the participant is engaged in care at the earliest possible opportunity.

2.1.1. Agency has documented protocol for the implementation of waiting list.
2.1.2. Prior to placement on the waiting list, prospective participants are screened and evaluated for appropriateness to services offered by agency.
2.1.3. Upon placement onto the waiting list, participant is informed of expected wait time and provided with contact information for crisis intervention services.
2.1.4. If the screening results in ineligibility, the agency will offer referral(s) to the individual and facilitate the referral process when needed.
2.1.5. Agency documents all communications with persons on the waiting list.
2.1.6. For the duration of time on the waiting list, persons on the list are contacted by agency on a regular basis to maintain contact and detect any new needs and offer referrals if necessary.

Special considerations: Certain populations may have specific requirements regarding waiting lists. It is the responsibility of the agency to ensure compliance with requirements related to the population(s) that the agency serves.

2.2. Screening

Rationale: The purpose of screening is to gather preliminary information about the needs of the participant, and determine whether the agency can effectively address those needs. The screening can be conducted face-to-face or by other means.

2.2.1. The agency documents and follows a protocol for the screening process.
2.2.2. Agency puts forth efforts to ensure that participant is engaged in care as soon as possible following initial contact.
2.2.3. Screening instrument is designed to identify emergent needs, crisis situations, and dangerous substance abuse. Staff members respond immediately and according to agency protocol if these situations are revealed during screening.
2.2.4. The screening is documented, includes (in)eligibility decision and basis for the decision, includes referrals if provided, and includes prospective participant's strengths, needs, preferences, and goals.
2.2.5. Screening gathers basic demographic information about the prospective participant.
2.2.6. Staff members administering screening are appropriately trained to do so.

Special considerations: For additional standards on addressing crises, refer to the Behavioral Health Crisis Intervention and Response section.

2.3. Orientation

Rationale: The purpose of orientation is to provide information to the participant and/or their family or guardian as to exactly what to expect from their treatment stay.

2.3.1. Agency provides orientation to each participant and/or family members/guardian as soon as possible upon beginning care, considering the participant's presenting state and what services are being accessed.
2.3.2. Attendance to orientation is documented for each participant.
2.3.3. Orientation educates participants on: their rights and responsibilities, grievance/appeal procedures, how participants may provide feedback, confidentiality, consent to treat, expectations of participants, transition/discharge criteria, handling of potential risk to participant, after-hours services accessibility, follow-up procedures, financial obligations/funding sources available, health and safety policies, facility layout, assessment, process of treatment, and name of staff members. Each participant receives this information in written form, for their records.
2.3.4. Written and verbal information provided during orientation is delivered in such a way that is understandable to participants.

2.4. Advance Directives

Rationale: An advance directive is a legal document that is completed by an individual who, at the time of creating the document, is capable of determining the type of care they wish to receive in the event they become incapacitated to make or communicate these decisions on their own. Advance directives can pertain to psychiatric health or physical health.

2.4.1. All participants are asked if they have an advance directive upon entry to services.
2.4.2. If a participant chooses to have an advance directive on file, it is clearly documented and staff members are aware of its existence.
2.4.3. Staff members are able to provide participants with information regarding what an advance directive is, and where to go to create one.

Special considerations: All legal requirements regarding Advance Directives are followed.

<u>References for Standard 2.0:</u>

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 106-109)

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(CTS pgs. 8, 12)

3.0 Assessment

3.1. Administered by Qualified Practitioners

Rationale: The purpose of an assessment is to accurately determine the strengths, needs, preferences and goals of the individual. It is also a method for getting to know the individual. This determination is best defined by practitioners who are trained/certified/licensed in their respective fields.

3.1.1. The agency verifies that practitioners are licensed and/or trained in assessing adults and/or children according to the laws and regulations of the state and the scope of the services rendered by the agency.

3.1.2. Verification of qualifications and renewal of credentials is performed by contacting the primary credentialing source or designated source and documenting the verification.

3.1.3. Education and experience are verified by the agency.

3.1.4. Qualified practitioners are knowledgeable and trained in the use of assessment tools used for the specific population(s) served by the agency.

3.1.5. The practitioner is able to communicate with the participant. Special accommodations may be used (i.e. interpreter, assistive technology devices).

Special considerations: Refer to standard on Human Resources for additional information on practitioner qualifications.

Refer to standard on Behavioral Health Crisis Intervention and Response for additional guidance on crisis response/intervention.

3.2. Conducted in a Timely Manner

Rationale: Assessments are conducted in a timely manner from first contact to improve the likelihood of participants following through with the assessment appointment and subsequent treatment.

3.2.1. The practitioner screens an individual to determine the need for further assessment.

3.2.2. The assessment is conducted within the timeframe specified by the participant's needs, the agency's policy, the law and regulation.

Special considerations: Refer to section on Entrance to Care for more guidance on screening of participants.

3.3. Assesses for Critical Needs

Rationale: Safety of the individual is critical. Assessing for the risk of imminent harm to self or others ensures a higher level of positive outcomes for participants and others.

3.3.1. The assessment includes questions regarding risk for suicide, self-harm, harmful behavior by others and harm to others.
3.3.2. The agency has a documented process for responding to imminent danger or harm.
3.3.3. The agency follows its process for responding to imminent danger or harm.
3.3.4. The assessment includes questions regarding the participant's basic needs, such as a place to live and availability of food.
3.3.5. The agency refers to another agency if the participant's needs are more suitable to another agency.

Special considerations: Knowledge of community resources is vital, especially for participants who are in dire need.

3.4. Components of the Assessment Process

Rationale: An accurate and comprehensive assessment consists of three components: collecting data, analyzing the data and making decisions based on the data.

3.4.1. The agency collects data regarding the participant's strengths, needs, preferences and goals, including the participant's perception of his/her strengths, needs, preferences and goals.
3.4.1.1. Strengths are internal and external resources unique to a participant's life, including but not limited to his/her talents, skills, support system, health, resources and level of hope; as viewed by the participant and others.
3.4.1.2. Needs are the tangible and intangible treatment components currently absent from the participant's life, including but not limited to the lack of food, shelter, health care, medication, support system, and hope, as viewed by the participant and others.
3.4.1.3. Preferences are the participant desires as related to their treatment and outcomes. These are inclusive of limits and boundaries of treatment, types of treatment, religious or spiritual beliefs, culture, and what participant feels will enrich the treatment experience.
3.4.1.4. Goals are the participant's short term and long term aims, including but not limited to length of treatment, feeling better, education, employment and social aims.
3.4.2. The agency collects data on the participant's current and past behavioral functioning.
3.4.3. If the agency utilizes assessment tools or instruments, the tools used are valid, reliable or standardized and they assist in determining level of care.
3.4.4. Participant and guardian are involved in a discussion with the practitioner regarding behaviors and level of functioning.
3.4.5. Data collected is analyzed to determine the participant's need for care and if further data is warranted.
3.4.6. Data is analyzed to determine level of care needed, readiness to change, types of treatment and the participant's response to treatment.

Special considerations: Person-centered care is demonstrated throughout the process.

The agency supports the adult participant's decisions about how treatment is to be delivered (psychiatric advance directive) during acute episodes of mental illness. The psychiatric advance

directive is documented at a time in which the participant is able to make the decision and staff members are made aware of it.

Parents/guardians may have additional input with the assessment of a participant given the nature of the parent's/guardian's roles.

3.5. Comprehensive Assessment

Rationale: The information collected through the assessment process depends on the needs of and the services sought by the participant and family members, when indicated and available. The purpose of a comprehensive assessment is to create a treatment plan that targets all of the participant's concerns; planning an intervention for each disorder that takes into account other disorders the participant may have. The assessment evaluates for the following:

3.5.1. Medical concerns (past and current diagnoses)
3.5.2. Mental Health concerns (including any diagnostic or treatment history and current mental status)
3.5.3. Substance Use concerns (past and current)
3.5.4. Medication Use (efficacy of past and current use, and allergies/adverse reactions)
3.5.5. Physical Health and Nutrition (Includes physical pain. If last physical exam was more than a year ago, one is to be recommended.)
3.5.6. Trauma, abuse, neglect or exploitation (Experienced or witnessed at any time in participant's life). Trauma-informed care strategies are utilized in serving the participant and in all aspects of the agency's interactions and duties
3.5.7. Familial/Social Supports (friendships/peer relationship, cultural awareness, social connectedness and gender expression)
3.5.8. Risk of Harm to Self and Others
3.5.9. Educational Status (Background, academic performance, learning disabilities, attitude, problems, and goals)
3.5.10. Intellectual Functioning
3.5.11. Vocational/Employment Status
3.5.12. Military Experience (Service Members, Veterans and their Families)
3.5.13. Languages spoken
3.5.14. Level of Functioning /Self-care (Including psychological and social adjustment to disabilities/disorders, cognitive, emotional and behavioral)
3.5.15. Community Resources already being accessed by participant
3.5.16. Legal Status and History (How this status influences treatment progress)
3.5.17. Living Situation/Environment
3.5.18. Culture (Religion/spiritual preferences, holidays, traditions)
3.5.19. Strengths, Needs, Preferences and Goals as reported by Participant
3.5.20. Clinical Formulation & Diagnostic Impressions (Include any testing that was completed along with a summary of findings)
    3.5.20.1. Include participant's strengths, needs, preferences and goals
3.5.21. Recommendations (treatment options, strengths and potential outcomes)
3.5.22. What participant is to do in case of a crisis
3.5.23. Written interpretive summary of findings

3.5.23.1. It is recommended to provide a copy of the assessment to the participant; however, may not always be appropriate. Agency protocol for release of assessment is followed, and is in compliance with HIPAA and 42 CFR (when applicable) requirements.

3.5.24. Participant is involved in a discussion with the practitioner regarding findings, anticipated level of care, available treatment services and the participant's rights and responsibilities

3.5.25. Agency provides assistance with linking the participant to appropriate and necessary community services. Evidence of linkages is documented.

Special considerations: Refer to standard on Children's Mental Health for additional information on assessments for children.

The time to collect all assessment data may be limited due to the nature of the participant's needs. Practitioner documents that inquiries were made in an attempt to collect as much data as possible to ensure an adequate assessment.

Refer to population-specific standards for additional guidance on assessments for individuals of specific populations.

3.6. Re-Evaluate as Necessary

Rationale: Due to life's changes, new circumstances, response to treatment and changes in the human body the need to re-evaluate a participant's status and needs may arise.

3.6.1. Agency is responsive to the changing needs of the participant.

3.6.2. Re-Evaluation reflects participant's life changes focusing on his/her strengths, needs, preferences and goals.

3.6.3. Updated Service Plans reflect identification of additional supports and needs, completion of goals and objectives, etc.

3.7. Family Members and/or Other Significant Individuals May Participate in the Assessment Process

Rationale: A comprehensive assessment requires a great deal of information gathering regarding the participant's life. Much of this information is collected from family members and/or other significant individuals who are a part of the participant's life. In addition, family members and significant individuals can be key players in the participant's recovery.

3.7.1. Participant grants permission for family member involvement and the level of their involvement, when applicable.

3.7.2. Participant grants permission for the involvement of other significant individuals and the level of their involvement, unless a legal relationship allows for contact without consent from the participant.

3.7.3. Family members and other significant individuals are involved in psycho-education regarding the participant's diagnosis, service plan and helpful resources.

Special considerations/limitations/barriers:

Assessments for children require parental/guardian consent rather than participant's consent, unless there is a legal reason for parent/guardian to not be involved.

Residential Care facilities have specialized standards.

References for Standard 3.0:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 109-112, 149)

New York State Department of Health AIDS Institute. (2009, September). *Living with HIV/AIDS.* Retrieved October 4, 2013, from New York State Department of Health: http://www.health.ny.gov/diseases/aids/resources/docs/mental_health_services.pdf

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(CTS pgs. 10-11, 13, 19; RI pg. 5; HR pgs. 4-5; IM pgs. 4, 6)

4.0 Participant-Centered Service Plan

4.1. Development of Participant-Centered Service Plan

Rationale: A service plan gives both the practitioner and the participant a sense of direction for their work together. The participant-centered service plan is the umbrella under which all planning for treatment, services and supports occurs. It is a written record of the agreements and decisions between the participant and members of the treatment team, along with other important people in the participant's life. The service plan may also be referred to as a treatment plan, recovery plan, or plan of care.

- 4.1.1. All participants have a current service plan that reflects the individual participant's needs.
- 4.1.2. The process for developing the plan is participant-directed and participant-centered.
- 4.1.3. The plan is based on information and recommendations from a comprehensive assessment.
- 4.1.4. Responsibility for the development of the service plan is designated to an appropriate qualified practitioner.
- 4.1.5. The plan is developed within the timeframes specified by the participant's needs, the agency's policy, and/or laws and regulations.
- 4.1.6. The plan includes the following:
  - 4.1.6.1. Services deemed clinically necessary to meet the participant's needs and prioritized problems and needs.
  - 4.1.6.2. Goals that are based on the participant's unique strengths, preferences and needs.
  - 4.1.6.3. Objectives are simple, measurable, attainable, realistic and time-framed and clearly related to goals.
  - 4.1.6.4. Interventions that describe the kinds of services, frequency of services, activities, supports and resource the participant needs to achieve the short-term changes described in the objectives.
  - 4.1.6.5. Discharge criteria and plans for aftercare.

4.2. Participant and/or Family/Advocate Actively Involved in Development of Service Plan

Rationale: In the participant-centered planning process the participant is actively involved in and has a significant role in determining the direction of his or her plan. Development of the plan includes family and/or others freely chosen by the participant.

- 4.2.1. The participant's strengths, needs, preferences and goals are honored in the planning process.
- 4.2.2. The participant has reasonable control as to the location and time of planning meetings, as well as to who is involved.
- 4.2.3. The service plan involves family members, friends, and other supporters as appropriate or requested upon consent of the participant or in accordance with laws and regulations.
  - 4.2.3.1. Consent for family involvement is to be obtained from adult participants. For minors or those participants who cannot offer their own consent, permission is obtained in adherence to legal requirements.
- 4.2.4. There is documentation in the plan of who participated in the development of the plan.
- 4.2.5. The parent(s)/guardian and significant family members of minors participate in the planning process unless:
  - 4.2.5.1. The minor is sixteen years of age or older and has requested services without the knowledge or consent of parent(s)/guardian.
  - 4.2.5.2. The inclusion of the parent(s)/guardian or significant family members would constitute a substantial risk of harm to the person or substantial disruption of the planning process. Justification of exclusion is documented in the clinical record.

Special considerations: Parents/guardians may have more input in the development of the service plan given the nature of their roles.

Service planning for the elderly and adolescents who are reaching the age of adulthood should address life transition needs. For additional guidance regarding life transition needs see section on Provision of Care and sections related to specific populations.

4.3. Includes and Addresses Strengths, Needs, Preferences and Goals

Rationale: Participant-centered planning builds upon the participant's capacity to engage in activities that promote community life and honors the participant's choices. A participant-centered plan contains objectives that incorporate the unique strengths, needs, preferences, goals and desired outcomes self-determined by the participant.

- 4.3.1. The service plan reflects the assessed strengths, needs, preferences and goals of the participant.
- 4.3.2. Goals are:
  - 4.3.2.1. Written to capture the participant's words or ideas.
  - 4.3.2.2. Participant-specific and recovery-oriented.
  - 4.3.2.3. Tailored to participant's individual strengths and needs.
- 4.3.3. A participant's cultural background is recognized and valued throughout the planning process.

4.3.4. The plan identifies a range of supports and services which includes professional supports, natural supports, community supports and alternative strategies to support the participant's recovery.
4.3.5. The participant's assessed readiness for change is considered during planning.
4.3.6. Reasons for deferring a goal or related objective are documented.
4.3.7. The service plan addresses identified barriers to goals and objectives.

Special considerations: Goals and objectives in the service plan are not defined by staff based on clinically-valued outcomes (e.g. reducing symptoms, increasing adherence), but rather are defined by the participant with focus on building recovery capital and pursuing a life in the community.

4.4. Family Involvement

Rationale: An essential characteristic of the participant-centered process is the primacy it places on the involvement of the participant and his or her family in all aspects and phases of the care delivery process. This process enables people important to the participant, as well as people who will provide supports and services to come together to plan the specifics related to the supports and services that will be offered. The service plan is based on what is most important to and for the participant and the participant's family as identified by the participant and the participant's family.

4.4.1. The service plan reflects family participation in care, treatment, or services unless such participation is contraindicated.
4.4.2. The participant is offered the opportunity to identify what information will be shared and discussed during planning meetings in the presence of all participants and what information should be discussed privately.
4.4.3. The family's participation, or lack thereof, is documented in the service plan.

Special considerations: There are times when the involvement of parent(s)/guardian and/or significant family members may not be appropriate (i.e., restraining order, child protection court) or their inclusion would constitute a substantial risk of physical or emotional harm to the participant or substantial distribution of the planning process. Justification for exclusion under these circumstances should be clearly documented in the clinical record.

4.5. Clarifies Expectations of All Parties Involved

Rationale: A quality participant-centered service plan not only depicts the short- and long-term goals, but it also explicitly identifies the role and responsibilities of the participant and each team member contributing to the process. The service plan is an important tool that promotes accountability among all team members as both tasks and timelines are clearly spelled out.

4.5.1. The service plan identifies who is responsible for implementing and monitoring each component of the plan.
4.5.2. The plan is specific as to the supports to be provided, who/how those supports will be delivered and the planned frequency.

4.6. Expected Outcomes

Rationale: In person-centered planning, the outcomes of the plan are defined by the individual and driven by what the participant says he or she want to accomplish. The outcomes are desired by the individual and not a goal of the agency or program.

4.6.1. Outcomes are identified based on participant's strengths, needs, preferences and goals.
4.6.2. The way for measuring progress toward achievement of outcomes is determined by the participant.
4.6.3. The participant and those he or she has selected, explore the desired future outcomes and determine what resources and supports are needed to support those outcomes. The focus is on the strengths, abilities and building on the capacities of the program.
4.6.4. Participant is not expected or required to progress through a pre-determined continuum of care in a linear or sequential manner.

Special considerations: As a result of health or safety concerns, or court-ordered treatment, limitations may exist for individual choice. Within the context of any such limitations the participant will be offered the maximum input and control over decisions.

4.7. Need for Special Accommodations (Americans with Disabilities Act of 1990)

Rationale: Effectively addressing barriers related to concurrent disabilities and/or disorders is critical to a participant's successful recovery. Concurrent disabilities to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, physical disabilities, health conditions and social and environmental factors. Support and accommodations to assist the individual to participate in participant-centered planning are provided.

4.7.1. The service planning process addresses concurrent disorders or disabilities and, when needed, identifies supports needed to accommodate needs.
4.7.2. Service planning occurs at a time and place convenient and comfortable to the participant and others who have been invited to participate in the process. Any needed accommodations for communication are provided.
4.7.3. The participant or the participant's family may request special accommodations at any time to participate in services.
4.7.4. The agency accommodates preferences of the participant or, if it cannot, finds the best options available.

Special considerations: New technologies (e.g. telemedicine and web-based applications and self-help resources) should be considered and, where appropriate, incorporated as service options to enhance self-management treatment relationships.

Language assistance including assistance with TTY, sign language interpretation, interpretative services for non-English speaking participants and assistance for the visually impaired should be made available when needed.

4.8. Safety Plan

Rationale: In order to protect a participant's health, safety and consequently the person's freedom, it is necessary to identify his or her health and safety factors. The Safety Plan is an individualized back-up plan for what is to be done in the event of a crisis.

4.8.1. A safety plan is developed as soon as possible with the participant when the assessment identifies a potential risk for dangerous behavior.
4.8.2. The safety plan includes supports/interventions aimed at preventing a crisis and support/interventions to employ if there is a crisis.

4.8.3. Participant and participant's family are educated on the safety plan.
4.8.4. A copy of the safety plan is provided to the participant and the participant's family when applicable.

Special considerations: An individual may want to create an advance directive, a legal document that describes the services desired if an illness reduces the ability to make decisions.

4.9. Participant is Educated on their Plan

Rationale: Education/preparation regarding the recovery process, expectations, and desired outcomes is necessary to encourage maximum participant engagement. Education also affords the participant an opportunity to provide feedback, request additional services, and/or modify portions of their plan.

4.9.1. The language of the service plan is understandable to all team members, including the participant and his or her non-professional, natural supports.
4.9.2. The participant is educated on their plan in a manner that is understandable to him/her. Reasonable accommodations are accessed if necessary for educating the participant.
4.9.3. The participant is offered a written copy of the service plan.
4.9.4. There is documentation that the participant has been educated on and agreed to the service plan.
4.9.5. The participant is fully informed of the rationale, evidence and risks of specific service, support/intervention and treatment options.

4.10. Plan is Regularly Reviewed With Participant

Rationale: Regular review of the service plan is necessary to evaluate the progress toward anticipated outcomes and ensure that the participant-centered plan remains current at all times. The service plan is reviewed with the participant to determine whether progress is being made and the next steps to be taken in the participant's recovery journey.

4.10.1. The agency identifies the frequency that the plan will formally be reviewed based on the participant's needs, the agency's policy, and/or laws and regulations.
4.10.2. The agency reviews and monitors the provision of supports and services at the frequency identified in the planning process to assure implementation and to assess the effectiveness of supports in achieving the outcomes identified.
4.10.3. Participant may request a review of the service plan at any time.
4.10.4. Participant may request a written copy of the service plan at any time.
4.10.5. Review and progress toward achievement of goals/objectives are documented.

4.11. Plan is Modified When Necessary

Rationale: The participant-centered planning and the plan that results are flexible. As the participant's interests and priorities change, the planning process is revisited as often as necessary to ensure that both the major and day-to-day decisions also change in response. Participant-centered planning is an ongoing activity that reflects changes in the intensity of the participant's needs, condition or preferences for support.

4.11.1. The plan is updated when goals are achieved or new problems are identified.
4.11.2. Planning is responsive to changing priorities, opportunities and needs.

4.11.3. The participant is offered opportunities to provide ongoing feedback regarding their individual support and services. The plan is updated and refined as frequently as needed.
4.11.4. A written copy of the service plan is provided to the participant when modifications are made.

References for Standard 4.0:
Americans with Disabilities Act of 1990, Pub. L. 110-325, 42 USC §12182.

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.

IDAPA Adult Mental Health Rule 16.07.33, § 200 (2009).

IDAPA Alcohol and Substance Use Disorders Services Rule 16.07.17, § 200 (2013).

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(CTS pgs. 29, 39, 43)

5.0 Provision of Care

5.1. Services are Provided According to Participant-Centered Service Plan

Rationale: Services that are provided according to a Participant-Centered Service Plan afford direction and delineation of responsibilities for all involved (i.e. participant, staff, other agencies, etc.). It also ensures that the necessary care, treatment or services will be provided and when they will be done.

5.1.1. The agency bases its services on the strengths, needs, preferences and goals of the individual served utilizing the Participant-Centered Service Plan.
5.1.2. The agency provides services in a manner consistent with its scope of care, treatment or services.
5.1.3. The agency builds capacity to meet the participant off-site if necessary, to remove as many barriers to care as possible.
5.1.4. Services are welcoming, accessible and focused on recovery and resiliency.
5.1.5. Practitioners value and respect individual cultures and support systems.
5.1.6. The provision of care is tailored to individual strengths and needs. Practitioners are mindful of restorative practices; providing care *with* the participant, rather than *to* or *for* the participant.
5.1.7. The participant and any others he/she identifies as supportive take part in every aspect of treatment from planning to discharge.
5.1.8. The participant is educated on his/her illness, care plan, treatment and recovery, including available supports and what to do in a crisis.
5.1.9. The participant is made aware of grievance procedures and rights, and the agency ensures that reasonable accommodations are made in communicating these procedures and rights while accounting for any barriers in communication (i.e. the participant's need for braille, auditory devices, and an interpreter).

5.2. Care Coordination and Documentation of Referrals

Rationale: Coordination of care ensures that the participant's needs are being met from within the agency or in collaboration with other practitioners. It also safeguards that the treatment plan is being carried out. Documentation of referrals is necessary to discourage duplication of services.

- 5.2.1. The agency coordinates with other practitioners and between settings to ensure seamless and timely treatment.
- 5.2.2. When the agency does not directly provide a specific service that is needed by the participant, the agency refers the participant to an outside agency.
- 5.2.3. Outside agency referrals are addressed and documented in the participant file.
- 5.2.4. Referrals to outside agencies are completed in a timely manner.
- 5.2.5. Coordination to a referral agency includes a process for receiving and sharing information to ensure continuity of care and a time frame that meets the needs of the participant.

Special considerations: Confidentiality of participant is respected in accordance with agency, state and federal requirements/laws.

5.3. Agency Monitors Care Outcomes and Individual Progress

Rationale: Agencies that provide treatment services strive for continuous improvement of outcomes for their participants. This ongoing effort to improve warrants monitoring the care provided as well as individual treatment outcomes.

- 5.3.1. Agency monitors participant's treatment plan progress and achievements, which allows for participant-centered care, recovery-oriented principles, and restorative practices.
- 5.3.2. Treatment and services are provided as a comprehensive continuum of care.
- 5.3.3. Agency evaluates the outcome of services it provides to the participant.
- 5.3.4. Participants have access to information regarding their assessment, treatment, goals and progress.
- 5.3.5. Practitioner utilizes trauma-informed care strategies when working with participants.

5.4. Case Staffing

Rationale: Each case is unique as each participant has individual strengths and needs. Therefore, it is important not to generalize treatment based on diagnosis or other factors. Additionally, it is important to hear from all persons who are involved in the participant's treatment and life care. To decrease duplication of services and increase effective outcomes, cases need to be staffed by the various givers of care who are involved with a participant.

- 5.4.1. Agency develops a plan for staffing each case on a regular basis.
- 5.4.2. Staffings occur within a time frame that is in accordance with the agency's policies and procedures.
- 5.4.3. Staffings include relevant persons working with and/or supporting the participant's treatment and recovery, and may include the participant and, as appropriate, family members and other supportive persons of the participant's choosing.
- 5.4.4. Staffings note adherence to treatment and progress.

5.4.5. Staffings may take place, in part, utilizing telecommunications devices (not all members will be face-t-face).

5.4.6. Staffing documents are signed by all present at the staffing, including the participant. When telecommunication devices are used, those members not physically present are noted as being present via telecommunications and no signature is necessary.

5.5. Physical Health Status of Participant

Rationale: An individual's physical health care needs and ability to participate in his/her behavioral health care treatment increases the opportunity for improved outcomes.

5.5.1. Staff members working with participants are knowledgeable of participants' physical health care status, medications and conditions.

5.5.2. Participant s' physical health care needs and status are documented in each participant's file.

5.5.3. Staff members are aware of and plan for physical conditions that may possibly deter one's behavioral health treatment.

5.5.4. Staff members are aware that medication side effects may interfere with treatment, and treatment and recovery, and treatment may need to be adjusted accordingly.

5.5.5. Agency screens for any physical pain that the participant may be experiencing. If it is within the scope of the agency's focus, further assessment and treatment can be provided. If it is not within the scope of the agency, an outside referral is made.

5.6. Outside Supports

Rationale: A comprehensive continuum of care is essential for recovery to take root and grow. This continuum consists of a multitude of supports both within treatment and outside of treatment. Outside supports enable the participant to build relationships and maintain social skills, as well as provide accountability for one's recovery. Therefore, it is important for the provider to know what other resources the participant is utilizing as well as what resources are available.

5.6.1. Agency maintains support resources and knowledge of how to access support services from which participants, their family members and friends may choose what they need. Support resources may include: housing, employment, education/training, transportation, crisis support, providers of various types of therapies, support groups/peer support, schools, parenting, social supports, respite, financial, spiritual, and criminal justice systems, as well as others.

5.6.2. Practitioner documents outside resources that the participant is utilizing and any which are recommended by the provider.

5.6.3. Practitioner assists participant in referral to an outside resource if requested by participant.

5.6.4. Practitioner documents outside resources provided to family and friends in participant file.

5.7. Life Stage Transitions

Rationale: Throughout life, individuals pass through numerous developmental stages. When faced with a behavioral health condition, individuals also pass through stages of recovery

that influence or motivate how they behave at any given period of time. These life stage transitions may cause changes in the participant's ability to follow through with his/her service plan and/or result in the need for changes to the service plan.

5.7.1. Developmental stages of life are considered throughout the provision of care for every participant (i.e. childhood, adolescence, transition to adulthood. adulthood, middle-aged, elderly).
5.7.2. Evidence-based interventions align with the specific needs of the participant for each specific diagnosis, the participant's stage of change and the stage of treatment and recovery for each disorder.
5.7.3. Treatment services are adjusted as needed as the participant transitions through life stages.
5.7.4. Recovery expectations are consistent with the participant's current stage of life, changes made toward a healthy lifestyle and symptom-control.

References for Standard 5.0:

Aune, MSW, D. M. (2010, July 23). *Assessing Your Recovery IQ: Is Your Organization's Service Delivery System Recovery-Oriented?* Retrieved from Minnesota Association of Community Mental Health Programs: http://www.macmhp.org/pdfs/AssessingYourRecoveryIQ.pdf

Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Persons With Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.

IDAPA Alcohol and Substance Use Disorders Services Rule 16.07.20, § 380 (2013).

National Quality Forum. (2009, September 9). *National Standards for the Treatment of Substance Use Conditions.* Retrieved from The Treatment Research Institute: http://www.tresearch.org/download/policy_briefs/NQF_Standards_Summary(2).pdf

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(CTS pgs. 15-17, 39-48; EC pgs. 13-14)

Tondora & Davidson. (2006, May 19). *Recovery Standards for Beahvioral Healthcare.* Retrieved from State of Connecticut Department of Mental Health and Addiction Services: http://www.ct.gov/dmhas/lib/dmhas/publications/practiceguidelines.pdf

6.0 Facility Safety

6.1.Written Plans, Policies, and Procedures

Rationale: Developing and implementing written plans, policies, and procedures to address facility safety and risk prevention/ response ensures a safe environment for staff, participants, and guests. Written documentation evidences the following:

6.1.1. Agency develops and implements plans, policies, and procedures that address identified risks in the care environment and how to respond to risks.

6.1.2. Personnel and participants are educated on how to avoid and to effectively handle unsafe situations as per agency's written plans, policies, and procedures. Education/training is ongoing and documented on a regular basis.

6.1.3. The agency employs a policy and procedure on reporting and analyzing risks and unsafe occurrences.

6.1.4. Documentation of emergency procedures addresses what to do and if necessary, where to go, in the event of: fire, bomb threat, natural disaster, utility failure, medical emergency, behavioral health emergency, and violent or threatening situations. (IDAPA SUD Facilities 16.07.20.391)

6.1.5. Agency has written documentation of means of communication/alert in the event of emergency/critical incident. The method of communication will depend on the type of emergency that occurs, and backup plans exist for situations in which the primary means of communication is disabled.

6.1.6. Policies and procedures document clear chain of command, including how to contact supervisors at all times. (IDAPA SUD Facilities 16.07.20.391)

6.1.7. Agency has policies and procedures that describe actions to be taken in the event of disruption of services, including management of space, participant records, supplies, communications, and security. (IDAPA SUD Facilities 16.07.20.391)

6.1.8. Agency employs written policies and procedures that describe the type of medical emergency services available and the arrangements for referring or transferring participants to a medical facility. (IDAPA SUD Facilities 16.07.20.392)

6.2. Critical Incident Preparedness

Rationale: Being prepared for critical incidents before they occur ensures seamless handling of the situation if and when an occurrence takes place. Documentation of incidents allows for analysis and can serve as the first step to prevent similar incidents from occurring in the future. Critical incidences may include, but are not limited to: errors in medication, utilization of seclusion or restraint, events related to injuries, communicable diseases/infections, and acts of aggression or violence, weapons, elopement, car accidents, biohazard, use and/or possession of substances, abuse, neglect, suicide /attempted suicide, sexual assault, or any other sentinel event.

6.2.1. Agency develops and implements policies and procedures that discuss prevention, reporting, documentation, handling, and debriefing of critical incidences.

6.2.2. All staff members receive ongoing, documented training on how to handle a variety of critical incidences.

6.2.3. Documentation of critical incidences are reviewed and analyzed by management on a regular basis. The review focuses on causes, trends, actions for improvement, results from improvement plans, appropriate staff training, prevention of future occurrences, and internal/external reporting.

6.2.4. Agency conducts regular analysis of critical incident preparedness activities. Evaluation may be based on outcomes of drills or actual critical incidents. Results

of analysis are used to guide future management of critical incidences, and changes are reflected in the agency's written policies, procedures, or plans as they are made.

6.3. Care of Participants and Personnel During Emergencies

Rationale: In the event of an emergency or critical incident, precautions are taken to ensure the safety and well-being of all participants, staff members, and guests. As emergencies may require much attention from staff, care is taken to effectively handle the emergency as well as ensure safety of all individuals at the facility, and minimize the possibility of experiencing trauma.

6.3.1. Agency includes, as part of the emergency preparedness plan, a safety and security plan to address the agency's strategy for ensuring safe and secure premises in the event of emergency.

6.3.2. Staff members have a clear understanding of their responsibilities in the event of emergency. Responsibilities are documented in the emergency preparedness plan for easily accessible reference.

6.4. Health, Safety, and Security

Rationale: The health, safety, and security of staff, participants, and guests are considered at all times. Every effort is made to ensure that possible risks are identified in order to prevent and/or efficiently respond to occurrences.

6.4.1. Designated staff members are appointed to identify, prevent, and manage/respond to risks.

6.4.2. Staff members receive ongoing, documented training related to health, safety, and security procedures.

6.4.3. Agency produces and applies written procedures regarding prevention and control of infectious diseases.

6.4.4. Participants are made aware and trained on the prevention of risks to themselves or their environment.

6.4.5. Access to first aid equipment and expertise is readily available at all times.

6.4.6. Thorough inspections of facility are conducted by the agency on a regular basis to ensure health and safety precautions are being followed. The inspections are recorded in writing for analysis of needed improvements and how the agency addressed suggested areas for improvement.

6.4.7. Facility has adequate number of marked, accessible emergency exits.

6.5. Emergency Preparedness Plan

Rationale: Agency establishes and maintains an Emergency Preparedness Plan and ensures easy accessibility for reference to help manage the consequences of natural disasters or other internal or external emergencies that could disrupt the agency's ability to provide care.

6.5.1. Agency develops and implements an Emergency Preparedness Plan to follow in the event of fire, explosion, flood, earthquake, high wind, or other emergency. (IDAPA SUD Facilities 16.07.20.399)

6.5.2. All participants and staff members are advised of the actions required under emergency conditions. Diagrams of the building that include emergency protection areas, evacuation routes, and exits are conspicuously posted throughout

the building. An outline of emergency instructions is posted with the diagram. (IDAPA SUD Facilities 16.07.20.399)

6.5.3. Agency administers drills on a regular basis to serve as practice for emergency procedures/evacuations. A run-through of each type of emergency is completed; drills are conducted on each shift and at each location; and the results are documented and evaluated to determine areas for improvement.

6.5.4. Emergency Preparedness Plan discusses how agency intends to handle resources and assets during times of emergency.

6.5.5. Agency addresses in Emergency Preparedness Plan how it will manage safety and security during an emergency situation.

6.5.6. Emergency Preparedness Plan includes how agency will manage staff members, participants, and guests during times of emergency.

6.5.7. Responsibilities of personnel are clearly defined in Emergency Preparedness Plan for easily accessible reference. Staff members have a clear understanding of their responsibilities in the event of emergency.

Special considerations: Reference section on Reducing Risk of Spreading Infection for additional guidance.

6.6. Smoking and Smoking Materials

Rationale: Because smoking has been acknowledged as a potential health and fire hazard, a continuous effort is made to reduce such a hazard in the facility.

6.6.1. Agency develops and implements regulations governing the use of smoking materials. (IDAPA-SUD 16.07.20.399)

6.6.2. Designated areas are assigned for participant, staff member, and public smoking. (IDAPA-SUD 16.07.20.399)

6.6.3. Participants, staff members and public are made aware of the regulations, which are conspicuously posted at the facility. (IDAPA-SUD 16.07.20.399)

6.6.4. Tobacco products are not used by children, adolescents, staff members, volunteers, or visitors in any building used to house children or adolescents, or in vehicles used to transport children or adolescents. (IDAPA-SUD 16.07.20.399)

Special considerations/limitations/barriers: Agency abides by all state and federal requirements regarding smoking and smoking materials. Agencies are not required to permit use of smoking materials/tobacco on the premises.

6.7. Hazardous Materials

Rationale: If not handled, stored, and disposed of appropriately, hazardous materials can result in harm to persons and/or the environment. Agency takes precautions to ensure safe handling of hazardous materials by participants and staff members. Items considered hazardous materials may include, but are not limited to: cleaning supplies, biohazard substances, solvents, oil-based paints, fluorescent light bulbs, and copier toner.

6.7.1. Materials that require special handling, storage, and/or disposal are identified and documented by agency.

6.7.2. Agency employs written policies and procedures for safe handling, storage, and disposal of hazardous materials.

6.7.3. Incidents related to hazardous materials are documented and analyzed, and appropriate actions are taken by agency to discourage future similar instances.

6.7.4. Staff members receive documented training on appropriate handling, storage, and disposal of hazardous materials.

Special considerations/limitations/barriers: Agency follows local, state and federal requirements regarding safe handling, documentation, storage, and disposal of hazardous materials.

6.8. Fire

Rationale: Agency employs a fire safety plan to ensure preparation in the event of actual fire. Fire safety plan includes:

6.8.1. Agency employs a written plan that describes activities to take place in the event of a fire. The plan includes how and when to operate fire alarms, evacuation procedures, how to operate a fire extinguisher, how and when to contact off-site responders, and how to suppress fire and smoke.

6.8.2. Fire drills are conducted on a regular basis, on each shift and at each location, and the results are documented and evaluated to determine areas for improvement.

6.8.3. Agency retains records documenting that fire safety equipment is regularly tested to ensure proper functioning.

6.8.4. Performance of staff, fire safety equipment, and adequacy of building features during fire drills is documented and evaluated to ensure effectiveness of fire safety plan. Changes are made to fire safety plan as needed.

6.9. Utilities

Rationale: Interruptions in utility systems, including but not limited to: power failures and plumbing issues may result in the inability to provide care as usual. The agency takes necessary precautions to plan for utility failures.

6.9.1. Agency identifies potential issues with utility systems and employs written policies and procedures that address how to handle interruptions in utility systems. Written policies and procedures include performing essential functions, backing up computer data, obtaining urgent medical data to provide to primary care physician, how to disable utility sources, and how to communicate among staff for notification purposes.

6.9.2. Agency has policies and procedures that address what to do in the event that power/utility failure results in the inability to provide services in a safe manner.

6.9.3. Staff members receive training on how to respond to utility failures/interruptions.

6.9.4. Emergency power source is available for alarm systems, exits, and communication modalities.

6.9.5. Emergency power source is regularly tested, maintained, and inspected.

6.10. Inspection, Testing, and Maintenance

Rationale: Regular inspection, testing, and maintenance of safety equipment and utility systems are critical in order to ensure proper functioning in the event of emergency. The agency takes necessary measures to preserve the appropriate functioning of safety equipment and utility systems.

6.10.1. The agency or an appropriate outside party regularly inspects the premises for possible health, safety, and security threats-and makes necessary improvements in a timely manner.

6.10.2. Inspection and maintenance schedules and actions are determined by agency. Agency ensures completion and documentation of schedules and activities.
6.10.3. Agency ensures that space, equipment, and facilities meet federal, state, and local requirements for safety, fire prevention, health, and sanitation.
6.10.4. Emergency power source is regularly tested, maintained, and inspected.

6.11. Dining

Rationale: Facilities that provide food services ensure that any dining areas in the facility are set up in a manner that is conducive to a comfortable dining experience. Agency ensures that the eating environment is safe and practical.

6.11.1. Dining room furniture is set up in such a way that fosters conversation and eating.
6.11.2. Agency follows relevant codes and regulations related to food service.
6.11.3. Dining area is away from disruptive noises.
6.11.4. Food and beverage preparation areas are safe, practical and have adequate facilities and utensils.

Special considerations: Agency follows federal and local requirements pertaining to food/beverage service and preparation, as appropriate to their facility.

6.12. Facility Structure and Maintenance

Rationale: Facilities are structurally sound, maintained, and equipped to assure safety of personnel, participants, and guests. (IDAPA SUD Facilities 16.07.20.399)

6.12.1. Exits and exit access are clear from blockage and visibly marked at all times. (IDAPA SUD Facilities 16.07.20.399)
6.12.2. Safety is considered when planning and performing construction on the facility.
6.12.3. Ramps, open porches, sidewalks, and open stairs are to remain free from snow and ice buildup. (IDAPA SUD Facilities 16.07.20.399)
6.12.4. Heating mechanisms such as wood stoves, fireplaces, boilers, hot water heaters, and unfired pressure vessels are maintained in the safest way possible. (IDAPA SUD Facilities 16.07.20.399)
6.12.5. Facility is regularly inspected by an internal or external entity to ensure structural soundness and to identify potential risks. Agency makes necessary improvements as the need arises.

Special considerations: Agency considers federal and state requirements for safety, accessibility, and building code requirements.

6.13. Observing, Assessing, and Enhancing Care Setting

Rationale: Aspects of the care environment can have an impact on every individual who enters the facility, including the treatment outcome of participants. Agency maintains an environment that is conducive to treatment, recovery, comfort, and safety.

6.13.1. The facility provides a physical environment that meets the needs of persons with mobility or sensory impairments in a manner that is conducive to independent mobility. New construction meets the requirements of the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Existing facilities comply, to the maximum extent feasible, with 28 CFR Sections 36.304 and 36.305 regarding removal of barriers under the Americans with Disabilities Act, without creating an

undue hardship or burden on the facility, and provide as required, reasonable accommodations. (IDAPA SUD Facilities 16.07.20.390)

6.13.2. Agency ensures that the care environment is safe, clean, comfortable, and functional according to the care provided and accessibility needs of participants.

6.13.3. Facility has appropriate number of restrooms available for number of people served and employed.

6.13.4. Appropriate water sources are available to participants.

6.13.5. Private space is provided for personal consultation and counseling as well as family and group counseling sessions. All space for offices, storage, and supplies is appropriately accessible. (IDAPA SUD Facilities 16.07.20.390)

6.13.6. When construction of any kind (demolition, remodeling, or new) is performed, agency ensures safety of all persons in the construction area. Precautions are taken prior to construction to ensure that potential hazards are avoided and care is not interrupted.

6.14. Problems are Investigated and Addressed

Rationale: Problems in the care environment are reported, documented, investigated, and addressed as necessary. Agency ensures that the care environment is safe through regular monitoring of facility and addressing issues in a timely manner.

6.14.1. Agency employs policies and procedures that address ongoing monitoring, analyzing, reporting, and resolution of safety and security issues in the care environment.

6.14.2. Records of injuries, illnesses, and damage to property are kept and incidents are investigated to determine effectiveness of agency's Emergency Preparedness/safety plans.

6.14.3. Agency makes improvements to facility as needed.

6.15. Facility Emergencies

Rationale: Emergencies impact the agency's ability to provide services as usual. In order to maintain a safe environment for staff, participants, and guests, it is essential to have processes in place that determine how to handle a variety of emergency situations. Staff members, participants, and guests are included in the consideration of these processes.

6.15.1. Agency produces and employs a preparedness plan for emergencies, to serve as a guide for staff, participants, and guests in the event of emergency. The preparedness plan addresses risks that could negatively impact the treatment environment, including, but not limited to: bomb threats, fire, adverse weather conditions, and power outages.

6.15.2. Agency implements trauma-informed care strategies in drills and responses.

6.15.3. All participants and employees are advised of the actions required under emergency conditions. Diagrams of the building that display emergency protection areas, evacuation routes, and exits are conspicuously posted throughout the building. An outline of emergency instructions is posted with the diagram. (IDAPA SUD Facilities 16.07.20.399)

6.15.4. Drills/practice are conducted and documented on an ongoing basis, and should involve staff as well as participants. These tests address each

emergency/evacuation procedure identified by the agency's emergency preparedness plan.

6.15.5. Staff members and participants receive ongoing and documented training on how to effectively handle facility emergencies.

6.15.6. Agency identifies and documents means of communication/alert in the event of emergency. The method of communication will depend on the type of emergency that occurs, and backup plans exist for situations in which the primary means of communication is disabled.

6.15.7. Communication related to emergencies refers to internal and external interactions between staff members, participants, visitors, and parties involved in responding to or broadcasting the emergency.

6.15.8. Evacuation plan addresses needs of individuals who may require assistance with getting to safety.

6.15.9. Access to first aid equipment and expertise is readily available at all times.

6.15.10. Thorough inspections of facility are conducted by the agency on a regular basis to ensure health and safety precautions are being followed. The inspections are recorded in writing for analysis of needed improvements and how the agency addressed suggested areas for improvement.

6.15.11. Facility has adequate number of marked, accessible emergency exits.

<u>References for Standard 6.0:</u>

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 60-68, 71-72)

IDAPA Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs 16.07.20, §§ 390-392, 399 (2013).

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(EC pgs. 5-6, 9, 11, 15-16, 18-24; EM pgs. 4-12)

7.0 Behavioral Health Crisis Intervention and Response

7.1. Agency Protocols for Behavioral Health Crisis Intervention and Response

Rationale: Effective interventions and responses to behavioral health crisis situations can substantially enhance participants' recovery experiences, improve their overall quality of life, and even result in fewer future crisis situations. Agency has protocols in place to help guide how to effectively intervene and respond to a wide range of crisis situations.

7.1.1. Agency develops and implements strategies for guidance of staff members in carrying out crisis response and intervention strategies.

7.1.2. Agency defines 'crisis', as it applies to the services provided/population served.

7.1.3. Agency's scope as it relates to the ability to intervene or respond to crises is clearly documented.

7.1.4. Agency defines actions to be taken if it is not prepared or qualified to handle certain crisis situations.

7.1.5. Agency employs protocol for managing crises during, as well as, outside of business hours.
7.1.6. Interventions/responses foster recovery and empowerment of individual served.
7.1.7. Crisis interventions/responses are intended to stabilize participant as soon as possible so he/she may function at the same level as prior to the crisis.
7.1.8. Agency practices only within their scope of care, and provides referrals as necessary when it cannot provide required crisis services.
7.1.9. A protocol is developed and implemented for following up with participants after a crisis is experienced.

Special Considerations: For guidance on environmental disasters, reference Facility Safety section of manual.

For guidance on infection control, reference section on Reducing Risk of Spreading Infection.

7.2. Crisis Identification During Screening and Assessment

Rationale: Identifying crisis (or the potential for development of crisis) during screening and assessment can lead to effective earlier intervention to prevent harm to those involved. It can serve as an education opportunity so the person served learns how to handle future crisis situations on their own without having to access services.

7.2.1. Agency's screening and assessment tools evaluate for presence or potential of crisis situation.
7.2.2. Agency has a plan for how to handle crisis situations that are presented during screening/assessment.

7.3. Personal Safety/Crisis Intervention Plan

Rationale: A Personal Safety/Crisis Intervention Plan is a participant-centered plan that includes de-escalation techniques and specific, practical interventions that are intended to ensure safety of the person served and assist in the mitigation of crisis situations. This plan allows for identification of triggers and calming strategies prior to the occurrence of a crisis.

7.3.1. Agency evidences that participant actively participated in creation of Personal Safety/Crisis Intervention Plan.
7.3.2. Plan includes basic participant information, such as: diagnoses, medications/health conditions, insurance, and contact information for supports, to allow for easy reference in the event of crisis.
7.3.3. Plan is unique to participant's strengths, needs, preferences and goals, and is realistic for the participant to follow in the event of crisis.
7.3.4. Changes are made to plan as needed.
7.3.5. Personal Safety/Crisis Intervention Plan identifies internal and external resources that are to be accessed when addressing a crisis.
7.3.6. Plan is easily accessible in participant file and easy to quickly reference in the event of a crisis situation.
7.3.7. Family members/supports identified by the participant are included in the development and application of the Personal Safety/Crisis Intervention Plan.
7.3.8. Personal Safety/Crisis Intervention Plan includes the signatures of all parties present in the development, as well as those who are identified as having tasks.

7.4. Inclusion of Participant's Family Members and Other Supports

Rationale: Involvement of the participant's family members and other supports identified by participant are encouraged in a crisis situation, if appropriate. Family members and other supports can be major contributors to the success of the participant and offer comfort and assistance in times of crisis, as well as valuable information regarding the participant and his/her situation.

7.4.1. Participant identifies family members/supports to be included in their Personal Safety/Crisis Intervention Plan.

7.4.2. In the event of crisis, family members/other supports are involved in participant's care to the greatest and most appropriate extent possible.

7.4.3. Agency follows local and federal confidentiality requirements, to ensure that the participant's (and their family members') confidentiality while effectively addressing their immediate needs.

7.5. Crisis Screening

Rationale: The crisis screening process is intended to gather preliminary information regarding the potential crisis situation. The screening may be conducted over the phone or face-to-face.

7.5.1. Screening identifies basic information about the situation, including: the name of individual(s) involved; contact information of the person reporting the problem and the location of individual(s) involved and specifics of the incident such as what happened and actual behaviors displayed.

7.5.2. The screening establishes whether the situation requires crisis intervention/response services, other types of services, or no further action.

7.5.3. The person conducting the screening is not required to have specific qualifications or credentials; however, the screener receives training on how to gather pertinent information.

7.6.Crisis Assessment

Rationale: The purpose of the crisis assessment is to obtain specific information about the crisis situation and the person experiencing the crisis, ultimately resulting in recommendations for the course of action that would be most appropriate to address the needs of the individual.

7.6.1. Upon identification of imminent or active crisis situation, participant is assessed to ascertain the nature of the crisis and determine whether there is need for emergency services.

7.6.2. As time allows, assessment includes evaluation of: presenting concerns; current living situation; justice involvement; psychiatric health; diagnoses and history; potential for causing harm to self or others; suicidality/homicidality; trauma history; current and past substance use.

7.6.3. Participant's strengths, needs, preferences and goals are explored in assessment.

7.6.4. Staff member conducting assessment has appropriate qualifications and credentials in accordance with state, local and/or federal requirements.

7.6.5. Recommendations for care are based on findings from assessment.

7.7. Crisis Intervention

Rationale: Individuals experiencing a crisis may have urgent needs that require appropriate and immediate response. The agency has a process for triaging possible crisis situations and providing resources needed to stabilize the crisis. Crisis interventions aid the individual in having as active a role as possible in mitigating the situation so they learn skills to control future situations, ultimately preventing crises in the future.

7.7.1. Agency follows an established protocol to facilitate crisis stabilization.
7.7.2. Agency takes into consideration participant's resources when responding to a crisis situation.
7.7.3. Agency follows an established protocol for making a warm transfer available to individuals in crisis.
7.7.4. Agency develops and follows a protocol for notification of social services/law enforcement when necessary.
7.7.5. The goals of crisis intervention are to help prevent hospitalization, incarceration, and harm to self or others by assisting participant with stabilization.
7.7.6. The intervention process is based on shared responsibility, where it is done *with* the participant, instead of *to* the participant.
7.7.7. The crisis intervention plan is participant-centered, trauma-informed, and culturally informed, and includes safety concerns and participant resources.

7.8. Accessibility and Referrals to Crisis Response Services

Rationale: It is crucial that crisis response services are easily accessible for those experiencing a crisis. Additionally, providing appropriate referrals and assistance with access to services is essential to ensure that the individual served receives necessary care.

7.8.1. Crisis interventions are carried out in a suitable amount of time and easily accessible for those in crisis.
7.8.2. Agency establishes and follows a protocol for assisting individuals with accessibility to other services if it is necessary to refer ("warm transfer").
7.8.3. Agency is knowledgeable of services available in the community, and how to refer participants
7.8.4. Agency establishes protocol for how to execute referrals and assist individuals with obtaining services that are appropriate for their needs.

7.9. Qualifications of Those Providing Services

Rationale: Depending on the crisis situation and the needs of the individual, appropriately trained, competent and credentialed staff provides crisis services.

7.9.1. Staff are trained and qualified to provide crisis intervention/response services as appropriate to agency's scope of practice.
7.9.2. Staff members receive ongoing, documented training regarding crisis intervention and response.
7.9.3. Staff members are trained on safe crisis intervention and response techniques.
7.9.4. Agency ensures that staff members maintain appropriate qualifications and credentials in accordance with local and federal requirements.
7.9.5. Staff provide services only within their scope of practice and provide referrals if the individual's needs are beyond their scope.

7.10. Managing/Preventing Recurring Crises

Rationale: Behavioral health crises often recur as a cyclical process. In order to decrease the likelihood of repeated crisis situations, interventions and responses should be meaningful and educational to participants so they learn coping strategies to use in the future.

7.10.1. Interventions and responses to crises are intended to assist participant with preventing future crisis situations.

7.10.2. Agency works with participant to identify and effectively cope with situations before a crisis occurs.

7.10.3. Participant is educated on services available, as well as how and when to access them, to avoid future crises.

7.11. Performance and Outcomes Measurement and Improvement

Rationale: In order to ensure the effectiveness of services provided, it is necessary to complete ongoing performance and outcomes evaluations. The findings from these evaluations provide valuable information that can improve future outcomes and quality of service delivery.

7.11.1. Agency develops and employs protocol for measuring performance and outcomes related to crisis intervention and mitigation.

7.11.2. Agency establishes and follows protocol for documentation and review of crisis intervention/response situations.

7.11.3. Performance and outcome measurement results are used to improve future service delivery, staff training/education and policies and procedures.

References for Standard 7.0:

US Department of Health and Human Services. (2009, Sepember 1). *Practice Guidelines: Core Elements in Responding to Mental Health Crises.* Retrieved from Substance Abuse and Mental Health Services Administration: http://store.samhsa.gov/shin/content//SMA09-4427/SMA09-4427.pdf

8.0 Human Resources

8.1. Staff Competence and Performance

Rationale: Ongoing evaluation of staff competence and performance is key to ensuring that qualified, trained and capable staff are providing consistently safe, appropriate and quality treatment services to participants.

8.1.1. Agency has written documentation of job descriptions based on responsibilities and competencies related to the position.

8.1.2. Documentation of staff competence and performance includes details as to the frequency of performance evaluations and the methods used to ensure the confidentiality of evaluations.

8.1.3. Tools and methods to measure staff competence and performance include the opportunity for staff to provide feedback to the direct supervisor on the performance assessment results relating to the previous reporting period, and on the performance objectives for the upcoming reporting period.

8.1.4. Agency provides opportunities for training at orientation and at regular intervals in the required position competencies and expectations for confidentiality, customer service, ethical practice, cultural awareness, reporting abuse or neglect, facility safety, participant rights and provision of person-centered services that focus on

recovery and wellness. Documentation of completed training and training needs is kept in the employee's file.

8.1.5. Agency has requirements for professional, ethical and courteous employee conduct toward participants, other employees, stakeholders, and guests.

8.2. Verification of Staff Competence and Qualifications

Rationale: Verification of staff competence and qualifications ensures that the offered credentials for positions requiring specific education, experience, licensure, certification or registration are valid and current. Valid qualifications and assurance of staff competence facilitate the provision of high quality services and success of both the agency and participants.

8.2.1. Agency verifies and documents staff licensure, certifications or registration are current for positions that require these credentials at the time of hire and throughout employment.

8.2.3. It is acceptable to verify licensure, certification or registration through secure electronic communications as long as these methods and results are documented.

8.2.4. Agency verifies and documents staff education and experience related to position requirements at the time of hire.

8.2.5. Agency verifies and documents results of any criminal background checks that may be required for the position according to agency policies and timelines. Staff that provide services prior to receipt of the results of the criminal background check are supervised.

8.2.6. Agency has existing procedures to implement in cases where education, experience or required credentials cannot be verified.

8.3. Ensuring Appropriate Staff-to-Participant Ratios

Rationale: Ensuring appropriate staff-to-participant ratios is key to providing safe and high quality services to program participants. Provision of quality services facilitates successful outcomes for participants as well as for the agency.

8.3.1. Agency ensures that there are adequate numbers of staff to meet the needs of program participants and to facilitate positive participant outcomes.

8.3.2. Agency ensures that there are adequate numbers of staff to allow the program to address the safety needs of program staff and participants.

8.3.3. Agency ensures that there are adequate numbers of staff to meet organizational performance expectations and needs.

8.4. Staff Supervision

Rationale: Staff supervision provides an opportunity for the agency to assess and provide ongoing training and support for staff skill development. Well-supported and trained staff provide better quality treatment services to program participants.

8.4.1. Agency ensures that program staff have access to regularly scheduled supervision with program supervisors.

8.4.2. Agency supervisors provide regularly scheduled supervision and performance evaluation assessments that include identification of training needs.

8.4.3. Agency supervisors review staff documentation for adequacy and clarity.

8.4.4 Supervisors ensure that documentation training is available for those who need additional training or support in this area.

Special considerations: Refer to General Agency Guidelines for further direction on Supervision of Direct-Care Staff.

8.5. Personnel Records

Rationale: Personnel files track information related to staff performance, progress and training needs.

8.5.1. Agency maintains personnel policies that are accessible and reviewed by agency staff on a regular basis.

8.5.2. Agency supervisors keep staff personnel records in a secure location.

8.5.3. Personnel files include documentation of regularly scheduled supervision and annual performance evaluation assessments, completed training and training needs.

References for Standard 8.0:

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual*. Tucson: CARF International.

(pgs. 74-75)

9.0 Discharge/Transfer

9.1. Agency Protocols

Rationale: Discharge planning is a structured and standardized process for ensuring the safe and successful transition of participants between programs, levels of care or community-based services. Agency protocols that describe the process to be followed for discharging/transferring participants ensures that all involved understand expectations for transitioning a participant to another program, level of care or community-based services.

9.1.1. There are established descriptions of the discharge/transfer requirements for all participants.

9.1.2. The agency has a process for referral and/or transfers of participants deemed inappropriate for services offered by the agency that includes communicating the rationale for the referral/transfer to the participant and providing them with a list of alternative service providers.

9.1.3. The agency has protocols for referrals, transfers, discharges and follow-up of participants.

9.1.4. The agency has a protocol for follow up to ensure access to and effectiveness of resources implemented after discharge or transfer.

9.1.5. The agency has a protocol for documenting discharge/transfer planning in the participant record.

9.1.6. The agency establishes time frames for initiating discharge/transfer planning and completing discharge summary.

9.1.7. Staff responsible for discharge planning is trained on participant-centered discharge planning process.

9.1.8. The agency has a process for monitoring staff compliance with procedures for referral, transfer, discharge and follow-up of participants.

9.2. Begins as Early as Possible

Rationale: The discharge/transfer planning process begins at the time the participant is admitted to services. Based upon the information obtained during the initial assessment, immediate efforts need to begin to secure the services and care needed following discharge or transfer to another level of care.

9.2.1. The agency begins discharge/transfer planning immediately upon a participant's admission to services.

9.2.2. Discharge/transfer planning is included in the development of the person-centered service plan.

9.2.3. The discharge/transfer plan allows for transfer to less restrictive levels of care in addition to termination of services based on accomplishment of goals in the service plan.

9.2.4. Discharge plans are discussed at the onset of service provisions with the participant, his/her family and other concerned individuals as appropriate.

9.3. Updated as Needed

Rationale: Discharge/transfer criteria describe the degree of resolution to problems and priorities identified during the assessment process and are thus used to determine when a participant can be treated at a different level of care or discharged from treatment. To address changes that occur in the participant's condition and needs, the discharge/transfer plan is reassessed and updated on a regular basis.

9.3.1. The discharge/transfer plan reflects the participant's current progress in his or her recovery and the gains achieved during program participation.

9.3.2. The participant is provided with opportunities to provide ongoing feedback regarding his/her individual support and service needs at discharge.

9.3.3. The discharge/transfer plan is reviewed regularly and all involved are kept informed.

9.3.4. Reviews and changes to the discharge/transfer plan are documented.

9.4. Participant Involved in Development of Discharge/Transfer Plan

Rationale: The discharge/transfer plan determines the participant's continuing care needs for after he or she leaves current services and is meant to help prevent a recurrence of symptoms or reduction in functioning. Developing a plan based on the participant's strengths, needs, preferences and goals that is concise, complete and comprehensive ensures a smooth transition into the next level of care and/or supportive services. It is prepared with the active involvement of the participant.

9.4.1. The discharge/transfer plan is jointly developed by a qualified practitioner and the participant.

9.4.2. The discharge/transfer plan involves family members, friends, and other supporters as appropriate or requested upon consent of the participant or in accordance with laws and regulations.

9.4.3. The process for developing the discharge/transfer plan is participant-directed and participant-centered.

9.4.4. The discharge plan includes appointment details, prescribed medications, if applicable, resources and crisis and/or after hours phone numbers.

9.4.5. The participant receives a written discharge plan at the time of discharge.

9.4.6. The date of the discharge/transfer planning sessions and who participated in discharge/transfer planning are documented in the participant record.

Special considerations: Parents/guardians may have more input with discharge/transfer planning given the nature of their roles. Discharge/transfer services for the elderly and adolescents who are reaching the age of adulthood should address life transition needs. For additional guidance regarding life transition needs see section on Provision of Care.

9.5. Consideration of Participant Needs and Services Available

Rationale: It is important to consider and communicate specific participant needs to reduce the risks of repeat admissions and unsafe failed discharges.

9.5.1. The agency bases the discharge or transfer on the participant's assessed needs, strengths and preferences and agency's capabilities.

9.5.2. Availability of services is established prior to discharge/transfer.

9.5.3. The agency maintains a complete and accurate file of appropriate services and facilities to which participants can be transferred or referred.

9.5.4. The reason for discharge, alternatives available and/or anticipated need for continued care, treatment, or services are fully explained to the participant.

9.5.5. The discharge planning process addresses anticipated post-discharge problems and suggested means for intervention, including special needs related to the participant's functional ability to participate in aftercare planning, as well as accessibility and availability of community resources and support systems.

9.6. Discharge/Transfer Care Coordination

Rationale: Coordination of care for discharge/transfer is critical to assuring that the participant receives needed follow up care and services. It allows for continuity of care and helps all parties have a clear understanding and expectation of the plan of action at discharge.

9.6.1. The discharge/transfer plan is designed to achieve discharge/transfer at the earliest appropriate time and include plans for coordination of community services to ensure continuity of care.

9.6.2. The agency obtains the participant's consent to exchange information necessary for care coordination.

9.6.3. The agency proactively attempts to connect the participant with receiving service providers.

9.6.4. The agency coordinates with other practitioners and service providers and between settings to ensure seamless and timely treatment.

9.6.5. Referrals to outside agencies are completed in a timely manner.

9.6.6. When the participant is discharged/transferred to another practitioner or program, there is documentation that communication/collaboration occurred with the receiving practitioner/program.

Special considerations: Knowledge of community resources and needs of special populations (i.e. adolescent, criminal justice, etc.) is vital. Some participants may refuse to give consent to allow for the release of information. This decision is documented after reviewing with participant the potential risks and benefits of this decision.

9.7. Unscheduled Discharge

Rationale: There are many types of discharges that can take place, all of which require careful planning and coordination for continuity of care and ongoing support of the participant. However, for a variety of reasons, an unplanned termination from service may occur. An unscheduled discharge requires additional efforts by program staff.

9.7.1. The agency defines and establishes criteria for an unscheduled discharge.
9.7.2. Discharge/transfer planning ensures that, in the event of an unscheduled discharge, the participant will be able to return and services will be available.
9.7.3. Alternative services are offered to participants who choose to leave against professional advice.
9.7.4. The agency has a process for reporting unscheduled discharges as appropriate in accordance with agency policy and/or laws and regulations.
9.7.5. The agency has a process for conducting follow-up as soon as possible to clarify the reasons for the unplanned discharge and offer or refer to services as needed.

Special considerations: Notifications may be required based on participant safety and mandated reporting requirements such as child protection services, commitment or court-ordered services.

9.8. Administrative Discharge

Rationale: An administrative discharge is usually involuntary and used as a sanction of last resort. An administrative discharge might be initiated based on a participant's non-compliance with treatment that may include non-participation in groups/therapy, conflicts with staff/other participants, or threat of safety to staff/other participants.

9.8.1. The agency establishes written criteria for an administrative discharge.
9.8.2. The agency makes decisions about administrative discharges on a case-by-case basis.
9.8.3. The agency establishes an appeal process for all administrative discharges.
9.8.4. The participant is informed of the reason for administrative discharge
9.8.5. Whenever possible, a discharge plan will be presented to the participant.
9.8.6. The reason for an administrative discharge and intervention efforts of the agency are documented.

9.9. Discharge/Transfer Summary

Rationale: A discharge/transfer summary is a clinical report written by program staff involved in the services provided to the participant and is completed when the participant leaves services. It is a document that is intended for the record of the participant and released, with appropriate authorization, to describe the course of services provided, the participant's response and recommendations on discharge.

9.9.1. The discharge/transfer summary is entered into the participant record in accordance with the agency's policies and procedures
9.9.2. The discharge/transfer summary includes:
9.9.2.1. The reasons for the participant's admission to and discharge/transfer from services.
9.9.2.2. A summary of services provided and progress made by the participant in achieving goals and objectives
9.9.2.3. A summary of the physical, psychosocial and behavioral functioning of the participant at discharge.

9.9.2.4. The recommendations and arrangements for appropriate services for follow-up or aftercare
9.9.2.5. The date of discharge
9.9.2.6. Signature of the staff who prepared the summary

References for Standard 9.0:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 116-120)

IDAPA Adult Mental Health 16.07.33 §200 (2013).

IDAPA Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs 16.07.20 §§011, 360, 375, 640 (2010, 2013).

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(CTS pgs. 111-115)

10.0 Medication Management

10.1 Written Policy and Protocol/Procedure

Rationale: Medications are an important part of treatment for many participants of behavioral health services as they can enhance participants' quality of life by reducing targeted symptoms as well as the impact of side-effects. They can also become problematic for behavioral health agencies if proper procedures are not followed.

10.1.1. Agency/practitioner documents whether medications are used in their services/practice.

10.1.2. Agencies/practitioners that provide medication management services on-site have documented policies and procedures for any of the following processes for which they practice:

10.1.2.1. Ordering medications – If the agency purchases medications for its use in treatment services, a procedure for ordering these medications is in writing and is documented according to the agency's policy.

10.1.2.2. Storing medications – If the agency stores medications for the purpose of using them in its treatment services, a procedure for which medications are stored, where they are stored, who stores and monitors them, and who has access to them is followed. Adhering to manufacturers' guidelines is included in the written procedures, as are allowable substitutions.

10.1.2.3. Recalled/Discontinued/Expired/Unused/Returned medications are stored separately and away from usable medications until they can be removed from the premises safely. Removable of said medications is documented.

10.1.2.4. Availability of medications and refills is documented and the procedure is posted in a manner for which all participants have access.

10.1.2.5. Prescribing medications – If the agency prescribes medications, it is done by a qualified professional licensed to prescribe who evaluates a participant and determines what medication(s) is to be used. The procedure includes a

verbal or written order that identifies the name of the medication, the participant's name, formulation and dose of the medication, the method by which medication is to be taken, how often and for how long it is to be taken.

10.1.2.6. Dispensing medications – If the agency dispenses or performs pharmacy practices, safe procedures include receipt of preparing, handling and returning medications.

10.1.2.7. Administration of medications – If the agency administers medications to its participants, each episode (time, date, who administered it, etc.) and type of administration (oral ingestion, injection, inhalation, suppository, etc.) is documented.

10.1.2.7.1. Agency administration – A record of the participant's medication use is signed by the staff member who signed out the medication, by the staff member who gave the medication to the participant and by the participant vouching that he/she took the medication.

10.1.2.7.2. Self-administration – In a residential setting, if a participant takes medication on his/her own, this is documented in the participant's chart.

10.1.2.8. Monitoring of the process – Reviews and inspections are held periodically and these reports are communicated to the staff. Shortages and outages are communicated to staff.

10.1.3. These documented procedures detail who handles the medications, where they are handled, when they are handled, for whom they are prescribed, why they are being prescribed and the dose and instructions for taking the medication.

10.1.4. Each medication has its own medication record/log from the time of ordering to the time of usage or time of removal from the premises.

10.1.5. Each medication is labeled as to its contents, number of pills, and expiration date.

Special considerations: All policies/procedures align with federal, state and local laws. The term medication(s) includes sample medication(s).

Children do not self-administer medication. Any medication given to a child is administered and documented by a staff member.

10.2. Staff Training and Participant Education

Rationale: In order to prevent any problems that may be caused by misuse or mishandling of medications, agency staff and the participants receiving medications receive training on all aspects of medication use.

10.2.1. Staff members who handle the medications and/or directly serve participants are trained in proper procedures and the training is documented.

10.2.2. Participants and, when appropriate, their family members or persons important to the participant, are instructed in proper procedures and the instruction is documented.

10.2.3. Components of training staff and educating participants include, but are not limited to: How medication works, why the medication has been prescribed (targeted effects), instructions for taking medication, risks and side effects of taking medication, contraindications, importance of following instructions and identifying any obstacles to taking medication, wellness and recovery

management, any financial resources that can help with cost of medication and any follow-up needs.

10.3. Medication Risks

Rationale: In order to reduce misuse and abuse of medications, and medication errors, safety is a high priority in the management of medication use. Procedures for avoiding risks of mismanagement of medications are needed to ensure safety of participants and staff.

10.3.1. Where appropriate, high alert medications are listed and monitored. These medications include: those that are at high risk for abuse, controlled substances, investigational, not approved by FDA, psychotropic, and look-alike medications.

10.3.2. Medications are labeled as to content, expiration dates and applicable warnings.

10.3.3. In case of an emergency, written procedures for staff and for participants to follow are formalized and given to staff and participants.

10.3.4. Medication errors are reduced through the development and implementation of policies and procedures.

10.3.5. Agency has established protocol for documentation and reporting of medication errors.

10.4. Medical Records

Rationale: Accurate and updated files regarding a participant's medication management ensures proper treatment and safety.

10.4.1. Medical records are maintained and include each participant's medication usage, both current and past, including efficacy and reactions to medications.

10.4.2. Information regarding participants' alcohol, tobacco and other drug usage is documented in the participant's file.

10.4.3. Information about the participant is readily accessible to staff who administer medications. This information includes the participant's: age, diagnoses, allergies and reactions to medications, current medications with dosage information and instructions, prescribing professional's name and any other information deemed important by the agency.

10.4.4. Confidentiality of participant information is maintained at all times. Any disclosure is on a need-to-know basis and in compliance with HIPAA, 42 CFR, etc.

10.4.5. Coordination with other practitioners outside of the agency are documented and in compliance with HIPAA, 42 CFR, etc.

10.5. Medications Brought On-Site/Over the Counter Medications

Rationale: Many types of therapeutic substances can interfere with or cause adverse reactions when taken in conjunction with others. Prescription or over-the-counter medications that are brought on-site by staff or participants can be lost or stolen.

10.5.1. Medications brought on site by staff or participants are revealed to the prescriber and are documented. Approval and use of these medications are documented.

10.5.2. Over the counter substances that are used by participants are revealed to the prescriber and are documented.

10.5.3. Agency has established protocol regarding over-the-counter and prescription medications that are brought on –site by participants and staff.

10.6. Emergency Medications

Rationale: At times an emergency will occur in the behavioral health care setting. When this happens, having medications readily available can reduce the risk of participants having to go without their necessary medications.

10.6.1. Emergency medications follow the same safety procedures as other medications.
10.6.2. A plan is established to determine which medications will be necessary to have access to during any emergency.
10.6.3. These medications are readily available in their easiest form to administer.
10.6.4. When used, these medications are replaced as soon as possible.
10.6.5. Agency establishes a protocol for regular inventory check of emergency medications and to check expiration dates.

Special considerations: Also see section on Behavioral Health Crisis Intervention and Response.

10.7. Investigational Medication

Rationale: Agencies that decide to utilize investigational medications (used in research protocols or clinical trials), do so with the understanding that a new and different set of risks are involved.

10.7.1. If an agency chooses to utilize investigational medications, these medications are labeled as investigational.
10.7.2. Participants are screened for the appropriateness of the medication and voluntarily become a part of the study.
10.7.3. Participants are educated on the purpose and possible side effects of the medication.
10.7.4. There is a process for review, approval, supervision and monitoring of the medication.
10.7.5. Efficacy of the medication is documented and reported to staff members, participants and to the research institution that is studying the drug.

10.8. Monitoring Participants

Rationale: Participants can display a variety of reactions to medication for a number of reasons. To ensure best practices for an improved quality of life and a reduction in unfavorable events or errors, medication monitoring of each participant is performed and documented.

10.8.1. Medications prescribed to participants are the result of a thorough evaluation and review of the participant's medical history.
10.8.2. Participants are monitored on an on-going basis for reactions, side-effects, medication interactions, reduction in targeted behaviors and any other outcome that may be the result of medication use or a change in medication.
10.8.3. Further evaluations or testing may be recommended to rule out other medical problems.

10.9. Unfavorable Events/Errors Related to Medication

Rationale: Although errors can and do happen, it is prudent for the agency to establish procedures in an attempt to reduce errors.

10.9.1. The required elements of a medication order are established making them clear and concise.
10.9.2. The type of orders to be used (i.e. PRN, standing, automatic, taper, range, etc.) are documented.
10.9.3. Procedures for when an order is incomplete, illegible or unclear are documented.
10.9.4. There is an established procedure for clear communication between the prescriber and staff members.

References for Standard 10:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 120-122)

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(MM pgs. 5, 10-13, 25-27)

11.0 Behavioral Health Emergencies

11.1. Agency Protocols for Behavioral Health Emergencies

Rationale: Provision of behavioral health services can lead to safety and security risks resulting from behavioral emergencies. These emergencies have the potential to disrupt the ability to provide treatment, threaten safety of staff and participants, as well as pose danger to the individual experiencing the emergency or to others. Implementing protocols for preparedness for and response to behavioral health emergencies can ensure the safety of staff and participants in the event of emergency.

11.1.1 Agency develops and implements protocol that describes an emergency management plan for mitigation and preparedness before an emergency and response and recovery after an emergency.
11.1.3. Agency maintains guidelines that describe expectations for nonviolent and least restrictive risk management and reduction response to behaviors that may become dangerous to the participant or to others.
11.1.4. Agency has established protocol regarding expectations for implementation of seclusion and restraint procedures.
11.1.5. Agency ensures that all service staff are trained on protocols regarding behavioral health emergencies and implementation of seclusion and restraint procedures.

11.2. Direct Service Staff Receive Training

Rationale: Trained staff are able to make critical decisions that facilitate resolution of behavioral emergency situations in a safe and effective manner. Adequate training can avoid or minimize the risk of physical or psychological harm to participants or staff.

11.2.1. Agency ensures that program staff are trained and familiar with the agency's emergency management plan in the event of an emergency. Training on emergency management plan responses is regularly offered to staff and clearly documented.

11.2.2. Agency ensures that program staff are trained and familiar with positive interventions and nonviolent de-escalation techniques.

11.2.3. An agency utilizing restraint and seclusion ensures that program staff working in behavioral health facilities are regularly trained and familiar with safe seclusion and restraint techniques and methods.

11.4. Nonviolent Procedures

Rationale: Participants may engage in crisis behaviors that could become dangerous to themselves or others. Trained staff who implement nonviolent responses to crisis situations are more likely to be successful in resolving those situations with less risk, less trauma and increased safety for participants and staff.

11.4.1. Agency ensures that staff are trained and competent in the use of nonviolent de-escalation techniques that are designed to minimize the risk of physical or psychological harm.

11.4.2. Agency ensures that staff are competent in the use of positive behavioral interventions that may include the use of individualized behavioral contingencies or programs.

11.4.3. Agency requires documentation of incidents that result in the use of nonviolent procedures. Documentation includes descriptions of behaviors that precipitated the use of nonviolent procedures; and methods that were employed to de-escalate the situation and consequences of the use of nonviolent procedures.

11.5. Restraints and Seclusion

Rationale: Restraints and seclusion are high risk responses that may cause trauma and should only be used in unavoidable cases where there is extreme and imminent danger to the participant or others.

11.5.1. Agency ensures that staff have training in risk assessment, risk reduction, positive behavioral interventions and de-escalation techniques and requires that those assessments and techniques be used prior to implementation of restraints or seclusion.

11.5.2. Staff members receive training in safe and effective restraint and seclusion methods. Training is documented for each staff member.

11.5.3. Agency requires documentation of episodes where restraint or seclusion were used. Documentation includes descriptions of behaviors that precipitated the use of restraint or seclusion, other methods that were employed to de-escalate the situation prior to the use of restraint or seclusion, descriptions of the type and length of time of restraint or seclusion; and consequences of the use of restraint or seclusion.

11.5.4. Agency conducts a root cause analysis after any use of seclusion or restraint in an effort to identify the precursors to the event and to determine whether less restrictive approaches could have been employed to effectively contain the situation.

<u>References for Standard 11:</u>

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.

(EM pg. 5)

State Hospital South. (2013, October 8). *Behavioral Health.* Retrieved from Idaho Department of Health and Welfare: http://hwteamsites/behavioralhealth/SHS/SR/default.aspx

12.0 Reducing Risk of Spreading Infection

12.1. Identification of Risks

Rationale: In order to reduce the risk of infection and contagious diseases impacting the agency's participants, staff and services, the organization evaluates the risks within the facility where services are delivered as well as the potential for infectious diseases to spread within the agency.

- 12.1.1. Agency has a protocol for continuously assessing risks for the spread of infections and contagious diseases.
- 12.1.2. When the agency consults with health care professional(s) regarding contagious diseases, there is evidence of:
  - 12.1.2.1. Identification of contagious diseases that are most prevalent in geographical service area.
  - 12.1.2.2. Evaluation of risk of spreading contagious diseases with the agency.
  - 12.1.2.3. Identification of necessary medical diagnostic tests for all staff and, if necessary, participants and guests.
  - 12.1.2.4. Recommendation of vaccinations or other preventive measures for staff, based on risks.

12.2. Infection Prevention and Control Plan

Rationale: Infections can have a substantial impact on individuals, resulting in serious illness and sometimes, death. They can impact participant, staff and agency outcomes across all levels of care. Establishment of an infection prevention plan reduces these risks, including employee absenteeism and participant missed appointments.

- 12.2.1. Agency develops a protocol for the prevention of communicable diseases and identification of potential risks.
- 12.2.2. Participant risk identified during assessments results in a medical referral.
- 12.2.3. The plan identifies actions to be taken by the agency to eliminate/reduce risks.
- 12.2.4. A staff person or committee is assigned the responsibility for implementing, maintaining, monitoring and updating the plan.
- 12.2.5. Staff complete medical tests and receive recommended vaccinations in accordance with agency protocol.
- 12.2.6. Agency provides training on infection control procedures for staff and participants, as well as notification when any changes have been made to the plan.
- 12.2.7. Based upon the risk assessment and local, state and federal requirements, a first aid kit is supplied, maintained and located in an area where all staff, participants and visitors have access. (ASC QC, 2013)
- 12.2.8. Standard infection risk prevention/reduction procedures address:
  - 12.2.8.1. Hand hygiene (WDHS, 2013)
  - 12.2.8.2. Respiratory hygiene (sneeze/cough etiquette)

12.2.8.3. Waste disposal (WDHS, 2013)
12.2.8.4. Common vehicle transmission (CCAR-CCRA, 2007)
12.2.8.5. Maintaining a clean environment with housekeeping and ventilation systems (CCAR-CCRA, 2007 and CDC, 2008)
12.2.8.6. Screening for communicable diseases upon intake assessment (CCAR-CCRA, 2007)
12.2.8.7. Use of gloves/protective equipment
12.2.8.8. Immunizations for staff and participants
12.2.8.9. Location and contents of first aid kit(s)

12.3. Responding to Epidemics

Rationale: Neither the date nor the severity of a local or state epidemic can be forecast in sufficient time for an agency to establish a response plan. It is essential for agencies to have a plan ready to implement to minimize the impact on participants, staff and the community.

12.3.1. Agency establishes a plan for epidemic response.
12.3.2. The plan includes a process for reporting infectious diseases to community health districts or the state epidemiologist per state and federal requirements.
12.3.3. Epidemic response actions are in compliance with state and federal standards and include:
12.3.3.1. System for ensuring participants' needs are met in the event of agency closure;
12.3.3.2. Process for decision to close agency during epidemic;
12.3.3.3. Process for notifying staff and participants of agency closure. Participants identified as being at greatest susceptibility are given priority notice; and
12.3.3.4. The identified staff position(s) responsible to implement the plan and initiate epidemic response actions.
12.3.4. The identified lead staff person initiates epidemic response actions.

Special considerations: Reports of communicable diseases and conditions are made in accordance with state rules (IDAPA 16.02.10). A list of the diseases which must be reported is available at http://healthandwelfare.idaho.gov/Portals/0/Health/Epi/IDAHO%20REPORTABLE%20DISEASE%20POSTER.pdf

12.4. Vaccinations/Medical Tests

Rationale: Because behavioral health agencies serve a broad range of individuals, the potential for spreading infectious diseases is an ongoing risk. Agencies and individuals can limit these risks by taking preventive measures.

12.4.1. Based on CDC recommendations, agency determines the vaccinations that staff and participants are required to have. (ACIP and HICPAC, 1997)
12.4.2. Based on CDC recommendations, agency determines the medical tests staff and participants are required to undergo. (ACIP and HICPAC, 1997)
12.4.3. The agency identifies conditions under which staff and participants may decline to receive vaccinations and/or medical testing. (APHA, 2010)

Special considerations: Staff includes all workers who during the course of their work have direct or indirect contact with participants or with other staff who have contact with participants.

12.5. Evaluation of Infection Prevention and Control Procedures

Rationale: In order to ensure that infection prevention and control protocols are effective and address current issues, they should be reviewed on a regular basis and kept up-to-date.

12.5.1. A review is conducted after each incident involving an epidemic. The review results in recommendations to prevent future instances.

12.5.2. Agency develops an action plan and makes necessary changes if deemed necessary during the review.

12.5.3. Infection control and response plans are reviewed on a regular schedule to evaluate effectiveness and need for updates. (WHO, 2005)

References for Standard 12.0:

American Public Health Association. (2010, November 9). *Annual Influenza Vaccination Requirements for Health Workers.* Retrieved from apha.org: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1410

ASC Quality Collaboration (ASC QC). (2013, October 8). *Environmental Infection Prevention Toolkit.* Retrieved from ascquality.org: http://www.ascquality.org/EnvironmentalInfectionPreventionToolkit.cfm

Canadian Committee on Antibiotic Resistance. (June, 2007). *Infection Prevention and Control Best Practices for Long Term Care, Home and Community Care including Health Care Offices and Ambulatory Clinics.* Retrieved from Public Health Agency of Canada: http://www.phac-aspc.gc.ca/amr-ram/ipcbp-pepci/

Centers for Disease Control and Prevention. (1997, December 26). *Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC).* Retrieved from cdc.gov: http://www.cdc.gov/mmwr/preview/mmwrhtml/00050577.htm

William A. Rutala, Ph.D., M.P.H., David J. Weber, M.D., M.P.H., and the Healthcare Infection Control Practices Advisory Committee (HICPAC). (2008, November 12). *Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008.* Retrieved from CDC.gov: http://www.cdc.gov/hicpac/pdf/guidelines/disinfection_nov_2008.pdf

Wisconsin Department of Health Services. (2013, October 8). *Infection Control and Prevention.* Retrieved from Wisconsin.gov: http://www.dhs.wisconsin.gov/communicable/InfectionControl/StandardPrecautions.htm

World Health Organization. (2005, November 3). *Epidemic Alert & Response: WHO Checklist for Influenza Pandemic Preparedness Planning.* Retrieved from who.int: http://www.who.int/influenza/resources/documents/FluCheck6web.pdf

13.0 Conformance to National Patient Safety Goals

13.1. Minimum of Two Participant Identifiers Used in Provision of Care

Rationale: Errors involved in misidentification of participants served can occur in any stage or level of care. Using at least two ways to identify a participant improves the accuracy of participant identification and ensures that each participant gets the correct care, treatment and services. Acceptable identifiers include the participant's name, birthdate, assigned medical/participant number, health insurance number or other participant-specific identifier.

13.1.1. The agency uses at least two participant identifiers when providing care, treatment and services.

13.1.2. The two participant-specific identifiers are directly associated with the individual and the same two identifiers are directly associated with medications, blood products, specimen containers and other treatments or procedures provided by the agency.

13.1.3. The agency uses a standardized identification verification process throughout the agency to confirm the correct participant.

Special considerations: A common approach in behavioral health facilities is to include the participant's photograph in the clinical record for purposes of visual identification by staff. In behavioral health care settings where there is stability of the staff and participant/resident populations, and/or the individuals receiving care are well-known to the staff providing that care, visual recognition as an identifier is acceptable.

For high-risk interventions, like methadone, or in settings with less stable staffing and short length of stay, the full "two identifier" requirement is followed.

13.2. Medication Safety

Rationale: Maintaining and communicating accurate information regarding medications a participant is taking is important when planning care, treatment and services. The guidelines listed here are intended to help reduce negative outcomes associated with medication discrepancies. Guidelines that address administration and management of medications are listed in the Medication standard.

13.2.1. The agency defines the types of medication information to be collected based on the services provided by the agency. Examples of medication information that may be collected include medication name, dosage and purpose.

13.2.2. The agency obtains and documents the participant's medication information upon admission. The information is updated any time there are changes in the participant's medications.

13.2.3. The agency explains to the participant the importance of managing medication information.

13.2.4. Agencies that prescribe medication have a process for comparing the participant's current medications with those prescribed for the participant while under the care of the agency and resolving any medication discrepancies that are identified.

13.2.5. Agencies that prescribe medication provide the participant with written information on the medication the individual should be taking.

13.2.6. Agencies that prescribe medication provide the participant with a complete list of current medications upon discharge or transfer.

Special considerations: It is often difficult to obtain complete and accurate information on current medications from a participant. A good faith effort to obtain this information from the participant may be recognized as compliance with these standards.

13.3. Healthcare-Associated Infection Prevention

Rationale: Healthcare-associated infections (HAIs) are infections that participants acquire during the course of receiving care, treatment, or services in a healthcare organization. Incidents of healthcare- associated infections can occur in all types of health care settings and are a threat to participant safety. The guidelines listed here are intended to improve the hand hygiene of staff that is essential to reducing the risk of healthcare- associated infections.

13.3.1. The agency complies with the hand hygiene guidelines of the Center for Disease Control and Prevention (CDC) or the World Health Organization (WHO).

13.3.2. The agency has guidelines for infection prevention/control.

13.3.3. The agency sets goals for improving compliance with hand hygiene and infection prevention/control guidelines.

Special considerations: Refer to Reducing Risk of Spreading Infection standard for additional information on infection prevention and control.

13.4. Recognizing Participant Safety Risks

Rationale: Suicide and harm to self or others are frequently reported issues within the field of behavioral health. Identification of individuals at risk of harm to self or others while under the care of or following discharge from a behavioral health care program is an important step in planning the care of these at-risk individuals and protecting others from the possibility of harm by at-risk individuals.

13.4.1. The agency assesses the participant for risk of suicide and harm to self or others as part of the initial assessment for care and any time the participant's mental status changes.

13.4.2. The agency has precautions in place to ensure the safety of all participants and staff any time a participant is assessed to be at risk for suicide or harm to self or others.

13.4.3. When a participant is assessed to be at risk for suicide or harm to self or others, the agency:

13.4.3.1. Provides assistance with accessing services necessary to address immediate safety needs.

13.4.3.2. Provides suicide prevention information to the participant and the participant's family.

13.4.3.3. Provides necessary referrals to suicide prevention services for the participant and the participant's family.

<u>References for Standard 13.0</u>:

Centers for Disease Control and Prevention. (2013, October 8). *Hand Hygiene in Healthcare Settings.* Retrieved from cdc.gov: http://www.cdc.gov/HandHygiene/index.html

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(NPSG pgs 3, 5-6, 8)

14.0 Quality Assurance and Improvement

(QA/QI TO BE ADDED AT A LATER DATE)

15.0 Records Maintenance and Management

15.1. Agency Protocol for Maintenance and Management of Participant Records

Rationale: Participant records include a range of confidential information. Participant data collected and stored may be unique to the participant's funding source. In order to ensure participant information remains confidential, all funding requirements are met and necessary data are collected, it is essential that an agency have a defined protocol for what data will be collected, the collection process, method to be used for data storage and minimum requirements for releasing data.

15.1.1. Agency develops and implements a protocol for the management of participant records (electronic or hard copy) that addresses:

15.1.1.1. Location(s) of current and discharged participant records;

15.1.1.2. Method for securing access to all records;

15.1.1.3. Identification of staff who are allowed access to participant records; and

15.1.1.4. Plan for long-term storage of records of discharged participants.

15.1.2. Agency employs a protocol regarding timely development of new participant files.

15.1.3. Agency implements protocol for documentation to be entered into participant file in a timely manner.

15.1.4. Agency has guidelines for participants' access to their own records. Participants are informed of these guidelines.

Special considerations: If the behavioral health agency serves a substance use disorder population, the agency has protocols in place to meet the requirements of 42 CFR.

All behavioral health agencies meet HIPAA requirements.

Refer to sections on Participant Rights and Assessment for additional guidance regarding participant access to records.

15.2. Content of Participant Records

Rationale: It is necessary to maintain specific information in participant records to ensure up-to-date contact information, adequate documentation to provide quality care in the event that the participant's regular staff member is unavailable, and any legally required documents such as releases of information. Depending on the participant's funding source, additional information may be required in the participant record.

15.2.1. Agency establishes minimum participant record requirements including, but not limited to:

15.2.1.1. Intake date;

15.2.1.2. Participant demographics;

15.2.1.3. Funding source and supporting documentation;

15.2.1.4. Emergency contact;

15.2.1.5. Health history and pertinent medical records;
15.2.1.6. Releases of information;
15.2.1.7. Screening;
15.2.1.8. Assessment;
15.2.1.9. Service Plan;
15.2.1.10. Discharge Plan;
15.2.1.11. Case notes;
15.2.1.12. Service coordination/referral documentation;

15.2.2. Content of participant record is regularly updated.

Special considerations: Refer to funding source and IDAPA for additional requirements and guidance on participant files.

For agencies that serve a substance use disorders population, protocols meet the requirements of 42 CFR.

15.3. Electronic Records

Rationale: Utilization of electronic systems for participant records can help to increase efficiency and accuracy; however, they come with their own challenges related to privacy and signatures. In an effort to protect participants' health information, agencies who employ electronic record systems for participant records take precautions.

15.3.1. Any agency that uses an electronic system for maintenance of participant records, ensures that the electronic system is compliant with HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Economic and Clinical Health Act).

15.3.2. For documents that require signatures, the electronic records system offers a way to electronically sign, that is secure and in compliance with federal regulations.

15.3.3. Agency implements a protocol for securing electronic records from access by unauthorized parties.

15.3.4. Agency has a secure back-up plan for storage of, access to and backup of electronic records, in the event of power failure or other situation that causes limited access to electronic records.

15.3.5. Agency has a protocol for updating the electronic record system that does not interfere with the delivery of services to participants.

15.3.6. Agency ensures that all staff are trained on the utilization of electronic records system(s).

Special considerations: Refer to HIPAA and HITECH for additional guidance on protected health information and electronic records.

For agencies that serve a substance use disorders population, protocols meet the requirements of 42 CFR.

15.4. Record Storage, Retention and Destruction

Rationale: State and federal regulations require that agencies retain participant records for a specific amount of time after closure of the case. Even after case closure, privacy and confidentiality stipulations continue to apply to participant information.

15.4.1. Agency establishes and implements a protocol for storage of participant records in a secure manner.
15.4.2. Agency has a protocol for the retention and destruction of participant records.
15.4.3. Participant records are retained in accordance with requirements of state and federal regulations.
15.4.4. Agency identifies people who have access to participant records.

Special considerations: Refer to HIPAA and HITECH for additional guidance on records retention. IDAPA and Idaho Code may provide additional, more specific regulations on record storage, retention and destruction.

For agencies that serve a substance use disorders population, protocols meet the requirements of 42 CFR.

References for Standard 15.0:

Alameda County Mental Health Services. (2010, December 22). *Clinical Record Documentation Standards.* Retrieved from valueoptions.com: http://www.valueoptions.com/providers/Network/California_Counties/Documentation_Requirements_and_QA_Standards.pdf

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.

Commonwealth of Massachusetts. (2011, January 18). *Electronic Records Management Guidelines.* Retrieved from William Francis Galvin, Secretary of the Commonwealth of Massachusetts: http://www.sec.state.ma.us/arc/arcpdf/Electronic_Records_Guidelines.pdf

Disability Rights Network of Pennsylvania. (2007, February 12). *Confidentiality of Mental Health Records.* Retrieved from drnpa.org: http://drnpa.org/File/publications/confidentiality-of-mental-health-records.pdf

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.

16.0 Participant Rights and Expectations

16.1. Agency Guidelines

Rationale: Agency guidelines regarding participant rights and responsibilities ensure that staff and program participants understand participant rights and expectations. They are developed with the intentions of upholding the rights of each participant, and largely influencing the provision of services.

16.1.1. Agency employs a protocol for upholding participant rights and responsibilities and ensures that all staff members follow the protocol.
16.1.2. Agency guidelines pertaining to participant rights and responsibilities address confidentiality, freedom from abuse or exploitation, informed consent, respect for participant choice and preferences and other legal rights.

16.1.3. Agency procedures pertaining to participant rights include guidelines related to participant access to their own records.

Special considerations: For additional guidance on participant rights, refer to IDAPA Code on participant rights.

16.2. Participant has Clear Understanding of Rights and Expectations

Rationale: Ensuring that rights and expectations are described in a manner that the participant understands is key to obtaining the participant's informed consent to receive services. Assurance of informed consent may require that the material is presented in the person's primary language in written form and/or with the assistance of an interpreter.

16.2.1. Agency ensures that program participants are aware of their rights with respect to confidentiality, freedom from abuse or exploitation, informed consent, participant choice and preferences, filing a grievance or complaint and other legal rights as defined by state or federal laws.

16.2.2. Agency ensures that materials describing participant rights and expectations are presented to the participant in a manner that they can understand.

16.2.3. Agency provides information about participant rights and expectations in a manner that is understandable to participants who have challenges with vision, speech, hearing or cognition.

16.2.4. Agency establishes a protocol for facilitating situations where the participant is not able to give informed consent for treatment services. Facilitation may include assisting the participant to access family members, attorneys or other supports.

Special considerations: In an effort to ensure that the participant understands rights and expectations, reasonable accommodations are made, based on the unique needs of the individual.

16.3. Participant Grievances/Complaints

Rationale: Clear agency guidelines regarding procedures for participant grievances, complaints or appeals facilitate resolution of those grievances, complaints or appeals. Feedback from participant grievances, complaints or appeals is used to improve treatment services.

16.3.1. Agency has established practices to respond to participant grievances, complaints or appeals. Practices include an established response process, levels of review and expectations for written notification of actions to address the concerns.

16.3.2. Participants who register grievances, complaints or appeals are not subject to retaliation.

16.3.3. Agency responses to participant grievances, complaints or appeals are conducted in a timely manner, with the participant informed as to the process time frames and expected date for decisions.

16.3.4. Agency provides program participants with information as to the grievance process and with access to any grievance or complaint forms. Agency is responsible for ensuring that participant understands the forms and procedures for registering a grievance, complaint or appeal.

16.3.5. Agency retains documentation on formal grievances, complaints or appeals. Information from these procedures is used to inform practice and improve services.

References for Standard 16.0:
Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 79-81)

The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(RI pg. 7)

17.0 Sentinel Events

17.1. Agency Protocols

Rationale: Developing and implementing guidelines for how to handle sentinel events can help staff appropriately respond in the event of an occurrence.

17.1.1. Agency defines "sentinel event" as it applies to their facility and the population served, including the following elements: unforeseen, occurrence or risk thereof and results in a serious adverse outcome.

17.1.2. Agency has specific guidelines for the appropriate management, response, documentation, analysis and prevention of sentinel events. Staff are educated on the guidelines.

17.1.3. Protocols are intended to: prevent future sentinel events from occurring, decrease the severity of a sentinel event that is already happening, guide the analysis of sentinel events that have occurred and educate staff so they may be prepared to handle/prevent future instances.

17.2. Documentation and Report of Occurrence

Rationale: Documentation of sentinel events is necessary because it provides a lasting account of what happened and can aid with the completion of the Root Cause Analysis, as well as the development of the action plan. Ultimately, documentation serves as the first step in preventing future sentinel events.

17.2.1. Upon occurrence of a sentinel event, agency documents the occurrence as soon as possible to ensure thorough documentation.

17.2.2. Documentation includes all known details of the sentinel event, including those leading up to the event.

17.2.3. Sentinel event is reported to appropriate parties. This includes but is not limited to: funding agencies, accreditation organizations, law enforcement, next-of-kin, etc. Reports are completed in a timely manner and in accordance with organization policy and contractual requirements, as well as local and federal confidentiality requirements.

17.3. Root Cause Analysis

Rationale: After a sentinel event occurs, it is necessary to complete a Root Cause Analysis in order to identify the instigating factor(s) of the event. A Root Cause Analysis is a procedure used to identify initiating factors that led to the sentinel event, so future instances may be avoided.

17.3.1. Agency has a process for conducting Root Cause Analyses.

17.3.2. Following a sentinel event, a Root Cause Analysis is completed in a timely manner.
17.3.3. Root cause analysis evaluates agency processes and procedures rather than performance of staff.
17.3.4. The Root Cause Analysis results in an action plan that details steps to be taken by the agency as an attempt to avoid future similar events from happening.

References for Standard 17.0:
The Joint Commission. (2013). *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).* Oakbrook Terrence: The Joint Commission.
(SE pgs. 2-3)

18.0 Cultural Diversity and Respectfulness

18.1. Definitions

Rationale: In order to provide behavioral health services that are culturally appropriate for all participants, it is necessary to define what "culture" means, as well as the importance of the relationship between participants' cultures and their unique behavioral health needs and preferences.

18.1.1. **Culture:** "The integrated pattern of social behavior that includes thoughts, communications, actions, customs, beliefs and institutions of an ethnic, religious, racial or social group." (U.S. Department of Health and Human Services Office of Minority Health, 2001)
18.1.3. **Cultural Diversity:** A variety of cultures present within a system or agency, often difficult to quantify, but reflective of the local population regardless of citizenship, nationality, religion or subgroup status.

18.2. Cultural Diversity and Respectfulness in the Provision of Services

Rationale: Services are more effective when presented in a manner that is understandable and relatable to the participant. Agency ensures that services are provided in a manner that is considerate of participants' unique cultural needs and preferences.

18.2.1. Agency seeks information on the participant's culture during the intake assessment.
18.2.2. Agency incorporates methods to provide interpreters in service delivery for participants who better understand other languages.
18.2.3. Agency is sensitive to the norms, expectations and behaviors appropriate within the cultures served; including, but not limited to: age, gender, sexual orientation, spiritual beliefs, socioeconomic status, and language.
18.2.4. Treatment plan and service delivery reflect participants' cultural preferences and needs.
18.2.5. Agency provides materials and services that are clearly understandable to all participants, given their cultural background and linguistic preference.
18.2.6. Agency ensures that materials and services are presented in a manner that is understandable to participants.
18.2.7. Agency makes diligent effort to match participants with staff members who have similar cultural backgrounds if possible.

18.2.8. When feasible, the agency uses evidence-based practices that are specific to the population(s) served.

18.3. Cultural Diversity and Respectfulness Plan

Rationale: In order to ensure full engagement and confidence in services, participants must feel safe, comfortable and esteemed. The development and implementation of a Cultural Diversity and Respectfulness Plan provides documentation and direction on how the agency plans to meet the cultural needs and preferences of participants, staff members, and stakeholders.

18.3.1. Cultural Diversity and Respectfulness Plan details how the agency and its staff members will become aware of and show respect and appreciation toward the significance of cultural diversity.

18.3.2. The plan indicates how the agency will incorporate understanding and respect for cultural diversity into practices, documents, policies, and procedures.

18.3.3. The plan includes staff training requirements and recommendations.

18.3.4. Cultural Diversity and Respectfulness Plan determines how agency provides an environment that is acceptable and appropriate for the population(s) served.

18.3.5. The plan discusses agency process and rationale for collecting data on cultural backgrounds, needs and preferences of participants, staff members, and stakeholders.

18.3.6. Cultural Diversity and Respectfulness Plan establishes a logical system to identify cultures within the community on a regular basis, no less than annually.

18.3.7. The plan details a system to evaluate participants' cultural needs and preferences on a regular basis.

18.3.8. Plan is reviewed and updated regularly to ensure that practices are relevant to population(s) served.

<u>References for Standard 18.0:</u>

Amy Wilson-Stronks, Karen K. Lee, Christina L. Cordero, April L. Kopp, and Erica Galvez. (2008, June 5). *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations.* Retrieved from The Joint Commission: http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf

Commission on Accreditation of Rehabilitation Facilities (CARF). (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pg. 33)

Glover, W. (2008, February 8). *aacounty.org.* Retrieved from Anne Arundel County, MD Citizens Information Center: http://www.aacounty.org/Partnership/Resources/Cultural_Competency_Continuum.pdf

U.S. Department of Health and Human Services Office of Minority Health. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care.* Rockville: IQ Solutions.

PEER SUPPORT SERVICES

1.0 Certified Peer Specialist (CPS) Standards

1.1. Definitions

Rationale: A Certified Peer Specialist (CPS) is an individual in recovery from mental illness or mental illness with a co-occurring substance use disorder who uses his/her lived experience and specialized training to assist other individuals in their own recovery. The relationship between the CPS and the other recovering individual is one of mutual respect and support built on a connection and trust not obtainable through other service relationships.

1.1.1. Certified Peer Specialist has a mental illness or a mental illness and co-occurring substance use disorder diagnosis and at least one (1) year of lived experience receiving behavioral health services from a behavioral health service system.

1.1.2. Certified Peer Specialist completes the forty-hour Appalachian Group/DBSA (Depression and Bipolar Support Alliance) training.

1.1.3. Certified Peer Specialist passes the Appalachian Group/DBSA certification exam with a score of 70% or higher.

1.1.4. Certified Peer Specialist understands and lives by Idaho's Certified Peer Specialist Code of Ethics.

1.1.5. Certified Peer Specialist engages, educates, guides and supports recovering individuals to create new ways of seeing, thinking and doing in order to have healthy relationships and live successfully in the community. These new ways are determined by the individual being served.

1.1.6. Certified Peer Specialist is non-clinical and does not diagnose or offer primary treatment for mental health issues.

Special considerations: Eligibility to provide peer support services may depend on the nature of the employment and whether the CPS either passes a criminal background check or qualifies for a criminal background check waiver according to criteria outlined in IDAPA.

1.2. Qualifications

Rationale: The life experience of someone living with a mental illness or co-occurring diagnosis is most understood by someone who has also lived this sort of experience. Certain qualifications are needed to understand and know how to navigate the systems involved in creating a healthy and positive life. It is only ethical that the Certified Peer Specialist (CPS) meets certain criteria when working with individuals who may need support in working toward recovery.

1.2.1. Certified Peer Specialist (CPS) candidate has lived experience as someone who has a mental health diagnosis or co-occurring diagnosis and has at least (1) ongoing and continuous year of recovery as verified by a qualified health practitioner/behavioral health provider.

1.2.2. CPS candidate completes the Idaho Peer Specialist Certification Training Application which includes questions regarding one's lived experience.

1.2.3. CPS candidate submits two letters of recommendation with the training application.

1.2.4. CPS candidate completes 40 contact hours of training specifically designated for Idaho Certified Peer Specialists and approved by the State Behavioral Health Authority.

1.2.5. CPS candidate passes a post-training assessment established by the training entity and approved by the State Behavioral Health Authority.

1.2.6. A Letter of Completion is mailed to the CPS candidate. The letter states either approval for the individual to take the certification exam or it provides individualized recommendations for the candidate to complete before moving forward with the certification exam.

1.2.7. Work Experience and Education:

1.2.7.1. If the CPS candidate holds a bachelor's degree in human services (e.g. social work, psychology, education, sociology, social sciences), he/she documents 100 hours of work experience in the human services field within a year from completing the training. If the 100 hours of work experience are not completed within a year, a review is required by the certifying body.

1.2.7.2. If the CPS candidate does not hold a bachelor's degree in human services (e.g.. social work, psychology, education, sociology, social sciences), he/she must have a high school diploma or GED and documents 200 hours of work experience in the human services field within a year of completing the training. If the 200 hours of work experience are not completed within a year, a review is required by the certifying body.

1.2.8. CPS candidate completes 20 supervision hours with a designated Idaho CPS Supervisor within a year of completing the training.

1.2.9. CPS candidate passes the Idaho Certified Peer Specialist Exam with a score that meets the standard set by the certifying body authorized by the State Behavioral Health Authority.

1.2.10. Accommodations for the exam are provided as deemed necessary by the individual taking the exam. Examples of accommodations include, but are not limited to, extra time, a separate room, and use of a computer.

1.2.11. CPS Supervisor is a degreed professional in the field of human services who has supervisory capacity within the agency and is designated as a CPS Supervisor by the certifying body.

1.2.12. The CPS Supervisor obtains such designation by applying to the approved certifying body and following the approved process for said designation. The certifying body maintains a current list of approved Supervisors.

1.2.13. CPS maintains a working knowledge of current recovery trends and developments in the fields of mental health, substance use disorders, current research as it relates to behavioral health, wellness and recovery, ethical practices and peer support services by reading current journals, books, etc., attending webinars, workshops and conferences as they relate to these fields, and sharing with other CPSs.

1.2.14. CPS must be at least 18 years old.

1.2.15. To avoid role ambiguity and conflict, CPS does not fulfill other service roles (therapist, counselor, case manager, nurse, physician, clergy, etc.) to participants they are providing peer services to; nor do they practice outside the scope of their peer specialist training.

Special considerations: A clinician or professional person may hold certification as a CPS; however, a CPS working with a particular individual as a CPS provider cannot also be the clinician (i.e. other professional) who is providing any other services to that same individual. In other words, an individual cannot be the CPS provider and other professional provider of a participant at the same time.
Safety is an important concern, therefore background checks may be required by law and rule, but are the responsibility of the agency or place of employment, and are not part of the certification process.

1.3. Training

Rationale: Training equips the Certified Peer Specialist (CPS) with additional and necessary knowledge, understanding and skills. Documentation of trained Specialists establishes verification and credibility for agencies employing CPSs. Training adds to the participant's confidence and trust in the CPS's abilities with whom they are working.

1.3.1 CPS training includes, at a minimum, the following competency areas:

1.3.1.1 overview of mental illness and substance use disorders and their effects on the brain,
1.3.1.2 the stages of recovery and the role peer support plays in it,
1.3.1.3 the state behavioral health system and the role peers play within it,
1.3.1.4 advocacy for recovery programs and for the peers they serve,
1.3.1.5 the practice of recovery values: authenticity, self-determination, diversity, inclusion, etc.
1.3.1.6 how to use your recovery story to help others,
1.3.1.7 ethics (boundaries, confidentiality, HIPAA, etc.),
1.3.1.8 the identification of risk factors in participants' behaviors and how to respond in/to a crisis,
1.3.1.9 the use of interpersonal and professional communication skills,
1.3.1.10 effecting change,
1.3.1.11 work place dynamics and processes,
1.3.1.12 empowering others,
1.3.1.13 family dynamics,
1.3.1.14 the effects of trauma and use of a trauma informed approach,
1.3.1.15 wellness and natural supports,
1.3.1.16 maintaining one's wellness,
1.3.1.17 cultural sensitivity,
1.3.1.18 recovery plans, and
1.3.1.19 local, state and national resources.

1.3.2 Training is 40 hours of face-to-face instruction that is conducted by an IDHW DBH approved training entity. The training entity is separate from the certifying body. The certifying body is responsible for verifying competencies.

1.3.3 Curriculum includes all types of learning methods, including role-playing scenarios as a key element of building skills.

Special considerations: Any exceptions to the training as outlined here are reviewed by the certifying body.

1.4. Certification and Renewal

Rationale: Professional certifications lend credibility to the individual professional, as well as to the employer. Certification of Peer Specialists ensures that those who employ Certified Peer Specialists are employing individuals who have consistent experiences and qualifications. Certification provides employers and participants with evidence and documentation that the certificate holder has demonstrated a certain level of job-related knowledge, skills, abilities, and practical experience. Certification also empowers the holder via the knowledge and skills obtained, as well as by the fact that he/she has successfully accomplished the completion of all requirements.

1.4.1. Certified Peer Specialist (CPS) meets the qualifications as stated in section 1.2.

1.4.2. Persons claiming to hold certification status as a CPS hold documentation of said certification.

1.4.3. CPS certification is good for one year.

1.4.4. CPS professional renews his/her certification annually by:

1.4.4.1. completing at least 10 hours of continuing education approved by the certifying body for Idaho's CPS (e.g. trainings, workshops, webinars) per year and documenting said education. Continuing education topics can be from any of the competencies listed in the training competencies section in 1.3, AND

1.4.4.2. completing a renewal application, AND

1.4.4.3. maintaining a no-violations record regarding the CPS Code of Ethics

1.4.5. CPS follows the Certification Renewal Procedure put forth by the certifying body for Idaho's CPSs.

1.4.6. CPS is responsible for ensuring that the certifying body has all current documentation necessary for satisfying the certification criteria.

1.4.7. Employers of CPSs are responsible to check with the centralized certification body to ensure that the CPS which they wish to hire has current certification status as a certified CPS in Idaho.

1.4.8. The state's approved certifying agency tracks certifications and continuing education status of Idaho's Certified Peer Specialists.

Special considerations: Continuing education hours are approved by the certifying agency to renew certification.

1.5 Termination, Inactive Status & Reactivation

Rationale: Certification reveals to others that a person has reached a particular level of competency. If these levels are not maintained, a person's certification may be terminated or revoked. Termination can be due to, but is not limited to, deficient documentation or a Code of Ethics violation.

1.5.1. Deficient documentation is the failure to submit on time requested documentation and application for certification and renewal, or any other requested materials from the certifying entity

1.5.2. A Code of Ethics Violation is the failure to abide by the Certified Peer Specialist (CPS) Code of Ethics and/or providing false information on documents

1.5.3. Inactive Status is when a CPS in good standing requests such status because he/she is unable to meet the requirements for recertification due to a decline in physical or mental health or an extenuating circumstance; such as: death of a close relative, divorce or marriage, long-term illness of family member, loss of employment, birth

or adoption of a child, military deployment, or other circumstance that is approved by the certifying body.

1.5.4. Reactivation is accomplished by submitting all required documentation, including a new application packet and verification of CEUs earned within one year of resubmission.

1.5.4.1. It is the applicant's responsibility to ensure that all documentation is completed and submitted.

1.5.4.2. If application is incomplete, a deficiency letter is sent to the applicant and applicant has 30 calendar days to mail all required documents. If 30 days go by and documents are not received by the certifying body, the applicant's certification expires and applicant will need to re-apply, submitting all certification documentation and a new application.

1.5.5. Applicants who have violated the Code of Ethics will, in addition to the documentation in 1.5.4, submit a report that details the nature of the violation, admission of the violation, corrective actions taken and insurance that the violation will not recur. The CPS Peer Review Board, which is defined by the certifying entity, will determine re-instatement based on the seriousness of the violation, applicant's report and the corrective actions taken.

Special considerations: Inactive status is not granted for the failure to comply with continuing education requirements or a reported Code of Ethics violation.

1.6. Reciprocity

Rationale: The time and effort that a person expends obtaining a Certified Peer Specialist (CPS) certification is valued. Idaho also values its certification process and therefore, reciprocity from another state's certifying board is permitted as long as certain conditions are met.

1.6.1. Applicant requesting reciprocity to provide services in Idaho must have completed the Appalachian Group/DBSA curriculum and passed the Appalachian Group/DBSA certification exam within the past 2 years.

1.6.2. Applicant submits an Idaho CPS application along with a copy of his/her certification and a copy of his/her current CPS certificate or equivalent from another state.

1.6.3. If Idaho's certifying agency finds the applicant deficient in any of Idaho's requirements, a letter explaining needed documentation will be sent to the applicant. The applicant has 30 calendar days to respond with an explanation as to how the requirements will be completed and 60 days to complete said requirements.

Special considerations: Safety is an important concern, therefore background checks may be required by law and rule, but are the responsibility of the agency or place of employment, and are not part of the certification process.

1.7. Reporting Changes

Rationale: Idaho values its Certified Peer Specialists (CPSs) and wants to maintain communication with each person. The best way to do this is to know how to reach each CPS to report CPS news, events and any changes to the certification requirements. It also aids in

networking with all CPSs in the state. In addition, this allows IDHW to know how many CPSs are available in different parts of the state and who they are.

1.7.1. Certified Peer Specialist (CPS) reports changes in name, address, telephone number and email address.
1.7.2. CPS reports a change in supervisor's name.
1.7.3. CPS reports a change in employment status.
1.7.4. CPS reports a violation in Code of Ethics.

Special considerations: Failure to report changes may result in termination of certification or other disciplinary measure.

1.8. Grievance Procedures

Rationale: There are times when applicants will not agree with decisions made the certifying board. To be properly and fairly heard, a procedure has been identified for the applicant to voice his/her grievance.

1.8.1. Applicant may file a grievance when there is a valid factual reason to do so; such as, being denied certification, questioning the outcome of the review board, or applicant is subject to an action by the certifying board that he/she deems unjustified.
1.8.2. Applicant must file said grievance within 30 days of notice or action deemed unjustified to the certifying board.
1.8.3. Contracted entity reviews the grievance.

1.9. Provision of Peer Support Services

Rationale: Depending on the scope of work of the agency in which the Certified Peer Specialist (CPS) is employed, the tasks carried out by the CPS can vary. Generally speaking, the services that a CPS provides should be participant-centered, participant-driven, culturally sensitive, recovery-based and community-based with the participant's rights protected. These services broaden the continuum of care provided in the typical treatment setting; they are part of an array of services. Peer support services are partners to more traditional services, but should not be used as a substitute for clinical services when the need for clinical services is indicated. The purpose for these services is to complement treatment and help the participant feel less isolated and more empowered within their recovery and engaged in their community.

1.9.1. Certified Peer Specialist (CPS) services may be provided to all participants who are in need of such services.
1.9.2. Participant outcomes expected during and after a CPS works with a participant include, but are not limited to:
    1.9.2.1. Ability to identify and use wellness tools;
    1.9.2.2. demonstrated ability to live more independently;
    1.9.2.3. re-engaging with support systems that had been lost;
    1.9.2.4. increase in education, employment and/or volunteerism;
    1.9.2.5. improved housing situation;
    1.9.2.6. improved quality of life;
    1.9.2.7. sense of purpose;
    1.9.2.8. increased empowerment;
    1.9.2.9. belief that recovery is possible;

1.9.2.10. increased self-esteem;
1.9.2.11. demonstrated ability to self-advocate; and
1.9.2.12. increased participation in community and positive activities.

1.9.3. Services are non-clinical and designed to help initiate and sustain the individual in his/her recovery. Services provided by the CPS are voluntary and include, but are not limited to:

1.9.3.1. peer mentoring;
1.9.3.2. facilitating support groups;
1.9.3.3. assisting participant in engaging or re-engaging with participant's natural supports (e.g. family, friends, other loved ones, neighbors);
1.9.3.4. facilitating job readiness training;
1.9.3.5. facilitating wellness and recovery seminars;
1.9.3.6. providing educational materials or programs;
1.9.3.7. assisting in the development of participants' goals;
1.9.3.8. assisting participant to develop self-advocacy and problem-solving skills;
1.9.3.9. role modeling behaviors, attitudes and skills that promote recovery and wellness that is needed for resiliency and coping;
1.9.3.10. assisting participants with identifying and utilizing their strengths;
1.9.3.11. role modeling the facilitation of collaborative relationships;
1.9.3.12. assisting participants in accessing community and social services, including self-help groups;
1.9.3.13. link participant to professional treatment when necessary;
1.9.3.14. assisting with the development of community supports;
1.9.3.15. assisting at peer and consumer operated programs;
1.9.3.16. assisting with substance-free physical and recreational activities; and
1.9.3.17. advocating for the needs of participants.

1.9.4. These services shall be delivered primarily face-to-face, and secondarily by telephone or social media.

1.9.5. Services are delivered individually and in group settings.

1.9.6. CPS shares his/her personal story when appropriate for the benefit of the participant with whom he/she is serving and supporting, keeping in mind that this is but one experience and it does not mean that others will have the same experience or needs.

1.9.7. Frequency and Length of Service:

1.9.7.1. The frequency by which a CPS meets and works with the participant and the length of this service is determined by the peer, CPS and mental health clinician.

1.9.7.2. The frequency and length of service are periodically re-evaluated depending on the intensity of the CPS services needed. The higher the intensity and frequency of the services, the more often a reevaluation occurs.

1.9.8. CPS performs activities *with* an individual, and not *for* or *to* the individual so that the individual can regain control over their own life.

1.9.9. CPS is under the direct supervision of a designated CPS Supervisor.

1.9.10. CPS refers participant to the appropriate resources if they are unable to benefit from peer services.

1.9.11. CPS working within an agency adheres to the documentation requirements of the agency.

Special considerations: Services that a CPS does not provide: counseling/therapy, social work, drug testing, diagnosing of symptoms and disorders, prescribing, acting as a legal representative, participating in the determination of competence, and providing legal advice. CPS work to equalize the power differentials in the peer support relationship.

1.10. Organizational Readiness and Responsibility

Rationale: Optimal employment and use of a certified peer specialist requires awareness and understanding of peer recovery, resilience, trauma and hope as they relate to the Certified Peer Specialist providing services and to the participants who receive these services. Certified Peer Specialists are an equal member of the staff.

1.10.1. Organizational Readiness is preparing an organization or agency for the employment of a Certified Peer Specialist (CPS); ensuring that staff members understand the purpose of CPSs and how CPS duties enhance the organization's mission, including any unique issues to employing CPSs.

1.10.2. Agency establishes a readiness plan that includes criteria, by which the agency hires, supervises and works to maintain CPSs.

1.10.3. Agency that employs CPSs communicates clearly and respectfully with all employees, including CPSs, about practices that are most effective in promoting recovery and resilience of participants receiving services from the organization.

1.10.4. Agency engages in educational opportunities for all staff that prepare them to better understand the strengths and opportunities offered by the CPS

1.10.5. Agency adheres to Idaho's CPS standard and all other agency-related standards.

1.10.6. Agency ensures that all CPSs are supervised by a CPS Supervisor who has been designated as such by the certifying body, and that the services rendered by the CPS are under a comprehensive, individualized, participant-centered-and-driven plan.

1.10.7. CPS Supervisors are designated by each agency that employs CPSs and the Supervisor is approved by the certifying body. A list of approved CPS Supervisors is maintained by the certifying body.

1.10.8. Agency utilizes trauma-informed principles when employing CPSs.

1.10.9. The state's approved certifying agency tracks certifications and continuing education status of Idaho's Certified Peer Specialists.

1.10.10. Agency does not employ or utilize clients who are receiving services at their agency as a peer specialist for that agency.

1.10.11. Agency develops a written job description that specifies the duties and responsibilities of the CPS within that agency.

Special considerations: Dual relationships are important ethical considerations when staffing an agency. Hiring a former participant as a CPS could present difficulty for the CPS and staff. Several of the issues that arise from this practice include: privacy and access to records, access to treatment services for the CPS if needed, and residual power differential among staff.

1.11. Ethics

Rationale: A code of ethics in any profession guides the professional in areas of role-function, relationships, levels of responsibilities and liability.

1.11.1. Certified Peer Specialist adheres to the Idaho CPS Code of Ethics while performing duties of a CPS.

1.11.2. CPS completes at least annual ethics training, provided by either an employer or via other avenues approved by the certifying body.

1.11.3. Agencies that employ CPSs provide accessible opportunities for ethics training to all service- providing staff members, including CPSs, at least annually.

1.11.4. Provider organizations document completion of ethics training in each employee's file, including each CPS's file.

1.11.5. CPS keeps personal documentation of completed ethics training as required by the certifying body.

Special considerations: A clinician or professional person may hold certification as a CPS; however, a CPS working with a particular participant as a CPS provider cannot also be the clinician (i.e. other professional) who is providing any other services to that same participant. In other words, an individual cannot be the CPS provider and the other professional provider of a participant at the same time.

Additional Considerations: *Agencies that employ Certified Peer Specialists adhere to this standard and all of the Core Standards put forth by the State Behavioral Health Authority.*

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Questions:

What is the difference between a certified peer specialist and a peer specialist? Only the certified peer specialist has completed the required training and demonstrated competency in the Idaho Peer Specialist standards.

How can someone become a certified peer specialist if they have achieved a level of recovery that no longer requires professional support – since there is a 1 year documented experience requirement from a provider? Every situation is unique so contacting the certifying entity to discuss the specifics of your situation would be best. Different types of documentation from a professional may be accepted and it does not necessarily have to be from a currently treating provider.

Why does a certified peer specialist with a bachelor's degree in human services require fewer work experience hours than a peer without a degree? Knowledge of service delivery and theoretical approaches are core features of bachelor's degree programs. Given the graduate's experience in this area, fewer experience hours are needed.

Where did the requirement for 200 experience hours or 100 with bachelor's degree come from? The Department's behavioral health standards workgroup researched national and other states' standards for peer support, family support, and recovery coaching. Some standards require up to 1,000 hours of work experience. This requirement for Idaho's standards was

decided on among the workgroup to ensure an adequate amount of knowledge and experience while maintaining a level of feasibility for prospective peer service providers in Idaho.

How long does a certified peer specialist have to report changes to the certifying body? This is determined by the certifying entity but should be done as soon as feasible.

2.0 Recovery Coaching

2.1. Recovery Coach Definition

Rationale: All individuals play an important role in promoting recovery from a substance use disorder. Personal recovery, lived experiences and wellness bring a unique and significant benefit to recovery coaching. A recovery coach is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovering community and serves as personal guide and mentor in the management of personal and family recovery. Written descriptions of a recovery coach help clarify the role and functions of the recovery coach in supporting an individual's recovery. All recovery coaches, including certified recovery coaches and peer specialist recovery coaches meet the following standards.

2.1.1. Recovery Coach completes the 30 hour Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy (RCA) training and have a Certificate of Completion signed by a Department-approved RCA trainer.

2.1.2. Recovery Coach completes the 12 hour Connecticut Community for Addiction Recovery (CCAR) Ethical Considerations for Recovery Coaches and have a Certificate of Completion signed by a Department-approved Ethics trainer.

2.1.3. Recovery Coach is non-clinical and does not diagnose or offer primary treatment for addiction or any mental health issues.

2.1.4. Recovery Coach works with individuals beyond recovery initiation through stabilization and into recovery maintenance.

2.1.5. To avoid role ambiguity and conflict, Recovery Coach does not fulfill other service roles (therapist, counselor, case manager, nurse, physician, clergy, etc.) to individuals that they are coaching.

2.1.6. Recovery Coach supports all pathways to recovery and is not associated with any particular method or approach.

2.1.7. Recovery Coach supports any positive change, helping persons in recovery to avoid relapse, build community support for recovery, or work on life goals not related to addiction such as relationships, work, education etc.

2.1.8. Recovery Coach links persons in recovery to recovery community and helps persons in recovery build community relationships.

2.1.9. Recovery Coach promotes recovery by serving as a guide and mentor for persons in recovery.

2.1.10. Recovery Coach abides by the Idaho Code of Ethics for Recovery Coaches.

2.1.11. Recovery Coach must be at least 18 years old.

Special considerations: The clinical therapeutic relationship is by nature, unequal. The boundaries of the relationship are strictly defined and preclude the counselor or therapist from sharing personal information and the counselor or therapist tends to have significantly more power in the relationship than the participant. The recovery coach relationship is a reciprocal

relationship and the recovery coach not only shares personal information with the participant but is expected to act as a friend, mentor and companion to the individuals they are coaching.

2.2. Recovery Coach Trainers

Rationale: A Recovery Coach Training of Trainers (TOT) program is essential for capacity building and continued success and sustainability of Recovery Coaching in Idaho. The Training of Trainers courses provide trainers with background knowledge and skills that will enable them to effectively mentor and train other persons to become recovery coaches.

2.2.1. Recovery Coach Trainer meets standards as stated in section 2.1.

2.2.2. Recovery Coach Trainer completes an *Application for Recovery Coach Training of Trainers (TOT)* that includes:

2.2.2.1. Motivation for applying for training;

2.2.2.2. Willingness to do recovery coach trainings;

2.2.2.3. Willingness to work with the Division of Behavioral Health in planning trainings;

2.2.2.4. Letter of support from current employer;

2.2.2.5. Willingness to train the curriculum as it was presented by Connecticut Community for Addiction Recovery (CCAR);

2.2.2.6. Willingness to present as a positive supporter of the recovery coach model; and

2.2.2.7. Experience as a trainer.

2.2.3. Recovery Coach Trainer completes the Connecticut Community for Addiction Recovery (CCAR) 30-hour Recovery Coach Academy training.

2.2.4. Recovery Coach Trainer completes the 12-hour Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy Training-of-Trainers (TOT) course.

2.2.5. Recovery Coach Trainer completes the 12-hour Connecticut Community for Addiction Recovery (CCAR) Ethical Considerations for Recovery Coaches.

2.2.6. Recovery Coach Trainer completes the 12-hour Connecticut Community for Addiction Recovery (CCAR) Ethics Training-of-Trainers (TOT) course.

Special considerations: The TOT courses are designed to familiarize participants with the full Recovery Coach Academy and Ethical Considerations for Recovery Coaches curriculum and to learn optimal methods of delivering the training. It is not intended to train participants on how to train (training skills); therefore, those attending the TOT courses should be experienced trainers.

2.3. Certified Recovery Coach

Rationale: A certification process helps establish a valid, reliable and defensible methodology for the evaluation of recovery coach competency and promotes standards of training and competency that increases the professionalism of the recovery coaching field. Certification provides employers and participants with evidence and documentation that the certificate holder has demonstrated a certain level of job-related knowledge, skills, abilities, and practical experience. Certification also empowers the holder via the knowledge and skills obtained, as well as by the fact that he/she has successfully accomplished the completion of all requirements. A Certified Recovery Coach (CRC) is any individual that has completed the certification process through the certifying body and is actively certified as a Certified Recovery Coach.

2.3.1. Certified Recovery Coach meets standards as stated in section 2.1.
2.3.2. Certified Recovery Coach completes a total of 46 hours of training in the following performance domains:
2.3.2.1. Advocacy—10 hours;
2.3.2.2. Mentoring/Education—10 hours;
2.3.2.3. Recovery/Wellness Support—10 hours; and
2.3.2.4. Ethical Responsibility—16 hours.
2.3.3. Certified Recovery Coach has a high school diploma or jurisdictionally certified high school equivalency.
2.3.4. Certified Recovery Coach has 500 hours of volunteer or paid work experience specific to the domains of Advocacy, Mentoring/Education, Recovery/Wellness Support and Ethical Responsibility.
2.3.5. Certified Recovery Coach has 25 hours of supervision specific to the domains of Advocacy, Mentoring/Education, Recovery/Wellness Support and Ethical Responsibility. Supervision must be provided by an organization's documented and qualified supervisory staff per job description.
2.3.6. Certified Recovery Coach abides by the Idaho Code of Ethics for Recovery Coaches.
2.3.7. Certified Recovery Coach passes the Idaho Recovery Coach certification exam with a score that meets the standard set by the certifying body.
2.3.8. Certified Recovery Coach earns 10 hours of continuing education per year, including 3 hours in ethics.
2.3.9. The certifying body tracks certification and continuing education status of Idaho's Recovery Coaches.
2.3.10. The certifying body maintains sole discretion to suspend or revoke certification of Recovery Coaches certified under the auspices of the certifying body.
2.3.11. The certifying body oversees the Certified Recovery Coach certification process and approval of all certification materials including application forms, required documentation, continuing education, fees and testing tools.

2.4. Peer Specialist Recovery Coach (PSRC)

Rationale: People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery. The Peer Specialist Recovery Coach (PSRC) is a designation designed for Certified Recovery Coaches who are in recovery from a substance use disorder. A PSRC has specific knowledge and understanding through lived experience that makes him/her uniquely qualified to provide peer support for another person in recovery from a substance use disorder. It includes those who have received formal system services and those on pathways to recovery through other religious and spiritual approaches.

2.4.1. Peer Specialist Recovery Coach meets standards as stated in 2.1.
2.4.2. Peer Specialist Recovery Coach is certified by certifying body according to standards stated in section 2.3 prior to seeking designation.
2.4.3. Peer Specialist Recovery Coach has a substance use disorder and at least one (1) ongoing and continuous year of recovery.

2.4.4. Peer Specialist Recovery Coach is willing to self-identify as a peer, share his/her story and provide peer support to others who can benefit from the PSRC's lived experiences.

2.4.5. Peer Specialist Recovery Coach writes a *Statement of Personal Recovery* that demonstrates recovery status and personal commitment to recovery maintenance.

2.4.6. Peer Specialist Recovery Coach abides by the Idaho Code of Ethics for Recovery Coaches.

2.4.7. Designation as a PSRC is issued by the Department's contracted agency.

2.4.8. The PSRC designation is renewed annually by the Department's contracted agency. Peer Specialist Recovery Coach meets the following requirements for renewal:

2.4.8.1. Current certification through the certifying body as a Certified Recovery Coach and in good standing with the certifying agency;

2.4.8.2. 6 hours of continuing education related to the performance domains and tasks listed in the Training section 2.5 including 1 hour of ethics; and

2.4.8.3. 3 Letters of Recommendation/Support.

2.4.9. The Department contracted agency maintains sole discretion to inactivate or terminate a PSRC designation issued by the Department contracted agency. Reasons for inactivation or termination may include, but are not limited to:

2.4.9.1.1. Ethical violation substantiated by the Department's contracted agency;

2.4.9.1.2. Failure to comply with conditions of renewal;

2.4.9.1.3. Failure to document appropriate continuing education as required Department's contracted agency; and

2.4.9.1.4. Suspension or termination of recovery coach certification by the certifying agency.

2.4.10. The Department-contracted agency oversees the PSRC designation process and approval of all designation materials including application forms, required documentation, continuing education, fees and testing tools.

Special considerations: Continuing education required for Certified Recovery Coach recertification may meet continuing education requirements for PSRC annual designation.

2.5. Training

Rationale: The purpose of training is to introduce individuals to the key concepts, fundamental skills and core functions of recovery coaching. Training helps facilitate an individual's competence as a recovery coach and help ensure that individuals have the necessary knowledge and skills to provide quality services. Standardized training helps ensure that recovery coaches learn essential knowledge and skills needed to perform recovery coaching services.

2.5.1. Recovery Coach training includes, at a minimum, the following competency areas:

2.5.1.1. **Advocacy-**

2.5.1.1.1. Serve as participant's individual advocate;

2.5.1.1.2. Advocate within systems to promote participant-centered recovery support services;

2.5.1.1.3. Assure that the participant's choices define and drive their recovery planning process; and

2.5.1.1.4. Promote participant-driven recovery plans by serving on the participant's recovery-oriented team.

2.5.1.2. **Mentoring/Education-**

2.5.1.2.1. Serve as a role model of a person in recovery;

2.5.1.2.2. Establish and maintain a reciprocal relationship rather that a hierarchical relationship;

2.5.1.2.3. Promote social learning through shared experiences;

2.5.1.2.4. Teach participants life skills;

2.5.1.2.5. Encourage consumers to develop independent behavior that is based on choice rather than compliance;

2.5.1.2.6. Assure that participants know their rights and responsibilities; and

2.5.1.2.7. Teach participants how to self-advocate.

2.5.1.3. **Recovery/Wellness Support-**

2.5.1.3.1. Serve as an active member of the participant's recovery-oriented team;

2.5.1.3.2. Assure that all recovery-oriented tasks and activities build on participant's strengths and resiliencies;

2.5.1.3.3. Help the participant identify his/her options and participate in all decisions related to establishing and achieving recovery goals;

2.5.1.3.4. Help the consumer develop problem-solving skills so s/he can respond to challenges to their recovery; and

2.5.1.3.5. Help the consumer access the services and supports that will help him/her attain his/her individual recovery goals.

2.5.1.4. **Ethical Responsibility-**

2.5.1.4.1. Respond appropriately to risk indicators to assure the participant's welfare and physical safety;

2.5.1.4.2. Immediately report suspicions that the participant is being abused or neglected;

2.5.1.4.3. Maintain confidentiality;

2.5.1.4.4. Communicate person issues that impact ability to perform job duties;

2.5.1.4.5. Assure that interpersonal relationships, services, and supports reflect the participant's individual differences and cultural diversity;

2.5.1.4.6. Document service provision as required by employer; and

2.5.1.4.7. Gather information regarding participant's personal satisfaction with progress toward his/her recovery goals.

2.5.2. Training is 46 hours of face-to-face instruction with 10 hours in each of the domains of Advocacy, Mentoring/Education, and Recovery/Wellness and 16 hours in the domain of Ethical Responsibility.

Special considerations: Training conducted through interactive video telecommunications may be considered face-to-face. Any exceptions to the training as outlined here are reviewed by the certifying body.

2.6. Ethics

Rationale: Aspiring to be ethical involves sustained vigilance in preventing harm and injury to each person served. It is important that all recovery coaches are familiar with and follow ethical guidelines and expectations of service delivery for those served.

2.6.1. Recovery Coach adheres to the Idaho Code of Ethics for Recovery Coaches.

2.6.2. Recovery Coach completes ethics training at least annually.

2.6.3. Agencies employing or utilizing volunteer recovery coaches establish procedures for ethical decision making including methods for dealing with allegations of violations of ethical code.

2.6.4. Recovery Coach makes every effort to protect the confidentiality of the participant and adhere to limits of confidentiality as determined by applicable laws.

Special considerations: Recovery Coaching relationships are less hierarchical than the clinical counselor-client relationship. As such, the ethical guidelines that govern the clinical counselor are not applicable in the Recovery Coaching capacity.

2.7. Recovery Coaching Services

Rationale: Recovery Coaching is a set of non-clinical, participant-centered activities that engage, educate and support an individual to successfully make life changes necessary to recover from disabling substance use disorder conditions. Depending on the scope of work of the organization in which the recovery coach is providing services, the tasks carried out by the recovery coach can vary. Generally speaking, the services that a Recovery Coach provides should be participant-centered, participant-driven, culturally sensitive, recovery-based and community-based with the participant's rights protected. These services broaden the continuum of care provided in the typical treatment setting; they are part of an array of services. Recovery coaching services are partners to more traditional services, but should not be used as a substitute for clinical services when the need for clinical services is indicated. The purpose for these services is to help the participant feel less isolated and more empowered within their recovery and engaged in their community.

2.7.1. Recovery Coach utilizes a participant-centered recovery wellness plan to help participants develop effective recovery and general life goals.

2.7.2. The Recovery Wellness Plan is the participant's plan and is written, maintained and kept by the participant. Copies of the plan may be but are not required to be kept in the participant treatment file.

2.7.3. Recovery coaching services are delivered primarily face-to-face, secondarily by telephone, or via social media.

2.7.4. Recovery coaching services are delivered individually and in group sessions

2.7.5. Recovery coaching services are non-clinical activities designed to help initiate and sustain the individual in his/her recovery. The scope and types of recovery coaching services may include:

2.7.5.1. Mentoring or Coaching—assists participants with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery;

2.7.5.2. Recovery Resource Connecting—connects participants with professional and non-professional services and resources available in the community that can help meet the individual's needs for recovery;

2.7.5.3. Facilitating and Leading Recovery Support Groups—facilitates or leads recovery-oriented group activities. Some of these activities are structured as

support groups, while others have educational purposes. Many have components of both; and

2.7.5.4. Building Community—helps participants make new friends and begin to build alternative social networks.

2.7.6. Recovery Coach refers participants to the appropriate resources if they are unable to benefit from coaching.

2.7.7. Recovery coaching services are delivered in both clinical setting and the community including:

2.7.7.1. Free standing peer recovery support or consumer run organization locations;

2.7.7.2. Facilities where other outpatient substance use disorder services are provided;

2.7.7.3. Natural community settings;

2.7.7.4. Facilities where inpatient services are provided;

2.7.7.5. Prisons, jails, forensic facilities;

2.7.7.6. Other community based settings; and

2.7.7.7. Supportive housing locations (e.g. Staffed Safe and Sober Housing facilities).

2.7.8. Specific caseload sizes are determined by the complexity of issues presented by the treatment population and the availability of ancillary services in the area.

2.7.9. Frequency of service depends on where the person is in their stage of recovery but no less than monthly.

2.7.10. Recovery Coach working within an agency adhere to the documentation requirements of the agency.

Special Considerations: A clinician or professional person may hold certification as a Recovery Coach; however, a Recovery Coach working with a particular individual as a Recovery Coaching provider cannot also be the clinician (i.e. other professional) who is providing any other services to that same individual. In other words, an individual cannot be the Recovery Coaching provider and other professional provider of a participant at the same time.

Services that a recovery coach does not perform include: counseling/therapy, drug testing, diagnosing of symptoms and disorders, recommending medications or monitoring their use, acting as a legal representative, participating in the determination of competence, and providing legal advice.

Although a recovery coach could work with a larger caseload, it is important to consider the amount of time required by each individual receiving the service. As is the case across the behavioral health field – as caseloads increase, recovery coaches lose their capacity to effectively teach behavioral skills.

Billable recovery coaching services vary across funding sources. Agencies need to ensure that recovery coach services are approved for direct billing and meet criteria for reimbursement and have guidelines on how to bill for these services to foster financial sustainability.

The use of social media creates potential risks of unintentional improper disclosure of a participant's personal and private information. Recovery coaches should be aware of the

limitations of privacy online and ensure that they maintain confidentiality when using social media for recovery coaching services.

2.8. Reciprocity

Rationale: The time and effort a person expends obtaining a certification is valued. In circumstances where an individual has received certification from another state, it is important to have a process for reviewing whether reciprocity to provide similar services in Idaho is appropriate.

2.8.1. Individuals requesting reciprocity for Certified Recovery Coach submit an Idaho Certified Recovery Coach application along with a copy of his/her certification to Idaho's certifying body.

2.8.2. If Idaho's certifying body finds the application deficient in any of Idaho's requirements, a letter explaining needed documentation will be sent to the applicant. The applicant has 30 calendar days to respond with an explanation as to how the requirements will be completed and 60 days to complete said requirements.

2.8.3. Individuals requesting reciprocity for Peer Specialist Recovery Coach designation must have Idaho certification as a Certified Recovery Coach and may apply to the Department-contracted agency to qualify as a Peer Specialist Recovery Coach in Idaho.

Special Considerations: Certification titles and role of recovery coaches vary from state to state. An individual may qualify as a peer under the certification in another state but designation as Peer Specialist Recovery Coach is needed to qualify as a peer in Idaho.

2.9. Organizational Readiness and Responsibility

Rationale: Optimal employment and use of recovery coaches requires awareness and understanding of peer recovery, resilience, trauma, and hope as they relate to the recovery coach providing services and to the participants who receive those services. Recovery coaches can provide a unique perspective to the rest of the team and work to foster positive, effective relationships with the persons served. Organizational readiness is essential to ensure that recovery coaches have a place of employment that understands their purpose and is aware of the strengths and limitations in the recovery coaching scope of practice.

2.9.1. Recovery Coaches are treated as equal to any other staff of the agency, are provided equivalent opportunities for training and pay, and benefits competitive and comparable to other staff based on experience and skill level.

2.9.2. Agency engages in educational opportunities that prepare them to better understand the strengths and opportunities offered by the Recovery Coach.

2.9.3. Agency provides ongoing supervision to Recovery Coach that is non-clinical and trauma-informed, facilitated by a qualified supervisor that is trained on the unique issues of a recovery coach.

2.9.4. Agency ensures that performance evaluations reflect the Recovery Coach role and are completed in a way that promotes recovery.

2.9.5. Agency does not employ or utilize clients who are receiving services at their agency as a Recovery Coach for the agency.

2.9.6. Agency develops a written job description that specifies the duties and responsibilities of the Recovery Coach within that agency.

2.9.7. Recovery Coach assists in developing the plan for care, treatment, or services, when indicated by the participant served.

2.9.8. The plan for care, treatment, or services reflects the inclusion of recovery coaching as determined by the participant served.

Special Considerations: Implementing recovery coaching services likely requires modifications to existing treatment policies and guidelines and possibly the culture within existing treatment organizations. Traditional addiction treatment programs have been structured around a professionally-driven, short-term (e.g., four to six weeks), and residential- or outpatient-based model of treatment. Policies and guidelines have evolved to support these traditional treatment programs and, as a result, require some changes to support the application of a more client-centered, longer-term (e.g., 12 to 24 months), and community-based program. In addition, the culture and philosophical or ideological orientation of the treatment program also need to be modified to incorporate a community-based, client-centered model of care. Both the collective organization and the staff members within all levels of the agency will be impacted by introduction of the RC program. The implementation of the RC program requires the involvement of staff from all levels of the organization and modifications to how the agency engages and provides services to its treatment population.

Supervisors need clear guidance about the role of recovery coaches within the organization and how to support them. Supervisors should receive training in how to supervise recovery coaches, including how to support recovery coaches in maintaining their own recovery, how to deal with relapse and how to help recovery coaches manage workforce challenges.

Safety is an important concern; therefore background checks may be required by law and rule. It is the responsibility of the agency or place of employment to ensure that the Recovery Coach meets applicable background check requirements.

Additional Considerations: *Agencies that employ Recovery Coaches adhere to this standard and all of the Core Standards put forth by the State Behavioral Health Authority.*

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3.0 Certified Family Support Partner (CFSP) Standards

3.1. Definitions

Rationale: A Certified Family Support Partner (CFSP) is a parent or adult caregiver who, through lived experience and specialized training, has acquired an understanding of another parent's situation via the shared emotional and psychological challenges of raising a child living with a behavioral health diagnosis. The relationship between the CFSP and the family being served is mutual, built on a connection and trust not obtainable through other service relationships (e.g. counselor, psychologist, minister) or someone without the shared experience. The CFSP partners with other agencies which serve the child and his/her family to improve the quality of life and opportunities of recovery for the child in the home, school and community.

3.1.1. CFSP has at least one year of lived experience as a parent or an adult caregiver who is raising a child or has raised a child who lives with a behavioral health disorder diagnosis (mental illness or co-occurring mental illness and substance use disorder) and has successfully navigated the various systems of care.

3.1.2. CFSP has gained appropriate knowledge, experience and skill via Idaho's approved certification process.

3.1.3. CFSP understands and lives by a prescribed code of ethics.

3.1.4. CFSP engages, educates, guides and supports family members to help them make successful life changes necessary for recovery. These changes are determined by the family being served.

3.1.5. Lived experience comes from raising a child before his/her 18th birthday and the lessons learned from raising this child.

Special considerations: Raising a child who has lived with a substance use disorder only (without presence of mental illness) does not qualify the parent or caregiver as a CFSP.

3.2. Qualifications

Rationale: Because raising a child who is living with a behavioral health diagnosis is a unique parenting experience shared by those who have parented a child who lives with emotional or behavioral concerns, certain qualifications are needed to understand and know how to navigate the systems involved in raising the child. It is only ethical that the CFSP meets certain criteria when working with children and their families.

3.2.1. CFSP candidate has experience raising a child who lives with mental illness, behavioral or emotional disorders.

3.2.2. CFSP candidate writes a personal Lived Experience Essay which includes challenges, triumphs, problem-solving methods, personal support system, and strategies for living with stressors.

3.2.3. CFSP candidate has completed 40 contact hours of training specifically designated for Idaho CFSPs and approved by the State Behavioral Health Authority.

3.2.4. CFSP candidate passes a post-training assessment established by the training entity and approved by the State Behavioral Health Authority.

3.2.5. A Letter of Completion is mailed to the CFSP candidate. The letter states either approval for the individual to take the certification exam or it provides individualized recommendations for the candidate to complete before moving forward with the certification exam.

3.2.6. Work Experience and Education:

3.2.6.1. If the CFSP candidate holds a bachelor's degree in human services (e.g. social work, psychology, education, sociology, social sciences), he/she documents 100 hours of work experience in the human services field within a year of completing the training. If the 100 hours of work experience are not completed within a year, a review is required by the certifying body.

3.2.6.2. If the CFSP candidate does not hold a bachelor's degree in human services (e.g.. social work, psychology, education, sociology, social sciences), he/she must have a high school diploma or GED and documents 200 hours of work experience in the human services field within a year of completing the training. If the 200 hours of work experience are not completed within a year, a review is required by the certifying body.

3.2.7. CFSP candidate completes 20 supervision hours with a designated Idaho CFSP Supervisor within a year of completing the training.

3.2.8. CFSP candidate passes the Idaho Certified Family Support Partner Exam with a score that meets the standard set by the certifying body authorized by the State Behavioral Health Authority.

3.2.9. Accommodations for the exam are provided as deemed necessary by the individual taking the exam. Examples of accommodations include, but are not limited to, extra time, a separate room, and use of a computer.

3.2.10. CFSP Supervisor is a degreed professional in the field of human services who has supervisory capacity within the agency and is designated as a CFSP Supervisor by the certifying body.

3.2.11. The CFSP Supervisor obtains such designation by applying to the approved certifying body and following the approved process for said designation. The certifying body maintains a current list of approved Supervisors.

3.2.12. CFSP maintains a working knowledge of current trends and developments in the fields of children's mental health, substance use disorders, child and adolescent brain development, education/special education, child welfare regulations, juvenile justice regulations, wellness and recovery, ethical practices and peer support services by reading current journals, books, etc., attending webinars, workshops and conferences as they relate to these fields, and sharing with other CFSPs.

3.2.13. CFSP must be at least 18 years old.

3.2.14. To avoid role ambiguity and conflict, CFSP does not fulfill other service roles (therapist, counselor, case manager, nurse, physician, clergy, etc.) to participants they are providing peer services to.

Special considerations: A clinician or professional person may hold certification as a CFSP; however, a CFSP working with a particular family or child as a CFSP provider cannot also be the clinician or professional person who is providing any other services to that same child or family. In other words, an individual cannot be the CFSP provider and the clinical/professional provider of the same child or family.

Safety is an important concern, therefore background checks may be required by law and rule, but are the responsibility of the agency or place of employment, and are not part of the certification process.

3.3.Training

Rationale: Although lived experience equips the CFSP with knowledge and understanding of family issues and concerns, there are areas in which the CFSP needs to be trained to verify certain skill sets. This training adds to the families' confidence and trust in the CFSP's abilities with whom they are working.

3.3.1. CFSP training includes, at a minimum, the following competency areas:

3.3.1.1.mental illness and substance use disorders and their effects on the brain;

3.3.1.2.advocacy skills used in multiple systems (children's behavioral health system, education and special education systems, child welfare system and juvenile court system);

3.3.1.3.ethics (boundaries, confidentiality, HIPAA, etc.);

3.3.1.4.the awareness of risk factors in participants' behaviors and the ability to access appropriate services;

3.3.1.5.communication skills (interpersonal and professional);

3.3.1.6.effecting change;

3.3.1.7.empowerment;

3.3.1.8.parenting special needs children and family dynamics;

3.3.1.9.the recovery process;

3.3.1.10. the effects of trauma;

3.3.1.11. wellness and natural supports;

3.3.1.12. family-centered planning;

3.3.1.13. maintaining one's wellness;

3.3.1.14. cultural sensitivity;

3.3.1.15. recovery plans; and
3.3.1.16. local, state and national resources.

3.3.2. Training is 40 hours of face-to-face instruction that is conducted by an IDHW DBH approved training entity. The training entity is separate from the certifying body. The certifying body is responsible for verifying competencies.

3.3.3. Curriculum includes all types of learning methods, including role-playing scenarios as a key element of building skills.

Special considerations: Any exceptions to the training as outlined here are reviewed by the certifying body.

3.4. Certification and Renewal

Rationale: Professional certifications are widely found in a variety of professional fields in the United States today. In the field of behavioral health, employers have a general obligation to perform due diligence in ensuring competency to the best of one's ability of the personnel providing services to other human beings. Certification provides employers and participants with evidence and documentation that the certificate holder has demonstrated a certain level of job-related knowledge, skills, abilities, and practical experience. Certification also empowers the holder via the knowledge and skills obtained, as well as by the fact that he/she has successfully accomplished the completion of all requirements.

3.4.1. CFSP meets the qualifications as stated in section 3.2.

3.4.2. Professionals claiming to hold certification status as a CFSP maintain documentation of said certification.

3.4.3. CFSP certification is valid for one year.

3.4.4. CFSP professional renews his/her certification annually by:

3.4.4.1. completing at least 10 hours of approved continuing education (e.g. trainings, workshops, webinars) per year and documenting said education. Continuing education topics can be from any of the competencies listed in the training competencies section in 3.3; AND

3.4.4.2. completing a renewal application; AND

3.4.4.3. maintaining a no-violations record regarding the CFSP Code of Ethics

3.4.5. CFSP follows the Certification Renewal Procedure put forth by the certifying body for Idaho's CFSPs.

3.4.6. CFSP is responsible for ensuring that the certifying body has all current documentation necessary for satisfying the certification criteria.

3.4.7. Employers of CFSPs are responsible to check with the centralized certification agency to ensure that the CFSP which they wish to hire has current certification status as a certified CFSP in Idaho.

3.4.8. The state's approved certifying agency tracks certifications and continuing education status of Idaho's CFSPs.

3.5. Termination, Inactive Status & Reactivation

Rationale: Certification reveals to others that a person has reached a particular level of competency. If these levels are not maintained, a person's certification may be terminated or revoked. Termination can be due to deficient documentation or a Code of Ethics violation.

3.5.1. Deficient documentation is the failure to submit on time requested documentation and application for certification and renewal, or any other requested materials from the certifying entity

3.5.2. A Code of Ethics Violation is the failure to abide by the CFSP Code of Ethics and/or providing false information on documents

3.5.3. Inactive Status is when a CFSP in good-standing requests such status because he/she is unable to meet the requirements for recertification due to a decline in physical or mental health or an extenuating circumstance; such as, a death of a close relative, divorce or marriage, long-term illness of family member, loss of employment, birth of a child, military deployment, or other circumstance that is approved by the certifying body.

3.5.4. Reactivation is accomplished by submitting all required documentation, including a new application packet and verification of CEUs earned within one year of resubmission.

3.5.4.1. It is the applicant's responsibility to ensure that all documentation is completed and submitted.

3.5.4.2. If application is incomplete, a deficiency letter is sent to the applicant and applicant has 30 calendar days to mail all required documents. If 30 days go by and documents are not received by the certifying body, the applicant's certification expires and applicant will need to re-apply, submitting all certification documentation and a new application.

3.5.5. Applicants who have violated the Code of Ethics will, in addition to the documentation in 3.5.4, submit a report that details the nature of the violation, admission of the violation, corrective actions taken and insurance that the violation will not recur. The CFSP Peer Review Board, which is defined by the certifying entity, will determine re-instatement based on the seriousness of the violation, applicant's report and the corrective actions taken.

Special considerations: Inactive status is not granted for the failure to comply with continuing education requirements or a reported Code of Ethics violation.

3.6. Reciprocity

Rationale: The time and effort that a person expends obtaining a CFSP certification is valued. Idaho also values its certification process and therefore, reciprocity from another state's certifying board is permitted as long as certain conditions are met.

3.6.1. Applicant submits a CFSP application along with a copy of his/her certification and either a copy of the certifying state's requirements or a website where these can be found.

3.6.2. If applicant is deficient in any of Idaho's requirements, a letter explaining needed documentation will be sent to the applicant. The applicant has 30 calendar days to respond with an explanation as to how the requirements will be completed and 60 days to complete said requirements.

3.7. Reporting Changes

Rationale: Idaho values its CFSPs and wants to maintain communication with each one. The best way to do this is to know how to reach each CFSP to report CFSP news, events and any changes to the certification requirements. It also aids in networking with all CFSPs in the

state. In addition, this allows IDHW to know how many CFSPs are available in different parts of the state and who they are.

3.7.1. Certified Family Support Partner (CFSP) reports changes in name, address, telephone number and email address.
3.7.2. CFSP reports a change in supervisor's name.
3.7.3. CFSP reports a change in employment status.
3.7.4. CFSP reports a violation in Code of Ethics

Special considerations:
Failure to report changes may result in termination of certification or other disciplinary measure as determined by the certifying body.

3.8. Grievance Procedures

Rationale: There are times when applicants will not agree with decisions made the certifying board. To be properly and fairly heard, a procedure has been identified for the applicant to voice his/her grievance.

3.8.1. Applicant may file a grievance when there is a valid factual reason to do so, such as: being denied certification, questioning the outcome of the review board, or applicant is subject to an action by the certifying board that he/she deems unjustified.
3.8.2. Applicant must file said grievance within 30 days of notice or action deemed unjustified.
3.8.3. Peer Review Board reviews the grievance, but the certifying body has authority to make the final decision regarding any remedy to be made.

3.9. Provision of Family Support Services

Rationale: Depending on the scope of work of the agency in which the CFSP is employed, the tasks carried out by the CFSP can vary. Generally speaking, the services that a CFSP provides should be child-centered, family-driven, youth-guided, community-based with the child's rights protected and culturally sensitive. These services broaden the continuum of care provided in the typical treatment setting. They are not in lieu of other treatment practices; rather they enhance other practices. The purpose for these services is to help the family feel less isolated and more empowered within the recovery process and engaged in the community.

3.9.1. CFSP services may be provided to all participants who are in need of such services.
3.9.2. Participant and/or family member outcomes expected during and after a CFSP works with the family include, but are not limited to:
3.9.2.1. ability to identify and use wellness tools;
3.9.2.2. increased social skills;
3.9.2.3. demonstrated ability to live more independently;
3.9.2.4. re-engaging with support systems that may have been lost;
3.9.2.5. improvement in child's educational goals;
3.9.2.6. improved quality of life;
3.9.2.7. less stress;
3.9.2.8. sense of purpose;
3.9.2.9. increased empowerment;

3.9.2.10. belief that recovery is possible;
3.9.2.11. increased self-esteem;
3.9.2.12. demonstrated ability to self-advocate; and
3.9.2.13. increased participation in community, school and positive recreational activities.

3.9.3. Services provided by the CFSP include, but are not limited to:
3.9.3.1. advocating for the needs of the family;
3.9.3.2. teaching family members and participant how to develop self-advocacy and problem-solving skills;
3.9.3.3. mentoring the participant and family members to instill a sense of hope;
3.9.3.4. role modeling behaviors, attitudes and thinking skills needed for resiliency and coping;
3.9.3.5. helping family members identify and utilize their strengths;
3.9.3.6. role modeling the facilitation of collaborative relationships;
3.9.3.7. teaching participant and family about causes of disorders and importance to adhering to treatment; utilizing evidence-based interventions that assist in meeting goals;
3.9.3.8. assist family members in identifying and connecting to services and community resources;
3.9.3.9. assist family members in articulating their needs and goals in preparing for meetings as well as service plans;
3.9.3.10. provide family-based programs such as classes on parenting special needs children;
3.9.3.11. teach caregivers how to document all activities that pertain to the child's appointments, meetings, needs, goals, and strengths; and
3.9.3.12. assist in preparing for the child's transition to adulthood.

3.9.4. These services shall be delivered primarily face-to-face, and secondarily by telephone or social media.

3.9.5. CFSP shares his/her personal story when appropriate for the benefit of the family with whom he/she is working, keeping in mind that this is but one experience and it does not mean that other families will have the same experience or needs.

3.9.6. CFSP, in collaboration with the family, and any other professionals for which the family gives consent (i.e. the child's behavioral health provider, the child's primary care physician, and any other agency professional that is involved with the child's care), assists in developing an individualized family-centered service plan that includes a description of the family's goals, timeframes for meeting these goals, and the interventions that will assist in meeting the goals.

3.9.7. Frequency and Length of Service:
3.9.7.1. The frequency by which a CFSP meets and works with the family and the length of this service is determined by the child's mental health team (i.e. clinician, parents/caregivers, child [if child is an adolescent], and CFSP) and evidence-based practices.
3.9.7.2. The frequency and length of service are periodically re-evaluated depending on the intensity of the CFSP services needed. The higher the intensity and frequency of the services, the more often a re-evaluation occurs.

3.9.8. CFSP performs activities *with* an individual, and not *for* or *to* the individual so that the child and the family can regain control over their own lives.

3.9.9. CFSP is under the direct supervision of a designated CFSP Supervisor.

Special considerations: CFSP services augment other professional treatment services. Services that a CFSP does not perform include: counseling/therapy, drug testing, diagnosing of symptoms and disorders, prescribing, acting as a legal representative, participating in the determination of competence, and providing legal advice.

3.10. Organizational Readiness & Responsibilities

Rationale: Organizational readiness is essential to ensure that CFSPs have a place of employment that understands their purpose and in order for families to receive the care and support they need.

3.10.1. Organizational Readiness is preparing an organization or agency for the employment of a CFSP, ensuring that staff members understand the purpose of CFSPs and how CFSP duties enhance the organization's mission.

3.10.2. Agency establishes a readiness plan that includes criteria by which the agency hires, supervises, and works to maintain CFSPs.

3.10.3. Agency adheres to Idaho's standard of Certified Family Support Partners and all other agency-related standards.

3.10.4. Agency trains staff members in the purpose and value added by CFSPs.

3.10.5. Agency ensures that all CFSPs are supervised by a licensed mental health provider and that the services rendered by the CFSP are under a comprehensive, individualized, child-centered and family-driven plan.

3.10.6. CFSP Supervisors are designated by each agency that employs CFSPs and the Supervisor is approved by the certifying body. A list of approved CFSP Supervisors is maintained by the certifying body.

3.10.7. Agency utilizes trauma-informed care principles when employing CFSPs.

3.10.8. The state's approved certifying agency tracks certifications and continuing education status of Idaho's Certified Peer Specialists.

3.11. Ethics

Rationale: A code of ethics in any profession guides the professional in areas of role-function, relationships, levels of responsibilities and liability.

3.11.1. Certified Family Support Partner (CFSP) adheres to the Idaho CFSP Code of Ethics while performing duties of a CFSP.

3.11.2. CFSP completes at least annual ethics training, provided by either an employer or via other avenues approved by the certifying body.

3.11.3. Agencies that employ CFSPs provide accessible opportunities for ethics training to all service- providing staff members, including CFSPs, at least annually.

3.11.4. Provider organizations document completion of ethics training in each employee's file, including each CFSP's file.

3.11.5. CFSP keeps personal documentation of completed ethics training as required by the certifying body.

Special considerations: A clinician or professional person may hold certification as a CFSP; however, a CFSP working with a particular family or child as a CFSP provider cannot also be the clinician or professional person who is providing any other services to that same child or family.

In other words, an individual cannot be the CFSP provider and the clinical/professional provider of the same child or family.

Additional Considerations: *Agencies that employ Certified Family Support Partners adhere to this standard and all of the Core Standards put forth by the State Behavioral Health Authority.*

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SPECIAL POPULATIONS

1.0 Pregnant Women and Women with Dependent Children (PW/WDC)

1.1. Description of Population

Rationale: Pregnant women and women with dependent children bring a constellation of unique needs to the treatment setting, which require the provision of specialized treatment services. Due to the risks and complications involved with women who are using substances during pregnancy and/or while raising children, services for PW/WDC are most effective when provided comprehensively and tailored specifically for this population. For the purpose of these standards, PW/WDC includes:

1.1.1. Women with diagnosed Substance Use Disorders who have dependent children
1.1.2. Women with diagnosed Substance Use Disorders who are pregnant
1.1.3. Women with diagnosed Substance Use Disorders who are seeking to regain custody of their children
1.1.4. The dependent children of women with diagnosed Substance Use Disorders.

Special Considerations: For the purposes of these standards, the term *dependent child* refers to those children up to the age of 18 who are the dependents of women with diagnosed Substance Use Disorders. PW/WDC services are currently provided under Substance Use Disorders funding; there is limited research and funding opportunities for PW/WDC within mental health, so application of this standard across Behavioral Health is not absolute.

1.2. Screening and Assessment

Rationale: In order for services to be effective, not only must the woman be evaluated, but also her child(ren), when appropriate, so the comprehensive service plan accurately reflects their strengths, needs, goals, and preferences (individually and as a family). Accurate screening and assessment of the woman and child(ren)'s needs will result in more effective treatment.

1.2.1. Agency has a protocol to ensure that the screening and assessment process evaluates the current statuses of both the woman and her child(ren), as the first step in receiving treatment as a family unit or the mother re-gaining custody.
1.2.2. Agency screening protocol includes identification of participants who fit criteria for being treated as PW/WDC.
1.2.3. If screening indicates that a woman seeking services fits criteria for being treated under PW/WDC, agency assesses participant for presence/severity of needs related to:
1.2.3.1. Substance Use Disorders
1.2.3.2. Trauma history, including physical and/or sexual abuse and neglect
1.2.3.3. Mental health concerns
1.2.3.4. Medical needs including pre- or post- natal care, TB, HIV, sexually transmitted diseases, or other primary care needs
1.2.3.5. Life skills education such as parenting
1.2.3.6. Recovery support services, including but not limited to: child care, case management, transportation, alcohol/drug testing, and housing

1.2.4. If a mother and child(ren) are being served together under PW/WDC, agency assesses child (as appropriate, according to the developmental stage of the child) for presence/severity of needs related to:

1.2.4.1. Substance Use Disorders

1.2.4.2. Trauma history, including physical and/or sexual abuse and neglect

1.2.4.3. Mental health concerns

1.2.4.4. Medical needs including TB, HIV, sexually transmitted diseases, or other primary care needs

1.2.4.5. Recovery support services, including but not limited to: case management, transportation, alcohol/drug testing, and housing.

Special Considerations: Since the age group for children in this population covers a vast range of ages, some screening/assessment criteria may not be appropriate for certain ages/developmental stages of children. It is the duty of the agency/practitioner to ensure that the screening/assessment process is administered in a developmentally appropriate manner for the child being served.

1.3. Organizational Readiness/Staff Training

Rationale: The PW/WDC population has specialized needs that may not be a part of a standard addiction, psychology or social work degree program. It is essential that staff are aware of and trained in these areas to ensure quality and effectiveness of care.

1.3.1. Agency ensures continuing education opportunities related to serving PW/WDC are available to staff.

1.3.2. Staff who have contact with participants are trained on trauma-informed practices, gender-specific, and family-centered services.

1.3.3. Clinical staff are adequately trained on the delivery of trauma-informed, gender-specific, and family-centered treatment practices.

1.3.4. Agency establishes a protocol for contacting law enforcement in the case of reported or suspected domestic violence, child abuse, and sexual abuse.

1.3.5. Clinical staff are adequately trained on the recognition of mental health needs of both women and children, and can provide appropriate referrals for treatment when needed.

Special Considerations: While domestic violence victims are often considered competent adults, the presence of elders and children in these situations may be covered by separate mandatory reporting laws in which case staff have less discretion in making reports to law enforcement. In appropriate situations, any actions taken on behalf of a victim should include their consent and permission, as reporting to law enforcement has been correlated with increased lethality risk for the victim. Agency should link victim to local domestic violence agency to complete safety planning and obtain supportive services when appropriate, as well as consult with legal counsel when developing protocols to ensure compliance with multiple protection laws.

1.4. Service Needs

Rationale: Alcohol and drug use during pregnancy can result in severe complications and risks to the unborn child and often carries a strong stigma for the pregnant woman. Pregnant women or mothers may choose not to receive help for substance use disorders or prenatal care out of fear that they will lose custody of their child(ren) or experience other legal

implications such as incarceration. Another barrier that mothers seeking substance use treatment may face is a lack of adequate child care, which could cause them to not attend appointments, groups, and meetings.

1.4.1. Agency ensures that services for PW/WDC are as accessible as possible for those seeking and/or already involved in treatment.

1.4.2. Service environment encourages open, unbiased, educational, and supportive communication and fosters an ongoing therapeutic relationship for the duration of the treatment stay.

1.4.3. For agencies/practitioners who serve both the woman and her dependent child(ren), a protocol is developed and implemented for development of a comprehensive family treatment plan that reflects the strengths, needs, preferences, and goals of the family unit.

1.4.4. Gender-specific services are available for women, either directly from the agency, or through agreements with other agencies.

1.4.5. For agencies who serve children, age- and developmentally- appropriate services are available for children, either directly from the agency, or through agreements with other agencies.

1.4.6. Agency ensures that support services such as child care, case management, transportation, housing, alcohol/drug testing, and life skills are available when needed, either directly from the agency, or through agreements with other agencies.

1.4.7. As appropriate, agency provides medical services such as (or linkages to): primary medical care, pre- and post- natal care, and primary pediatric care.

1.4.8. Women receiving care under the PW/WDC priority population are provided comprehensive Substance Use Disorders treatment and other therapeutic interventions to address issues such as: parenting, physical/sexual abuse, and healthy relationships.

1.4.9. Children receiving care under the PW/WDC priority population are provided services or referrals that are appropriate to their developmental needs, and address issues such as: sexual or physical abuse and neglect.

1.4.10. Women receiving treatment under the PW/WDC priority population receive counseling and education on topics such as: the effects of alcohol/drug use during pregnancy and while nursing, parenting skills development, sexually transmitted diseases (including transmission to infants), and healthy relationships.

1.4.11. Women and children receiving care under the PW/WDC priority population are linked to comprehensive mental health treatment to address mental health issues.

Special Considerations: Any agency that provides child care services, does so in compliance with all state licensing requirements.

<u>References for Standard 1.0:</u>

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2.0 Service Members, Veterans, and Their Families (SMVF)

2.1. Definitions

Rationale: Service Members, Veterans, and their Families are a continuously expanding population due to the conflicts in Iraq and Afghanistan, which resulted in the deployment of approximately 2.5 million troops since 2001 (The Military Family Research Institute at Purdue University, 2013). Negative effects of war reach beyond those who directly experienced incidents, and spill over to family members and those who are close to the Service Members and Veterans. It is essential to ensure that not only the Service Members and Veterans receive care for traumatic experiences from war, but also the family members, by learning how to cope with having a loved one with service-related issues that cause problems with mental health, substance use, physical injuries, or traumatic brain injury.

2.1.1. **Service Member** – Someone who is currently a member of the Armed Services, including the Air Force, Army, Coast Guard, Marines, and Navy.

2.1.2. **Veteran** – A person who has previously served in the Armed Forces.

2.1.3. **Service Member or Veteran Family Member** – Any family member of a current or previous member of the Armed Forces.

Special considerations: Since there are many definitions for the term "Veteran" (mostly depending on the types of services being applied for/accessed), the above characterization for the term applies to Veterans as referenced in these standards.

"Family members" can include immediate or extended relatives, as well as people who may not be related, but are considered family because they are close.

2.2. Staff Training/Organizational Readiness

Rationale: Due to the high number of Reservists and National Guardsmen veterans who do not have access to VA or TRICARE benefits, increasing numbers of returning Veterans and their family members receive behavioral health care in the civilian sector. In order to provide high-quality and effective care for SMVF, providers must understand military culture and the unique issues faced by SMVF. For example, certain behaviors learned as part of military training or deployment (such as hyper vigilance) can be misinterpreted as symptoms if the provider does not have knowledge of military culture, which could lead to misdiagnosis and ineffective treatment (Kilpatrick, Best, Smith, Kudler, & Cornelison-Grant, 2011).

2.2.1. Staff members are familiar with services provided by the VA, Department of Defense, Veteran's Court, and other agencies that serve SMVF, their requirements for eligibility and referral processes.
2.2.2. Staff members have the knowledge and ability to provide appropriate referrals for SMVFs when needed.
2.2.3. Agency ensures that staff members are educated on commonly used military language and acronyms.
2.2.4. Staff are educated on military culture and understand the behavioral health implications of military culture.
2.2.5. Staff members are educated on combat-related stressors and trauma frequently experienced by SMVF, such as Post-Traumatic Stress, Traumatic Brain Injury, physical injury/amputation.
2.2.6. Staff members understand military family systems and interpersonal dynamics impacted by situations such as: repeated deployments, relocations, and physical or behavioral health stressors.
2.2.7. Staff members understand that Service Members and Veterans often experience more stigma than civilians in regards to seeking help for behavioral health, and provide services in a manner that comes across as supportive and non-judgmental.

2.3. Screening and Assessment

Rationale: Individuals who have current or past personal or family military involvement are exposed to risks and conditions that present unique treatment needs. It is important for the agency to identify SMVFs and the military-connected issues they are facing so appropriate services are rendered according to the participants' needs.

2.3.1. Agency employs a protocol for screening participants for past or current personal/family military involvement.
2.3.2. Agency assesses participants for the presence of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), Substance Use Disorders, co-occurring mental health and substance use disorders, and trauma associated with personal/family military involvement.
2.3.3. Agency assesses SMVF for homelessness or risk thereof.
2.3.4. Family members of service members or veterans are assessed for stressors specifically related to military involvement such as:
2.3.4.1. The presence of spousal/partner or child abuse
2.3.4.2. The extent to which they provide care for the Service Member or Veteran (including children who care for their parents)
2.3.4.3. Financial stressors
2.3.4.4. Familial stressors such as: divorce, reintegration after deployment, impact on children of having deployed parents, and military-related relocations.

2.4. Service Needs

Rationale: As the number of Service Members and Veterans returning from combat increases, so does the need for specialized services geared toward the SMVF population. In response to this need, the Department of Defense (DoD), Department of Veterans Affairs

(VA), and many private sector providers have increased the amount and types of services they provide to SMVF.

2.4.1. Agency provides education and information for SMVF either in individual or in group settings on:

2.4.1.1. Post-Traumatic Stress Disorder (PTSD)

2.4.1.2. Traumatic Brain Injury (TBI)

2.4.1.3. Substance Use/Dependence

2.4.1.4. Family Issues/Relationships

2.4.1.5. Suicide Prevention

2.4.2. Staff are trained to provide trauma-informed care to SMVF.

2.4.3. Service Members and Veterans are offered support services such as case management, transportation, life skills, drug/alcohol testing, child care, and housing, either directly or through referral.

2.4.4. Agency provides services to SMVF in a manner that promotes wellness and encourages resiliency.

2.4.5. When possible and with appropriate consent of participant, behavioral health provider collaborates with the participant's physical health provider.

2.5. Women Veterans

Rationale: According to the Department of Defense (DoD) website, the fastest growing population among veterans is women, who experience unique stressors that their male service member and veteran counterparts do not. Additionally, the DoD reports that twice as many women experience rape or sexual assault while in the military, as civilian women do. Other common issues that women veterans face are: they are often not recognized as "real" veterans, and struggles with transitioning back into civilian life with children, marriage/divorce, work/unemployment, and homelessness.

2.5.1. Agency implements a protocol for identifying women Veterans and Service Members.

2.5.2. Agency employs female staff who can meet the gender-specific needs of female Service Members and Veterans.

2.5.3. Women Veterans and Service Members are screened for previous or current rape or sexual assault connected to their military service.

2.5.4. Agency ensures that services for Service Members and Veterans are not just geared toward men, but also women.

2.6. Military Family Members

Rationale: It has often been said and is a widely accepted notion that military families serve, too. Many stressors that Service Members and Veterans face due to deployment or normal military life experiences will also have a high impact on their family members. It is important for providers to be aware and mindful of the concerns that military family members commonly face, so treatment and services can be tailored to the participants' specific needs.

2.6.1. Staff are aware of the following types of stressors often experienced by military family members, and have adequate training on providing appropriate care and/or referrals:

2.6.1.1. Financial issues

2.6.1.2. Spouse, partner, children or other family members as the disabled Veteran's caretaker
2.6.1.3. Spousal/partner or child abuse
2.6.1.4. Stress related to the reintegration of the Service Member or Veteran into the family unit after deployment(s)
2.6.1.5. Stress related to military-connected relocation

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3.0 Intravenous Drug Use (IVDU)

3.1. Definition

Rationale: Most individuals who use injection drugs inject their drugs intravenously, but subcutaneous injection (i.e., "skin-popping") is also common. Injecting drug use is associated with many physical complications for the individual and is also associated with the transmission of infectious diseases via needle and equipment sharing, blood contact and sexual activity. For the purposes of this standard:

3.1.2. An Intravenous Drug User (IVDU) is an individual who reports intravenous injection as the primary route of administration for their primary or secondary drug of choice and any frequency of use within the last thirty (30) days of the time of the service assessment.
3.1.3. An Injection Drug User (IDU) is an individual who reports subcutaneous injection as the primary route of administration for their primary or secondary drug of choice.

3.1.4. IDU/IVDU meets criteria for substance use disorder dependence/abuse.
3.1.5. Needles and equipment used by IDU/IVDU individuals may include but are not limited to the following: syringes, cottons, water, spoons, citric acid, cookers, or any other materials required to prepare and uptake a substance.

3.2. Screening/Assessment

Rationale: By identifying IDU/IVDUs prior to treatment, providers are better able to deliver effective behavioral health services. Screening and assessment are utilized to help make decisions about appropriate interventions specific to addressing IDU/IVDU.

3.2.2. Agency has a demonstrated method of identifying IDU/IVDUs.
3.2.3. Agency assesses participants for the presence of HIV, hepatitis, tuberculosis, and other infectious diseases.
3.2.4. The assessment includes questions to determine the risk behaviors associated with drug injection leading to adverse health consequences.

3.3. Organizational Readiness/Staff Training

Rationale: Providing effective services to IDU/IVDU requires awareness and understanding of issues associated with IDU/IVDU. It is essential that staff are trained in areas specific to IDU/IVDU to ensure quality of care.

3.3.2. Agency engages in educational opportunities that prepare staff to better understand issues specific to IDU/IVDU.
3.3.3. Agency regularly evaluates program to ensure prejudice, stigmatization and discrimination do not occur.
3.3.4. Staff is able to assess risk factors for Hepatitis, HIV and TB infections.
3.3.5. Staff is trained to provide education and treatment referral for significant IDU/IVDU health issues, including HIV, hepatitis, abscess prevention and wound care.
3.3.6. Staff is educated on high risk behaviors and the effects of these behaviors on the safety of the treatment environment.
3.3.7. Staff understands specific issues associated with IDU/IVDU (i.e. increased risk of overdose, increased risk for infectious disease, associated physical health problems like abscesses and medication-assistive therapy).
3.3.8. Staff is adequately trained in the recognition of health problems associated with IDU/IVDU.

3.4. **Service Needs**

Rationale: Although there are various methods of taking drugs, injection is favored by some users for it's more powerful and immediate effect of the drug. In addition to general problems associated with any injection drug administration there are some specific problems associated with the informal injection of drugs by amateur injectors. Among the numerous possible health repercussions of using a syringe to inject substances are transmission of blood-borne diseases between users, abscesses and cutaneous skin infections, overdose and cardiovascular disease. In addition, the practice of injection drug use and unsafe sex among IDU/IVDUs is associated with an increase in HIV/STDs prevalence rates among IDU/IVDUs. Treatment of individuals who use injection drugs may be complicated by social

and political barriers to treatment and by a lack of resources for public health approaches to treatment.

3.4.2. Agency establishes procedures to ensure an individual identified as an IVDU is admitted to treatment not later than 14 (fourteen) days of the individual making a request for admission.

3.4.2.1. When the agency lacks the capacity to admit an IVDU within 14 (fourteen) days, the agency makes interim services available not later 48 (forty-eight) hours of the request for admission.

3.4.3. The participant-centered service plan includes intervention for addressing specific needs related to IDU/IVDU.

3.4.4. Agency provides education and information either in individual or in group settings on:

3.4.4.1.HIV

3.4.4.2.Hepatitis

3.4.4.3.STI/STDs

3.4.4.4.Safer injection and harm reduction

3.4.4.5.Safer sex practices

3.4.4.6.Overdose management

3.4.4.7.Early treatment and services available to IDU/IVDU

3.4.5. Agency provides information and referrals for screening and counseling for Hepatitis and HIV infection.

3.4.6. Participant is actively involved in developing the service plan and has the opportunity to accept or decline particular interventions.

3.4.7. Agency provides targeted risk-reduction counseling to help participants modify or change behaviors that place them at risk of contraction or spreading infectious diseases.

Special Consideration: Immediate access to treatment is imperative for individuals identified as IDU/IVDU. Agencies should make every effort to admit an IDU/IVDU to services at the time of initial contact. Research shows that individual motivation is paramount in successful program completion; delays in access may adversely impact client success potential (Simpson and Joe, 1993).

3.5. **Female IDU/IVDUs**

Rationale: Female IDU/IVDUs differ from their male counterparts in terms of their background, their reasons for using drugs and their psychosocial needs. Female injection users have different needs in treatment settings based on their differing vulnerabilities and higher likelihood of having domestic responsibilities over male IDU/IVDU. Compared with men who inject, female IDU/IVDUs report being more influenced by social pressure and by sexual partner encouragement. It is common for female IDU/IVDUs to engage in sex work to provide for their partner and/or family and women have specific needs related to pregnancy and child-rearing, whether for contraception or maternal and child health care. Gender sensitive services addressing the specific needs of female IDU/IVDUs are essential for effective treatment of female IDU/IVDU.

3.5.2. Staff is knowledgeable about the specific needs and concerns of female IDU/IVDUs.

3.5.3. Services are provided in a supportive, culturally sensitive and non-judgmental environment.
3.5.4. Staff is knowledgeable about methods for safely reducing, eliminating and/or managing drug use during pregnancy.
3.5.5. Agency provides services for pregnant women and women with dependent children in accordance with the Idaho standard "Specialized Services for Pregnant Women and Women with Dependent Children."

3.6. IDU/IVDUs Living With HIV

Rationale: Injection drug use is a common mode of HIV infection; however, injection drug users living with HIV are often stigmatized and discriminated against, resulting in their receiving inadequate services for both substance dependence and for HIV. Substance use disorder treatment for IDU/IVDUs living with HIV should occur concurrently with HIV treatment and care with staff who are non-judgmental and unbiased staff.

3.6.2. The human rights of IDU/IVDUs living with HIV are fully respected to ensure appropriate treatment and psychosocial support.
3.6.3. IDUs/IVDUs living with HIV have access to a full range of biological, psychological and social interventions including:
3.6.3.1. Primary health care
3.6.3.2. Substitution maintenance therapy for opioid dependence
3.6.3.3. Psychosocial care
3.6.3.4. HIV testing and counseling
3.6.3.5. Antiretroviral therapy
3.6.3.6. Treatment adherence support
3.6.3.7. Post-exposure prophylaxis
3.6.3.8. Treatment of opportunistic infections and co-infections (notable hepatitis B and C and sexually transmitted infections)
3.6.3.9. Access to harm reduction interventions
3.6.4. Staff are educated on the interactions between medication administered in maintenance pharmacotherapy for opioid dependence and medications commonly prescribed for HIV.
3.6.5. Staff are educated on the confidentiality requirements related to HIV status.

References for Standard 3.0:

Centers for Disease Control and Prevention, 2012. Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs Illicitly: Summary Guidance from CDC and the U.S. Department of Health and Human Services. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm?s_cid=rr6105a1_w

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United Nations Office on Drugs and Crime, 2011. Women Who Inject Drugs: A review of their risks, experiences and needs. http://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf

World Health Organization, 2006. Basic Principles for Treatment and Psychosocial Support of Drug Dependent People Living with HIV/AIDS. Retrieved from: http://www.who.int/substance_abuse/publications/basic_principles_drug_hiv.pdf

Simpson, D. Dwayne; Joe, George W. (1993). *Psychotherapy: Theory, Research, Practice, Training*, Vol 30(2), 357-368. Retrieved from: http://dx.doi.org/10.1037/0033-3204.30.2.357

4.0 Children's Mental Health

4.1. Definitions

Rationale: Children are at a different developmental stage than adults, therefore programs for children are designed for their particular treatment needs. However, the appropriate core standards apply as well. The following definitions apply for the purposes of these standards:

- 4.1.1. The term *children* refers to anyone up to the age of 18 who is seeking behavioral health intervention, treatment or support services.
- 4.1.2. Children and their families seeking behavioral health services do so on a voluntary basis or involuntarily if court ordered.
- 4.1.3. The term *behavioral health* is used to include both mental illness and substance use disorders.
- 4.1.4. Transitional-aged Youth, ages 18-24 are older adolescents who are transitioning from childhood to adulthood. They have specific needs of their own, (refer to the Transitional-aged Youth Standards for further information).

Special Considerations: For the purpose of these standards, the term *children* includes adolescents.

4.2. Identification

Rationale: Identifying children who need behavioral health intervention can be challenging, especially younger children. As they grow, children may be involved in a number of entities (e.g. family, school, community, medical care, religious activities, and special interest groups). It takes a system of care across these entities to identify the needs of children.

4.2.1. Pediatricians and medical staff are trained in the areas of children's behavioral health and how to identify for these concerns so that early intervention can take place.
4.2.2. Educators from pre-K through post-high school are trained in the identification of behavioral health concerns.
4.2.3. Family and community members are educated regarding the signs of behavioral health issues.

Special Considerations: Only licensed clinical personnel (e.g. psychiatrist, psychologist, social worker, psychiatric nurse practitioner) can make a behavioral health diagnosis.

4.3. Eligibility

Rationale: Determining who is eligible for Children's Mental Health services is important in order for the agency to adhere to federal and state laws, as well as establishing and utilizing budgets appropriately. This is especially true for public entities (e.g. Idaho Department of Health and Welfare [IDHW]). Private and non-profit agencies must adhere to laws, regulations, policies and procedures according to their organizational practice.

4.3.1. Private and non-profit agencies utilize eligibility and intake processes that coincide with their scope of practice.
4.3.2. Whether eligible or not, the child and family are given an explanation as to why. They are also provided with appropriate resources that will help with the child's recovery. This information is best delivered in written and oral form, and any other form needed to meet the cultural and physical needs of the family.

4.4. Assessment & Evaluation

Rationale: The purpose of an assessment is to accurately determine the strengths, needs, preferences and goals of the child and his/her family. It is also a method for attaining information regarding what has happened to the child.

4.4.1. Assessment and evaluation are comprehensive. They include a clinical interview, a review of data from other behavioral health professionals, the family, the school and the community, and the use of evidence-based assessment tools.
4.4.2. Comprehensive assessment and evaluation is obtained through a face-to-face clinical interview with the child and his/her parents/guardians.
4.4.3. Collateral information, with parental consent, is gathered from other sources, such as school, probation, and other service providers.
4.4.4. In addition to criteria the Core Standard on Assessments, assessments for children specifically consist of at least:
4.4.4.1. An examination to determine a child's developmental level in context with what is normative for the child's age/developmental stage and with respect to his/her culture.
4.4.4.2. Clinical formulation (strengths, needs, goals and preferences)
4.4.4.3. Diagnostic impression
4.4.4.4. Recommendations

4.5. Human Resource Development (Staff Training & Organizational Readiness)

Rationale: Professionally trained staff members are essential in order to properly identify and treat children who are living with behavioral health disorders. The National Institute of

Mental Health (NIMH) defines this as "the explicit and coordinated efforts of an organization to achieve the right number and right kinds of people in the right places at the right times doing the right things to carry out its mission effectively; planning and evaluation; workforce management; education and training; sanctions and regulations."(Sproul, 281).

4.5.1. Clinicians have clinical knowledge of human behavior theory, clinical knowledge and experience in psychotherapy techniques, and an understanding of diagnostic terms as well as an understanding of behavioral development of children and adolescents.

4.5.2. Clinicians have clinical knowledge in the area of family dynamics and they are skilled in working with family members.

4.5.3. Clinicians understand the need for a complete picture of the child's life and therefore have the ability to collaborate with other entities for which the child is involved (e.g. school, probation, and other types of therapeutic professionals).

4.5.4. Clinicians are knowledgeable of trauma-informed care and how trauma affects children.

4.5.5. Agency provides access to on-going education or training opportunities for its staff members in the areas of children's behavioral health issues.

4.5.6. Agency readies its staff and the environment with a child-friendly attitude and atmosphere.

4.6. Child-Centered and Family-Centered

Rationale: For children to recover from behavioral health disorders, services need to be individualized or child-centered, as no two children with the same diagnosis are the same. The same goes for families; their needs and strengths vary.

4.6.1. Children and families determine the types and mix of services they receive.

4.6.2. Families and surrogate families of children with mental illness are full participants in all aspects of the planning and delivery of services.

4.6.3. Children with mental illness receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.

4.6.4. Children with mental illness receive services within the least restrictive, most normative environment that is clinically appropriate.

4.6.5. Children with mental illness receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

4.6.6. The system of care is culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

4.6.7. The needs of children and families can more effectively be met through flexible funding strategies than through categorical funding restricted to the most expensive resources.

4.7. Support Services

Rationale: Raising any child takes multiple skills, a high level of responsibility, maturity and resilience, as well as support from others. Families living with children who have behavioral

health disorders require the same, but also services that educate and support them in ways that are mindful of their unique family situations. These services promote the well-being of children and families and are designed to increase the strength and stability of families, to increase the parents' confidence and competence in parenting abilities, and to enhance child development.

4.7.1. Family Support Services (e.g. Certified Family Support Partners, behavioral health education, peer-to-peer supports, advocacy, education, self-advocacy and respite care) are provided by community agencies, and families are referred to programs that provide these services.

4.7.2. Youth/Adolescent Support Services (e.g. opportunities for youth to provide input about prevention, awareness, anti-stigma, and self-advocacy) are provided by community agencies.

4.7.3. Family Preservation Services are available and address the following:

4.7.3.1. Family structure

4.7.3.1.1. Provide individual and relationship counseling for parents when needed

4.7.3.1.2. Provide family counseling when appropriate

4.7.3.2. Home and budget management

4.7.3.3. Communication

4.7.3.4. Behavior intervention techniques

4.7.3.5. Parenting a child with behavioral health challenges to include, but not be limited to self-advocacy training, self-case management training and consumer training

4.7.3.6. Problem solving

4.8. Outpatient Services

Rationale: Outpatient services, also referred to as outpatient therapy and in-home services, is defined in the 1999 Needs Assessment of Idaho's Children, as:

"Serious Emotional Disturbances (SED) and their Families, as individual, group, family, play and other therapies and/or counseling. Primary components include face-to- face contact with a trained professional; goal-directed strategies that are planned and implemented; the capacity to deliver services in the home, schools, and other community locations; and services offered at multiple levels of intensity. Outpatient treatment is among the least restrictive and is the most commonly used form of treatment provided to children and families in Idaho."

4.8.1. Outpatient is inclusive of all services that provide mental health treatment to a child or family and is delivered in the family home, at school, in the community or in a mental health clinic including psychiatric evaluation and treatment.

4.8.2. Types of outpatient services include, but are not limited to: brief intervention, Community-Based Rehabilitative Services (formerly PSR), psychiatric services, relationship therapy, individual therapy, play therapy, family therapy, group therapy, and day treatment.

4.8.3. All outpatient services are made available or recommended to children and their families when the need for that intervention is demonstrated in the comprehensive assessment.

4.8.4. Outpatient services are child-centered and family-focused as demonstrated by the comprehensive assessment and the service plan.

4.8.5. Discharge from outpatient services is completed at any time that the family and/or clinician believe it is time to end treatment or the courts determine a change in placement or termination is in order.

4.9. Out-of-Home Placements

Rationale: Behavioral health disorders range in severity and intensity at any given moment in a person's life, therefore requiring a continuum of care to meet the needs of individual children. Included in this continuum are out-of-home placements which are at the most restrictive end of the spectrum. In Idaho there are two types of out-of-home placements: residential treatment centers and therapeutic foster care.

4.9.1. **Residential Treatment** - A 24-hour licensed facility that offers behavioral health treatment specifically for children.

4.9.1.1. Placement in such a facility is to be done in a least-restrictive, philosophically-appropriate approach to meet the child's treatment needs. Geographic distance from family residence is considered.

4.9.1.2. A pre-placement staffing is held which includes the referring/placing provider, parents/guardians, child (if appropriate), and any other person deemed necessary by the referring/placing provider and the family.

4.9.1.2.1. The staffing results in a written document that focuses on the following areas for determining necessity:

4.9.1.2.1.1. Less restrictive options and documentation of past failures in lesser restrictive placements

4.9.1.2.1.2. History of hospitalizations

4.9.1.2.1.3. Specific behaviors requiring residential treatment

4.9.1.2.1.4. Outcome expectations

4.9.1.2.1.5. Criminal Behavior

4.9.1.3. A service plan is established that focuses on the specific needs of the child, incorporating periodic family involvement and periodic referring-agency involvement. At a minimum, the service plan includes:

4.9.1.3.1. Concrete and measurable objectives

4.9.1.3.2. Level of parental involvement necessary for positive outcomes

4.9.1.3.3. Preparing parents and family for the placement

4.9.1.3.4. Targeted behaviors to be addressed in the treatment center including the possibility of trauma-related effects as a result of separation from family and community

4.9.1.3.5. Initial discharge planning

4.9.1.3.6. Cultural considerations that need addressed

4.9.1.3.7. Visitation schedule for parent and staff

4.9.1.3.8. Designation of primary case manager and his/her responsibilities

4.9.1.3.9. Educational strengths and needs

4.9.1.3.10. Communication and collaboration with the facility, referring/placing provider, family, school, juvenile justice and community based service providers

4.9.1.4. A discharge plan that includes after-care services and re-entry activities is established 30 days prior to discharge.

4.9.1.4.1. This includes the collaboration and participation of all applicable parties (i.e. the facility worker, referring/placing provider, family, school, juvenile justice and community based service providers).

4.9.1.4.2. Roles and responsibilities of each entity are delineated.

4.9.1.5. All possible payment methods for the cost of this type of care are explored with the family prior to placement.

4.9.1.5.1. Families are aware of at least an estimate of their share of the cost prior to placement.

4.9.2. **Therapeutic Foster Care (TFC) -** Children are placed in natural home settings with families who receive advanced training to care for children with severe emotional problems. Children are placed in homes that are in their own community near family which enables them to attend their home school, thereby maintaining relationships with their social network. This proximity with what is familiar makes it possible for services to be delivered in the child's own environment and to deal with the actual problems associated with each of these entities.

4.9.2.1. Wrap around services are provided to children in TFC.

4.9.2.2. Meets the needs of both involuntarily and voluntarily placed children.

4.9.2.3. Parents/guardians are involved in TFC treatment process as a partner with the treatment team.

4.9.2.4. A continuum of support is available for the TFC family 24-hours a day, 7 days a week.

4.9.2.5. A service plan that identifies a course of treatment and clear delineation of roles is developed with all parties involved in the child's life at the table

4.9.2.6. Parents and family members are prepared for the placement.

4.9.2.7. Aftercare and transition planning begin at initial placement and strategies for transition no later than 90 days prior to the anticipated date of exit from TFC.

4.9.2.8. Families providing TFC meet the following criteria:

4.9.2.8.1. Hold a current foster care license

4.9.2.8.2. Complete required FC training for licensure

4.9.2.8.3. Complete 30 hours of TFC training that includes, but is not limited to crisis management; observation and documentation; implementation of positive behavior techniques; parenting techniques; treatment plan implementation; medication management; CPR, First Aid and HIV awareness; and involving the child's family in treatment delivery.

4.9.3. **Voluntary Placement** – A child is placed into an out-of-home service/program willingly and intentionally by the parents.

4.9.3.1. Parents sign a Voluntary Placement Agreement

4.9.3.2. Parents are responsible for all or partial cost of the placement depending on insurance and financial means of the family.

4.9.3.3. Parents are actively involved in the placement of child as much as possible.

4.9.4. **Involuntary Placement** – A child is placed in an out-of-home service/program unwillingly by the parents; usually set forth by a court order.

4.9.4.1. Parents sign an Involuntary Placement Agreement

4.9.4.2. Parents are responsible for all or partial cost of the placement depending on insurance and financial means of the family.

4.9.4.3. Whenever possible, clinicians should always consider voluntary placements before recommending involuntary placements.

4.9.4.4. Parents are actively involved in the placement and treatment of child as much as possible.

4.9.5. Education while in Out-of Home Placement

4.9.5.1. Every attempt is made to continue a child's education whether it is through the facility's on-campus school, the public school or other alternatives.

4.9.5.2. A child's educational strengths and needs are conveyed to the treatment facility as part of the service plan.

4.9.6. Discharge

4.9.6.1. Youth can be discharged from a treatment facility within 3 days when consenting adult provides written request for discharge unless there is other legal authority to hold child in the treatment facility.

4.9.7. All state rules and agency policies are followed as they pertain to out-of-home placements.

Special Considerations: As needed, some children with behavioral health disorders may be placed in Foster Care through the Division of Family and Community Services (FACS). All DHW FACS rules and policies apply in these circumstances.

4.10. Inpatient Hospitalization

Rationale: At the extreme end of the continuum of care is inpatient hospitalization for children who are experiencing serious acute disturbances. There are two types of inpatient hospitalizations in Idaho, community-based hospitals and psychiatric hospitals.

4.10.1. Community-based Hospitalization/Acute Psychiatric Hospitalization

4.10.1.1. Eligible children are under 18 years of age and are experiencing a behavioral health emergency. Parents are responsible for the placement; therefore a Voluntary Placement Agreement is not necessary.

4.10.1.2. A family can apply to DHW for financial support for children's mental health services, including a Fee Determination of the family's financial responsibility.

4.10.2. Psychiatric Hospitalization

4.10.2.1. In Idaho, State Hospital South (SHS) is the only psychiatric hospital for children.

4.10.2.2. Referrals to SHS are the responsibility of the DHW-CMH and therefore children can only be placed at SHS through DHW.

4.10.2.3. A stay at SHS is expected to last over 45 days.

4.10.2.4. The treating psychiatrist at an acute psychiatric hospital may initiate a referral to SHS by contacting the CMH program in the region where the child lives.

4.10.2.5. Placement at SHS is obtained through a voluntary placement agreement between the child's parent or guardian and the regional CMH program.

4.10.2.6. Parents and family members are prepared for the placement.

4.10.3. Children are never housed or treated with adults.

4.10.4. Discharge/Aftercare Planning

4.10.4.1. Planning begins at point of entry into the hospital and is a cooperative process involving the child's clinician, the facility, the parent or guardian and others selected by parent/guardian as having a role in the child's success toward transition.

4.10.4.2. One week prior to discharge from SHS, a conference call between the parent or guardian, SHS, the CMH clinician and others as identified and approved by family takes place focusing on the coordination of aftercare services.

4.10.4.3. A discharge/aftercare plan is documented outlining specific goals, services and responsibilities prior to discharge.

4.10.4.4. Any variance to these standards is documented and approved by division administration, unless otherwise noted.

4.10.4.5. All state rules and agency policies are followed as they pertain to inpatient hospitalization placements.

4.11. Transition Planning

Rationale: When children age out of children's behavioral health services it is important that a smooth transition occurs from children's services to adult services. Behavioral health concerns do not dissipate when children turn 18 years old. Guidance and support remain a necessary aspect of a lifelong recovery process, especially at a vulnerable stage of development.

4.11.1. Transition plans begin for children as early as age 16 and no later than age 17.5.

4.11.2. Child and, if appropriate, family select a transition team that will support him/her in the areas of identity formation, supportive relationships, physical and mental health, employment and career opportunities, educational opportunities, life skills education, living situation, community connections and community life functioning.

4.11.3. A transition plan is developed with the child that includes: demographic, diagnosis and social history factors; strengths (interests, dreams, positive personal characteristics, personal and family resources); current challenges related to transition; at least three goals; behavioral health resources (e.g. crisis, therapist, psychiatrist, other behavioral health professionals, health insurance); and a summary of coping strategies that have been useful for the child in the past.

4.11.4. At least 30 days before discharge, the young adult is connected with another therapist, a psychiatrist, and/or a medical home provider who is knowledgeable of behavioral health care.

4.11.5. At the time of discharge from children's services, the young adult is provided a copy of his/her transition plan and various resources that will help him/her through the transition (e.g. phone numbers of support groups and support agencies, websites, books, articles, etc.).

4.12. School Mental Health Services

Rationale: The Idaho Children's Mental Health Services Act of 1998 requires the collaboration of multiple agencies (i.e. DHW, DJC, SDE, counties and school districts) to plan and to develop comprehensive mental health services for children with serious emotional disorders (SED) and their families.

4.12.1. School mental health services are delivered in a school setting to a diverse population of children with behavioral or emotional disorders.
4.12.2. School mental health services consist of a wide array of comprehensive services.
4.12.3. School mental health services are delivered in a coordinated manner, designed to strengthen individual and family functioning and to prevent more restrictive placement of children.
4.12.4. Schools and State agencies may contract with private providers to carry out these services.
4.12.5. School mental health services are delivered by qualified professionals who meet licensure/certification requirements of their specific service area.
4.12.6. The provision of school mental health services is directed by a treatment plan that identifies specific, measurable objectives and is developed cooperatively between the district or agency, the family and other parties as agreed to by the family.
4.12.7. The effectiveness of services is determined through an ongoing quality assurance process that, at a minimum, measures consumer satisfaction and outcome achievement.
4.12.8. School mental health services include a family support component that, at a minimum, coordinates parent support and education with other community providers.
4.12.9. Agencies provide services to schools according to the agency's regulations and policies.
4.12.10. School mental health services are not reimbursed both by Medicaid and through a contract for the same service.

Special Considerations: School mental health services can include programs and services for teens at risk of behavioral health disorders when funding for this population is available. Schools are encouraged to include education, awareness and referral activities for staff to help them identify students in this population. Community agencies are also encouraged to reach out to this population to provide education, support and resources to them. These programs are intended to prevent suicide and to assist teens-at-risk in developing resiliency techniques.

4.13. Care Coordination with other Programs/Agencies

Rationale: Coordination is fundamental in the system of care for children who have behavioral health concerns based on the multiple needs of these children and their families. Their needs cut across a variety of systems making it imperative that linkages to these other systems and a blending of services be made to ensure an efficient delivery of services. Behavioral health, education, child welfare, health, juvenile justice, and other agencies need to work together in order for a child's needs to be met.

4.13.1. Parents/guardians have the right to determine with whom and when their child's information is shared.
4.13.2. Each agency works with other agencies and with families to share information in the most confidential manner while adhering to HIPPA and other applicable confidentiality laws and rules (see Special Considerations).
4.13.3. Agencies have a policy regarding the coordination and sharing of information with the divorced and separated parents of a child who is under their care.

Special Considerations: Practitioners/agencies may refer to Idaho Administrative Procedures Act (IDAPA) 16.07.20 (Substance Use Disorders), IDAPA 16.07.37 (Children's Mental Health),

Idaho Statutes 20-520, 16-2428, and 37-3102, HIPAA, and CFR 42 for specific guidance on sharing of participant information.

References for Standard 4.0:

Idaho Department of Health & Welfare Division of Behavioral Health Children's Mental Health Manual, 2007

Idaho Department of Health & Welfare's Family and Community Services Policy Memo, Implementation Protocol, Comprehensive Assessment Policy 01-04

IDAPA Medicaid Basic Plan Benefits 16.03.09 (Archive 2012).

Children's Mental Health: Creating Systems of Care in a Changing Society, (Sproul, 1996)

I.C. 16-2408 Discharge, Juvenile Proceedings

5.0 Transitional Age Youth (TAY)

5.1. Definitions

Rationale: When Transitional Age Youth are correctly identified at intake for services, providers can then provide behavioral health assistance that meets the distinctive requirements of this populace. They have special impediments that require unique assistance because they are beyond the age of children's programs but are frequently unprepared for or unentitled to adult services. Legally, individuals become adults at 18 years of age; however, young people frequently reside with their parent(s) and/or other caregiver(s) into their 20s.

5.1.1. Transitional Age Youth (TAY)-Individuals between the ages of 18 and 25 who may or may not live in the same household as their parents or primary caregivers.

5.1.2. Transitional Age Foster Youth (TAFY)-Individuals between the ages of 18 and 25 who have been cared for in the foster system as children/youth.

5.2. Screening and Assessment

Rationale: Because TAY are at a critical age transition and experiencing unique issues that are unlike children or older adults, services must be directed at meeting specific issues TAYs face; beyond just SUD and co-occurring disorders, and including a whole host of other age-specific issues.

5.2.1. Agency has a protocol for identifying Transitional Age Youth prior to placement in services.

5.2.2. Assessment can be done with the adolescent alone, parents/caregivers alone, and/or parents/caregivers and adolescents together.

5.2.3. TAY participants are assessed for their living situation/family relations/family history/foster care involvement.

5.2.4. Participants are assessed for the presence, nature, and complexity of co-occurring mental health and substance use disorders.

5.2.5. Agency has a protocol for assessing TAY for their developmental stage.

5.2.6. TAY participants are assessed for educational performance.

5.2.7. TAY participants are assessed for delinquent and or risky behaviors.

5.2.8. TAY participants are assessed for justice involvement.

5.2.9. TAY participants are screened for service linkage needs such as public assistance (e.g., WIC, Food Stamps, etc.)

5.3. Staff Training/Organizational Readiness

Rationale: Given the unique circumstances relating to treatment of TAY, there exists an increased need to ensure that staff are adequately prepared to meet the treatment needs of TAY with behavioral health, substance use, or co-occurring disorders.

5.3.1. Agency ensures that staff members are aware of unique treatment needs of TAY, as well as treatment modalities that address these particular needs.

5.3.2. Agency strives to ensure staff members are aware of cultural differences amongst TAY and ensure that the services made available take into account the cultural differences amongst TAY; to prevent impediments to successful services based upon staff member's own cultural values.

5.3.3. Staff members who work with TAY are trained to provide appropriate linkages to community resources (e.g., WIC, Food Stamps, etc.)

5.4. Service Needs

Rationale: TAY experience or have exposure to certain realities that result in specific treatment needs. TAY often have not developed good decision making skills, healthy relationships, or a network of positive alternatives to the negative behavior in which they frequently engage. Quite often TAY have not had the benefit of a stable family life in which to develop these key critical skills.

5.4.1. TAY are educated on healthy peer and family relationships and interpersonal skills.

5.4.2. Service providers teach TAY positive alternatives to behavior that causes them to engage in substance use or behavioral issues.

5.4.3. For TAY who have substance use disorders, agency provides education on community-based tools that are designed to address substance use.

5.4.4. TAY are educated on how to apply for necessary public assistance programs such as WIC, Food Stamps, etc.

5.4.5. Agency supports education and employment needs of TAY by offering convenient hours of operation, assistance with job searching, and linkage to GED and higher education programs.

5.4.6. Agency encourages and facilitates family or support person involvement in TAY treatment stay when appropriate.

5.4.7. Agency endeavors to instill upon contracted service providers the optimal results for treatment when TAY are welcomed, supported, nurtured and valued for the positive contributions they have to offer: to their own treatment, to the service provider environment and to the greater community at large.

Special Considerations: Since the age span of TAY can cover different developmental stages, it is important to ensure that TAY are receiving services that are appropriate to their current stage of development.

There are times when the involvement of family during TAY treatment stay would not be appropriate (e.g., restraining order, child protection court, etc.), or their inclusion would constitute a substantial risk of physical or emotional harm to the participant. Prior to engaging the TAY's family in treatment, provider ensures that it is safe and beneficial for the TAY to do so.

5.5. TAY With Co-Occurring Disorders

Rationale: Data from the National Survey on Drug Use and Health (NSDUH) indicate that, among young adults ages 18-25 with a serious mental illness, 48% report past-year illicit substance use, and 36% meet criteria for a substance use disorder. In a large sample of emerging adults utilizing mental health services, substance use disorders were the principal psychiatric diagnosis for 8% of 16- to 21-year-olds, 13% of 22- to 23- year-olds, and 15% of 24- to 25-year-olds TAY with COD receive treatment for both MH and SUD. Youth who experience a major depressive episode were twice as likely to begin using alcohol or an illicit drug, compared to youth who had not experienced a major depressive episode. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767039) *Substance abuse and problematic patterns of substance use among youth can lead to problems at school, cause or aggravate physical and mental health-related issues, promote poor peer relationships, cause motor-vehicle accidents, and place stress on the family.*

5.5.1. Service providers are educated on the prevalence of SUD amongst TAY with co-occurring mental health and substance use disorders.

5.5.2. TAY may have been self-referred has having a Substance Use Disorder or co-occurring disorder.

5.5.3. TAY may have been referred by a third party entity has having a Substance Use Disorder or co-occurring disorder.

5.6. Pregnant and Childbearing TAY

Rationale: Parenting at any age can be challenging, but it can be particularly difficult for adolescent parents. In 2012, just over 305,000 babies were born to teen girls between the ages of 15 and 19. Childbearing during adolescence negatively affects the parents, their children, and society. (http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy). *TAY who experience pregnancy are less likely to finish high school; TAY who experience pregnancy are more likely to rely on public assistance, more likely to be poor as adults; and are more likely to have children who have poorer educational, behavioral, and health outcomes over the course of their lives than do kids born to older parents.*

5.6.1. TAY who are pregnant, are linked with additional resources on pre-and post-natal care available in their community.

5.6.2. TAY who are of child-conceiving age will be afforded education on making good choices regarding pregnancy, as dictated by the individual TAY's needs.

5.6.3. TAY who are, or who may be, pregnant will be afforded education on the effects of alcohol or drug use by mothers on infants, such as fetal alcohol syndrome.

5.6.4. TAY who are pregnant or have already had children are assisted with applying for public assistance such as WIC, when necessary.

References for Standard 5.0:
http://contemporarypediatrics.modernmedicine.com/contemporary pediatrics/news/transitional-aged-youth-and-substance-use-teenaged-addicts-come-age?page=full
http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/
http://www.findyouthinfo.gov/youth-topics/teen-pregnancy-prevention
http://pathprogram.samhsa.gov/ResourceFiles/cyw4m4nr.pdf
http://www.samhsa.gov/co-occurring/
http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders

http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/minority-health-and-health-disparities
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767039/
http://www.findyouthinfo.gov/youth-topics/substance-abuse

http://www.findyouthinfo.gov/youth-topics/substance-abuse/screening-tools-can-be-used-assess-youth-substance-abuse

Quality Assurance Program

Division of Behavioral Health

Submitted by Candace Falsetti- CO 3rd, 4-24-2015, #2

2015

Idaho Department of Health and Welfare

Quality Assurance Program

Quality Assurance Program

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Quality Assurance Program

Revisions:

Title	Date	Revision #	Notes
Quality Assurance Program	**March 16, 2015**		
“”	**March 27, 2015**	**1**	**Added definitions Clarified role of Qa Checked BPA QA description Checked IYTP description**
Same	**April 24th, 2015**	**2**	**Clarified role of QA compared to Contract Monitors**

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): 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: A program for 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

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.

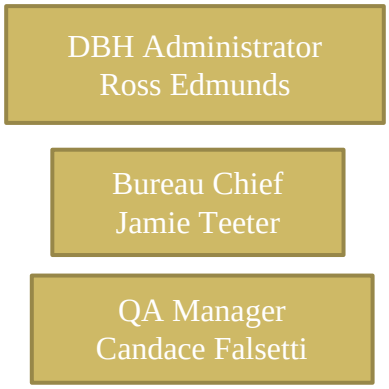
A set of key outcome/performance measures that will be used for evaluation are in development. The measures will be identified based on the following philosophy:

- 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.

A list of possible 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.

Once key indicators of performance and outcome measures have been identified the process for reporting of outcomes will be developed. Outcome measures will be utilized to evaluate the impact of the QAP.

DBH QA Management Structure



Quality Assurance Program

Quality Assurance Methodology

The Quality Assurance (QA) methodologies that will be employed will include review of State operated and contractor records, reports, policy and procedures, site visits, direct interviews, and surveys. QA findings will be assessed and addressed as quality improvement (QI) through various quality techniques such as Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis.

QAP Functional Areas

QAP identifies the areas of responsibility specifically assigned to the Quality Assurance Unit. These functional areas are listed below.

Idaho Behavioral Health Plan (IBHP)

Managed Services Contractor (SUDS)

19-2524

Preadmission Screening and Resident Review (PASRR)

Continuous Quality Improvement (CQI)

Facility Approval

Critical Incident

Jeff D – Quality Management Improvement Activity (QMIA) plan Development

Idaho Youth Treatment Plan (IYTP) Evaluator

Quality Improvement (QI) Work Plan

Performance Improvement Projects (PIPs)

A high level description of each functional area follows.

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

Quality Assurance Program

DBH QA monitors the IBHP progress toward the goals for transformation through:

i. Evaluating targeted IBHP responsibilities and processes to ensure they are within an acceptable range meet state and federal laws, requirements and standards.

   IBHP responsibilities that DBH QA will evaluate include, but are not limited to:

   a. Transformation
   b. Care Management:
      i. Authorization and Denials
      ii. Records of ICM, Discharge Coordination
      iii. Care Coordination with PCP
   c. Provider Network:
      i. Provider credentialing
      ii. Provider audit findings, action plans
      iii. Provider training plans
   d. Quality Assurance:
      i. Member Rights
      ii. Member Satisfaction

ii. Assessing the impact of IBHP processes based on the quality aims set by the Institutes of Medicine (IOM) for quality assurance: effectiveness, efficiency, equitable, safe, timely, client centered.

   The impact will be measured utilizing identified key outcome measures

Managed Services Contractor (SUDS)

In addition to, and in support of, contract monitoring central office 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.

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 ensure that consideration is given to the behavioral health needs as part of presentencing determination.

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. If the information is not adequate to develop a treatment recommendation the DBH clinician requests a full MHE. Information regarding treatment recommendations are communicated to the PSI and are notated in the final report.

In addition to the Utilization Management processes noted 19-2524 staff work with IDOC and 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 screening to develop recommendations, which may include a comprehensive MH evaluation. 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.

Quality Assurance Program

Facility Approval

In accordance with Idaho Statute and IDAPA all SUDs provider must have facility approval by the state authority. DBH QA staff designated lead completes all initial site certifications and monitors the work of the MSC.

DBH is in the process of developing IDAPA rule for Facility Approval for a Behavioral Health Agency.

Critical Incidents

Regional Programs report all Critical Incidents to central office administrators and QA. Critical incidents are also reported by the IBHP and 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

Jeff D Quality Management Improvement Activities (QMIA) Plan Development

DBH QA will work with the Jeff D implementation team to develop a Quality Management Improvement Activities (QMIA) plan that will define the QA processes to be implemented in regards to Jeff D Members.

Idaho Youth Treatment Program (IYTP) Project Evaluation

QA acts in the role of Project Evaluator for the grant for the Idaho Youth Treatment Program. The Project evaluator performs a variety of monitoring, evaluating and reporting functions as described in the IYTP Project Evaluation Plan.

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)

Systemic issues that are appropriate may be addressed through a PIP. A PIP 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.

Quality Assurance Program

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:

Quality Assurance Program

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

Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
Client/Family Centered (Engagement)	Parent/Family voice, choice, and preference are assured throughout the process	What proportion of cases involves caregivers and children in case planning and service delivery?	Number of cases in which client or family were involved in service planning Number of cases in which age-appropriate children were involved in case planning	Client satisfaction surveys Direct client survey (phone calls?)
		How do clients/family perceive the quality of the collaboration?	Client and family perception of collaborative service delivery	
	Collaborative Assessment of Environmental Factors	Are client and family strengths and needs integrated into treatment?		
	Services are maintained	Are clients 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 Clients have improved family mental health/substance abuse and relationship status	To what extent are family strengths and needs assessed and integrated into treatment?	Items from the *CANS*, CALOCUS, CAFAS , GAIN, LOCUS Measure for Social connectivity? Wellness Assessment (Optum's WA)	Results of outcomes tools
	High utilizers	Are clients and families receiving appropriate services?		Encounter data
Linkages	Evidence of Care coordination with other mental health providers	To what extent is the treatment plan coordinated with other agencies?	Treatment plan indicates coordination with other agencies as needed Client perceptions of service availability, access post-	

Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
			discharge	
	Evidence of Care Coordination with Primary Care	To what extent is treatment integrated?	Treatment plan indicates coordination with other primary care	
	Evidence that physical health issues are assessed	To what extent are physical health issues assessed?		
Safety	Risks are identified and clients 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		

Business Psychology Associates (BPA)
Standard Operating Procedures

Dept: **Provider Network Management (PNM)**

Title: **SUD-Provider Audits**

Current Review/Revision Date:
Original Effective Date: 10/22/2014
Revision No.:

Purpose:

To establish guidelines which meet BPA contractual obligations under the State of Idaho Substance Use Disorders (SUD) contract for the completion and follow up of Clinical Chart Audits, Clinical Supervision Audits, Pregnant Women or Women with Children (PWWC) Chart Audits, Evidence-based Practices and Programs Audit, Recovery Support Services Audit, Facility Renewal and For Cause Audits.

Policy:

BPA's Clinical Regional Coordinators (RC) will conduct annual audits of all contracted BPA SUD Treatment Provider and RSS Network. RC staff will conduct initial Technical assistance (TA) audits of new network providers within 90 calendar days of the agency joining either of the aforementioned networks as applicable.

The audit tools created by BPA and are based on IDAPA Code 16.07.20, the BPA Provider Contract, the Northwest Frontier Addiction Technology Transfer Center (NFATTC) and the DHW Clinical Supervision "How to Manual" as applicable.

Audit scores will determine the audit schedule:

- If a provider scores 80% or greater, the next audit of same type will be conducted in one year.
- If a provider scores below 80%, the next audit of same type will be conducted every three months until scores are above 80%.

Two consecutive audits that score below 80% may result in inactivation, recoupment of claims dollars, and loss of incentive dollars.

Providers may appeal audit results by submitting a written notice of appeal to BPA within 10 business days of receiving the audit results. The provider Network Manager, the RC that conducted the audit and, if clinically appropriate, the Manager of Clinical Services, the Medical Director and other RC staff will review the appeal. Appeal results will be communicated in writing to the provider and DHW within 30 calendar days of BPA receiving the appeal.
BPA will report to DHW a quantitative summary of audit results on a quarterly basis per our contractual obligation.

All Audits:

1. Regional Coordinator will check the SUD Provider Audits Due workbook \\Pv1\office\Departments\Provider Relations\SUD Provider Relations\Audits\SUD Provider Audits Due.lnk and contact the agency representative to schedule on-site audits at the agency location.

2. Utilize the appropriate audit tool to score the agency.

3. At the completion of the on-site audit the RC will meet with the provider to complete a brief overview of results. The RC will then enter the results into the appropriate eCura event under the provider's eCura file.

4. The RC will request a Corrective Action Plan if the overall audit score is less than 80%. The RC will write the formal request by utilizing the applicable template letter and submit it to the PNM specialist along with the results of the audit. The request for Action Plan must detail the specific areas of deficiencies that need to be addressed.

5. The RC will submit all audit results including any applicable Corrective Action Plan Request/Findings Letter to the PNM specialist within 5 business days of the audit being concluded.

6. The PNM specialist will review the audit eCura event for accurate scores, date of the audit, funding source involved, whether Adult and/or Adolescent, who conducted the audit and the date the next audit is due and save all final reports in the appropriate folder at the following location: \\Pv1\office\Departments\Provider Relations\SUD Provider Relations\Electronic Provider Files**.** The PNM specialist will also complete the date a Corrective Action Plan was requested of the provider, date received by the provider, whether approved by BPA and also track whether additional information was requested of the provider in the eCura audit event.

7. PNM Specialist will send all audit results will to the provider within 10 business days of the audit being conducted. An exception to this rule can be made by the Provider Network Manager, or designee and a written explanation of the delay must be sent to the provider within 5 business days of the audit being conducted.

Corrective Action Plan/s:

If a Corrective Action Plan is requested by the RC the provider will have 10 business days to submit it to BPA. RC will contact providers that fail to supply BPA with a Corrective Action Plan by the due date as applicable. If the provider fails to submit a Corrective Action Plan and/or fails to request an extension, the following consequences may occur: facility or site inactivation, suspension, termination, recoupment of claims dollars and/or loss of incentive dollars.

When a Corrective Action Plan is received from the provider and logged in the PNM specialist will e-mail the plan to the appropriate RC. The plan must be reviewed by the

RC who will prepare a response to the provider within 5 business days. One of the two following actions will take place:

1. If the Corrective Action Plan is accepted, a template letter will be completed by the RC and sent to the provider via email by the PNM specialist. The template letter explains that a follow up visit or Quarterly Audit will occur in no more than 90 calendar days as applicable. The RC will schedule the appointment with the provider.

2. If the Corrective Action Plan is not accepted, a template letter will be completed by the RC explaining why it was not accepted. The letter will state that the provider needs to submit a revised Corrective Action Plan that specifically addresses and resolves identified deficiencies. The PNM specialist will e-mail the letter to the provider. The provider must submit the updated Action Plan to BPA within 5 business days.

If the updated Corrective Action Plan is not received from the provider or accepted by the RC, they will consult with the Provider Network Manager to determine possible consequences, to include but not limited to the following; facility or site inactivation, recoupment of claims dollars and/or loss of incentive dollars.

Should the provider need additional time to submit a Corrective Action Plan the request should be submitted in writing to the RC stating the reason for the request. The RC's decision should be based on the reason for the request and they will communicate the extension to the Provider Network Manager and the PNM specialist who will notify the provider via e-mail. Additional requests or a request exceeding a 5 business day extension must be approved by the Provider Network Manager. Failure to meet the deadline following an extension will result in a letter to the provider and the following consequences may occur: facility or site inactivation, suspension, termination, recoupment of claims dollars and/or loss of incentive dollars.

Clinical Chart Audit:

The PNM Specialist will request a the RC conducting the audit oversight permissions to the provider's WITS client files for 5 days prior to the scheduled audit and 5 days after the scheduled audit. The WITS Help Desk needs to be notified 3 days in advance of the requested start date for the access to be given. Providers are also notified of access.

The PNM Specialist will check the Provider Notification Calendar for all Clinical Chart Audit dates and send notification for oversight permissions by e-mail to the provider and through a support ticket to the WITs Help Desk.

BPA will ensure for each audit conducted a random sample of clients for the identified time frame in the amount of 2.5% or 5 charts, whichever is greater, based on funding source (General or Idaho Supreme Court) and client population (Adult or Adolescent).

Another set of 3 client names & dates of service will be included with the random data pulled as alternates in case a specific client record is not at the provider site being audited.

The following methods will be utilized for gathering a random sample:

1. Random Sample will be based on all clients who received a minimum of one billed service at the agency location, under the identified funding source and whether an Adult or Adolescent.

2. PNM will be asked to provide a random sample for all sites for a given time frame. For the Annual audits the time frame will be from the date of the last audit to the present and for Quarterly audits the time frame will be from the date the provider's corrective action plan was accepted by BPA to the present. If the provider's corrective action plan has not been accepted by BPA, the time frame will be determined by the Clinical Leadership Committee or the Provider Network Manager.

3. The Random Sample will include clients only for the specified time frame. This process is utilized to ensure the services audited reflect the agencies response to the last Clinical Chart Audit and includes any changes that may have occurred as a result of the prior audit.

4. The Random Sample of clients will include up to 5 dates of service. These dates of service will be the only dates of service utilized to review each audit indicator.

A Claim Recoupment form will be completed by the RC at time of audit if unsubstantiated claims are discovered during audit. The RC will send the completed Claim Recoupment form to the PNM specialist.

Clinical Supervision Audit:

Regional Coordinators will conduct a Clinical Supervision Audit utilizing the audit tool and "How to Manual" as a guide.

Facility Renewal & Additional Site Services Audit:

Regional Coordinators will conduct renewal audits of all contracted BPA SUD Treatment Providers and audit additional site/service requests.

Renewal Application:

1. IDAPA requires providers submit their renewal application 90 days prior to facility certificate expiration to the Idaho Department of Health & Welfare (IDHW).
    a. IDHW has designated BPA to receive renewal applications

2. When application is received the PNM specialist saves the application and P&Ps in the appropriate folder, reviews application with application checklist, reviews policies & procedures, notes any missing information and begins completing the audit tool.

3. The PNM Specialist sends audit tool with all sites and services entered to the RC conducting the audit.

Renewal site visit:

1. RC conducting audit targets the scheduling of renewals 30 days prior to expiration.

2. On the day(s) of the on site visit the conducting RC will complete the facility audit tool while performing a facility walk through. The RC reviews clinical supervision and chart files if they have not been audited in the last 6 months. If the agency has had no staff changes and the previous audit scores are high, RC can request the RC Team to waive the additional audit(s).The RC reviews the findings with the facility representative at the end of the audit.

Approval & Scores:

1. When the facility audit tool has been completed the RC will complete the Facility Summary. The Facility Summary report will include recommendations following IDAPA's scoring criteria.

2. The PNM specialist will send the audit results and approval certificate to the provider and only the approval certificate to IDHW via email.

3. The PNM Specialist updates the provider's facility renewal date in eCura and saves the approval certificate in the appropriate folder at the following location: **\\Pv1\office\Departments\Provider Relations\SUD Provider Relations\Electronic Provider Files\Tx.**

Additional Sites or Services Requests:

1. Provider submits Additional Site Form
2. PNM specialst notified RC when an Additional Site/Services request has been made.
3. RC completes the Walkthrough and Approval Summary Worksheet of the Facility Renewal Audit and the sends to PNM Specialist.
4. The PNM specialist will send the Approval Summary Worksheet of the Facility Renewal Audit Tool to IDHW via email.
5. IDHW is responsible to send a Facility Approval certificate or denial notification to the PNM Specialist. The PNM Specialist updates the provider's eCura file and

saves the approval certificate in the appropriate folder at the following location: **\\Pv1\office\Departments\Provider Relations\SUD Provider Relations\Electronic Provider Files\Tx.**

Recovery Support Services Audit:

The PNM Specialist will request a the RC conducting the audit oversight permissions to the provider's WITS client files for 5 days prior to the scheduled audit and 5 days after the scheduled audit. The WITS Help Desk needs to be notified 3 days in advance of the requested start date for the access to be given. Providers are also notified of access.

The PNM will check the Provider Notification Calendar for all RSS Audit dates and send notification for oversight permissions by e-mail to the provider and through a support ticket to the WITs Help Desk.

BPA will ensure for each audit conducted a random sample of clients for the identified time frame in the amount of 2.5% or 5 charts, whichever is greater for each approved RSS service. Another set of 3 client names & dates of service will be included with the random data pulled as alternates in case a specific client record is not at the provider site being audited.

The following methods will be utilized for gathering a random sample:

1. Random Sample will be based on all clients who received a minimum of one billed service at the agency location, under the identified RSS Service.

2. PNM will be asked to provide a random sample for all sites for a given time frame. For the Annual audits the time frame will be from the date of the last audit to the present and for Quarterly audits the time frame will be from the date the provider's corrective action plan was accepted by BPA to the present. If the provider's corrective action plan has not been accepted by BPA, the time frame will be determined by the Clinical Leadership Committee or the Provider Network Manager.

3. The Random Sample will include clients only for the specified time frame. This process is utilized to ensure the services audited reflect the agencies response to the last Recovery Support Services Audit and includes any changes that may have occurred as a result of the prior audit.

4. The Random Sample of clients will include up to 5 dates of service. These dates of service will be the only dates of service utilized to review each audit indicator.

Evidence-based Programs & Practices Audit:

The RC conducting the audit will contact the provider and request a copy of the Evidence-based Programs and Practices the agency is utilizing for review 30 days before

the audit. The audit is intended to review treatment modality and effectiveness based on group observation and client interviews.

For Cause Audits:

BPA will utilize contractual authority to audit provider performance as needed. Stakeholders may request BPA to conduct a For Cause Audit. The Provider Network Manager will instruct RC staff to conduct a For Cause Audit if they determine there is sufficient cause to do so.

1. At the completion of the audit the RC will meet with the provider to complete a brief exit interview. The exit interview will be a written form and it will include areas of concern, areas of excellence and initial recommendations. The form must be signed by a provider staff member and the RC. Final results will not be delivered at this time.

2. The RC will review the audit findings with the Provider Network Manager before sending information to the PNM Specialist. The Provider Network Manager may decide to take one or more of the following actions; request an Action Plan, inactivate the provider, recoup claims dollars, stop incentive payments or put the provider on a probationary status if the audit results substantiate a serious deficiency. If the audit results do not substantiate a deficiency an audit results template letter will be prepared by the RC and sent to the PNM Specialist. A copy of the audit findings letter will be sent to DHW or any applicable Stakeholder as determined by the Provider Network Manager.

Quality Assurance:

To ensure ongoing quality improvement, all audit processes and tools will be reviewed yearly or as changes occur. As new contract initiatives and provider related expectancies are implemented, PNM will review and develop audit processes to monitor network performance and needs. Audit results will be reported to the Credentialing Committee at each meeting (every other month) and the Quality Management Committee on a semi-annual basis.

Confidentiality:

All information in this policy is to be considered confidential and will be handled in a manner as prescribed by company policies, and state and federal laws.

Substance Use Disorder Treatment and Recovery Support Services Network

Continuous Quality Improvement Program

January 27, 2013

Submitted by:

Business Psychology Associates

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Introduction

Partnerships with clients living with substance use disorders and their families, stakeholders, and the provider networks are essential in meeting the changing needs and choices with service provision. This important aspect of recipient empowerment and choice drives Business Psychology Associates' (BPA) Substance Use Disorders system's (SUD) Continuous Quality Improvement (CQI) program. BPA is committed to working with the Partners to provide quality services to our SUD clients. This commitment mandates an interactive system that involves clients and their families, providers in the network, BPA staff, and stakeholders. This quality system must function as a collaboration to set quality standards, identify system problems, require corrective action, and recommend solutions.

This document will be updated annually to reflect any changes to the BPA CQI program as a result of system changes and agreements between the Partners and BPA.

Purpose

BPA is the management services contractor (MSC) for the State of Idaho's Substance Use Disorder's (SUD) system of care. BPA directly manages multiple funding streams that include state and federal block grant funding. BPA maintains ongoing efforts toward seeking opportunities for and making continuous improvements in the quality of healthcare services and the health status of the populations served. A comprehensive Continuous Quality Improvement (CQI) program directs BPA's efforts.

The scope of the CQI program is designed to ensure the accessibility of services, availability of the network and the quality and appropriateness of services provided to our clients. Input and feedback into the CQI process from the clients, Partners, providers, and stakeholders are valuable components of the quality improvement program.

The CQI program encompasses all aspects of care delivered by providers as determined by each Partner's benefit plan. These services can include substance use disorders services, which are

provided in outpatient, residential, social, detoxification, and community-based settings. In addition to continuous assessment of the clinical elements of healthcare, the CQI program looks at administrative and service issues that affect the delivery of care.

This CQI Program description is designed to ensure BPA's efforts meet state and federal regulations and national accreditation standards.

Goals

The Quality Management Program aims to improve the health of the people we serve, enhance the patient experience of care, and promote quality access, while controlling or lowering per capita costs. Our program works towards achieving these aims by applying strategic focus on improvements in the following dimensions of care and services:

1. Accessibility
2. Appropriateness
3. Timeliness
4. Continuity
5. Effectiveness
6. Efficiency
7. Safety
8. Quality of client/provider relationships

Additional information on these quality domains is provided in the CQI Measures and Reporting section of this program description.

The BPA Quality Management Program achieves these aims by:

1) Assuring that services are always designed and delivered in a manner that safeguards member safety
2) Promoting member rights and regulatory protections
3) Monitoring the clinical competence of our network and service providers

4) Monitoring that the clinical care provided to members is consistent with recognized standards of care in accordance with best practices and/or evidence-based practices
5) Improving member (patient) health outcomes
6) Identifying areas for improvement and designing interventions or redesigning procedures that will lead to positive change
7) Ensuring member satisfaction with services rendered

CQI Structure and Accountability

Overview

BPA is committed to ensuring that customers and clients receive the highest quality health care and the most effective, efficient service from our employees and our providers. The BPA Quality Management (QM) Program is grounded in the concepts of consumer-driven recovery, resiliency, and results. The QM Program considers consumer and family, provider, and stakeholder involvement as an integral component to our quality assessment and performance improvement programs.

The BPA treatment and service delivery strategy is to drive and support recovery, which is defined by SAMHSA as, *a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*.[1] BPA recognizes that recovery, resiliency and ultimately self-management must be the common, recognized outcome of the services we provide.

Culture of Quality

The BPA QM program adheres to a Continuous Quality Improvement (CQI) philosophy through which we monitor and evaluate appropriateness of care and service, identify opportunities for improving quality and access, establish initiatives to accomplish agreed upon improvements, and monitor resolution of problem areas. Our philosophy is an ongoing process that spans

[1] http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

every aspect of our program operations and unites our organization, members, providers and other stakeholders in a continuous upward spiral of quality improvement through planning, action, and evaluation.

The Quality Management Committee (QMC) oversees the QM program. The QMC and designated quality committees utilize an analytic framework to establish departmental and organizational measures that includes, but is not limited to the following components: (1) the Triple Aim established by the Institute for Healthcare Improvement (IHI) and (2) the Model for Improvement[2].

The BPA QM program follows the framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. This model asserts that healthcare improvements must be developed to simultaneously pursue three dimensions, called the "Triple Aim". Below are the three dimensions of the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

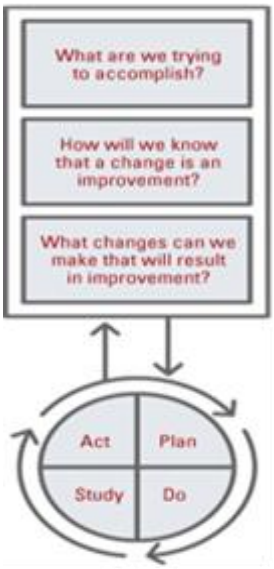
BPA's QM program utilizes the Model for Improvement to guide improvement activities. The Model for Improvement is a simple yet powerful tool for accelerating improvement[3]. Below is a description of the Model for Improvement:

- **Forming the Team**

[2] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

[3] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.



- **Setting Aims**

  Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

- **Establishing Measures**

  Teams use quantitative measures to determine if a specific change actually leads to an improvement.

- **Selecting Changes**

  Ideas for change may come from the insights of those who work in the system, from change concepts or other creative thinking techniques, or by borrowing from the experience of others who have successfully improved.

- **Testing Changes**

  The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

- **Implementing Changes**

  After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team may implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

- **Spreading Changes**

  After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

Comprehensive Outcome Measures Program

The BPA QM program acknowledges national excellence in service delivery within both health and behavioral health models through our embedded Comprehensive Outcomes Measures Program (COMP). The BPA COMP employs standardized, reliable, and valid industry measures for all outcomes tracking and reporting. Our Program utilizes all applicable Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as SAMHSA's National Outcomes Measures (NOMs) and Treatment Episode Data Set (TEDS) methodology for assessing system outcomes. The QM Program promotes the use and ongoing evaluation of additional National Quality Forum (NQF) measures for inclusion in the COMP. For more details, please refer to the Comprehensive Outcome Measures Program document.

Structure

BPA's internal Quality Management structure provides an objective, systematic and continuous process for assessing, monitoring and improving the quality of all our functions including the behavioral health services provided to clients. The QMC reports activities to BPA's Board of Directors at least annually. The QMC also provides feedback to all sub-committees, advisory groups and all ad hoc work groups and task forces acting as data feeds into the QMC. Subcommittee reports include a summary of activities performed and recommendations for action.

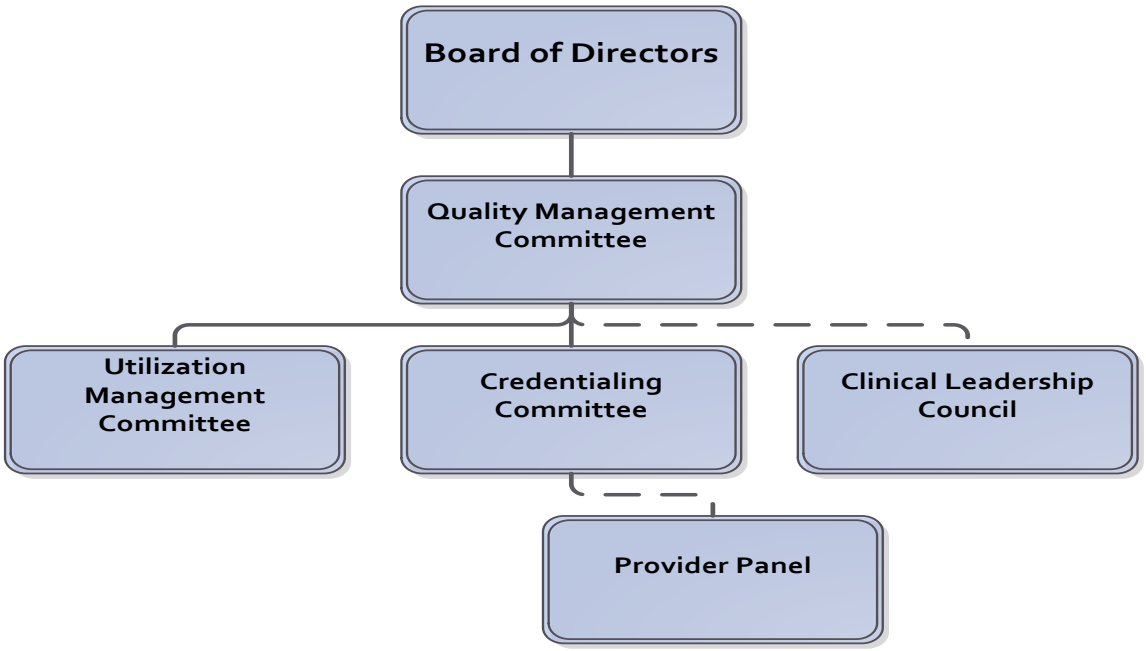
Subcommittees:

- **Utilization Management Committee (UMC)** The Quality Management Committee has delegated oversight of the utilization management function to the UMC. The UMC has responsibility to recommend policies for development; review and approve, and deny, or recommend revisions to policies related to UM activities; review utilization issues (cases) as requested by the Medical Director; review quarterly utilization reports and make recommendations for improvement, review and approve studies, standards, clinical guidelines, trends in quality and utilization management measures and outcomes.

- **Credentialing Committee** The Quality Management Committee (QMC) has delegated decision-making authority to the Credentialing Committee. This committee, chaired by BPA's Medical Director with membership that includes providers, is responsible for credentialing and re-credentialing providers who deliver services to clients. This committee is also responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of clients. The credentialing committee's major responsibilities are: (1) receive and review, at a minimum, health practitioner/professional and provider credentials that do not meet BPA's credentialing criteria (that are not complete, "clean" as defined by BPA, and approved by the BPA Medical Director); conduct peer review evaluations; and make decisions regarding actions on the credentialing or re-credentialing information presented.

In addition to the above committees, the QMC invites input from stakeholders to gain expert clinical recommendations and valuable stakeholder feedback. The QMC advisory panels include the Clinical Leadership Council (CLC) and the Provider Panel. The Clinical Leadership Council provides a multi-disciplinary clinical roundtable to support BPA's internal improvement and business activities. The Provider Panel is an advisory committee composed of behavioral health practitioners whose role is to advise BPA on organizational wide clinical, operational and quality activities. The Provider Panel meets at least quarterly.

The graph below reflects the structure of BPA's CQI/QM Program:



Oversight

The QMC meets no less than quarterly and is chaired by the President or appropriate designee. The committee is comprised of the following participants: President, appropriate Clinical and Operational leadership as designated by the President, Chief Financial Officer, Manager of Clinical Services, the Director of Provider Networks, and the Quality Support Supervisor. Because BPA strongly believes that quality management should be embedded in the entire organization, the QMC appoints ad-hoc members including staff, providers, customers, and members/clients.

The Executive Team is represented on the QMC. The QMC reports to the BPA Executive Team through the committee minutes. The Executive Team is responsible for ensuring that the organization provides the necessary resources for the Quality Management Program to achieve its objectives and the activities of the QMC are consistent with the organization's overall goals and objectives. The Executive Team is also responsible for reporting on quality improvement to the BPA Board of Directors.

Quality Management Committee Responsibilities

The QMC is responsible for the following:

1) Developing and maintaining the quality management program
2) Tracking and trending key indicators of:
    a. Compliance
    b. Member safety including access
    c. Clinical quality including provider performance
    d. Efficiency
    e. Stakeholder satisfaction including member satisfaction
3) Identifying and prioritizing annual quality initiatives
4) Identifying and prioritizing new quality initiatives during the year as issues of critical importance are identified
5) Implementing quality improvement projects based on items 1 through 4 (above)
6) Including provider input
7) Reporting routinely to the BPA Management Team and staff
8) Developing a semi-annual report to the Board of Directors
9) Assuring an appropriate and effective credentialing function by overseeing the Credentialing Committee
10) Assuring appropriate and effective care management by overseeing the Utilization Management Committee
11) Ensuring that appropriate training, resources and support are provided to the organization to achieve our quality aims
12) Development of an Annual Plan, to include:
    a. Designation and monitoring of core quality indicators
    b. Measuring, tracking, and trending core indicators
    c. Designation of at least one new quality improvement project based on:
        i. Data from core indicator measures
        ii. Identification of one or more areas of concern regarding a meaningful quality indicator that the committee determined require(s) improvement
        iii. Customer requirements
        iv. Company-wide quality initiatives

13) Annual review and assessment of program activities and achievements
14) Review of any critical incidents or critical quality of care concerns and development of action plans to address those as appropriate
15) Ongoing development and oversight of activities tailored towards improving quality of life or quality of care for members

Collaboration with Partners and other Stakeholders

BPA leadership will work collaboratively with the Partners and other stakeholders to ensure continuous quality improvement activities are effective and beneficial to clients and the system of care. The Governance Council, jointly comprised of BPA and Partner leadership, will provide oversight and direction for quality activities, including the Comprehensive Outcome Measures Program.

Contractor Regulatory and Contractual Compliance

In an effort to ensure BPA's compliance with applicable state and federal regulations, the Quality Support Supervisor (QSS) or their designee will continuously monitor legislative activities, and will make changes to the CQIP and related activities as needed. The QSS or their designee will conduct a regulatory compliance audit at least annually. The QSS will evaluate quality deliverables in conjunction with contract monitoring efforts at least annually. Results of each will be included in each annual CQIP evaluation and any necessary changes to the CQIP will be made in the annual CQIP update.

Provider Network Regulatory and Contractual Compliance

To ensure provider compliance with contractual and regulatory requirements, BPA will conduct compliance audits on the following schedule:

	Facility Review Audit	Initial Compliance and Training Audit	Client Record Audit	Clinical Oversight Audit	Evidence Based Practice (EBP) Audit	Client Assessment of Care Survey

Treatment Network	At renewal for all BPA network providers	w/in 90 days of contracting w/BPA	Annually	Annually	Fidelity audits are conducted quarterly during implementation and annually thereafter	Annual
Recovery Support Services (RSS) Network	At renewal for all BPA network providers	w/in 90 days of contracting w/BPA	Annual desktop audits	Case Management only	NA	Annual

Facility Review Audit

Regional field staff staff will conduct this audit for renewal of facility approval, ensuring that the provider meets requirements of Section 130 or Section 135 of IDAPA 16.07.20, as appropriate. BPA understands that our responsibility to conduct facility review audits is limited to providers that are in the BPA network at the time of renewal. BPA will work with IDHW to coordinate the audit schedule so that facility approval standards can be reviewed at the time of another scheduled on-site audit, if those audits fall within a mutually agreed upon window.

Initial Compliance and Training Audit

Clinical regional staff will conduct this audit within 90 days of provider entering the network. Providers are introduced to the standards and trained to the tools used by BPA to assess compliance within the provider's respective network.

Member Record Audit

Clinical regional staff will conduct this audit annually. Providers are audited to adherence to well-documented treatment records, facilitation of communication, coordination and continuity of care, to promote efficient and effective treatment.

Clinical Oversight Audit

Clinical regional staff will conduct this audit annually. Providers are audited to adherence to clinical supervision standards utilizing the "How to Manual", per IDAPA standards. In addition, providers reporting the use of EBP will be audited to ensure compliance to the EBP standards.

Evidence Based Practice (EBP) Utilization Audit (Fidelity Audit)

BPA's Provider Oversight Committee will review quarterly network, regional, and individual provider reports to assess and monitor adoption of and adherence to accepted best practices within the network. These reports will be valuable in establishing our understanding of provider EBP utilization rates, patterns and frequency of use within the SUD treatment network.

Member Assessment of Care Survey

This is a standardized survey that asks clients to report on and evaluate their experiences within the system of care and services. It will be designed to capture client perspectives on health care quality. The Member Assessment of Care Survey will be administered at time of discharge and annually at the date to be established by the Partners.

CQI Quality Domain Measures

The eight quality domains are detailed below. The Governance Committee will determine acceptable levels at a date to be determined.

Required Quality Domain	Assessment	Analysis Frequency	Review, by
Accessibility – the accessibility of services for clients.	Provider adequacy analysis Call Standards: -transfer rate -drop rate -abandoned rate -average hold time	Quarterly	Provider Oversight Committee, Governance Council
Appropriateness – the correctness of the treatment decisions of a provider for any one client.	Clinical decisions: -denial rate -appeal rate -overturned rate (appeals)	Quarterly	Provider Oversight Committee, Governance Council

Timeliness – the timeliness of services that is optimal for the benefit of the client	Treatment initiation rate Treatment engagement rate Complaints response rate	Quarterly	Provider Oversight Committee, Governance Council
Continuity – the provision of SUD services within a framework of a holistic approach to the behavioral health system in Idaho.	Claims payment comparison to authorized RSS Residential discharges receiving outpatient services within 30 days of discharge (excluding against professional advice) Average Length of episode	Quarterly	Provider Oversight Committee, Governance Council
Effectiveness – the effectiveness of the treatment to meet the identified outcomes for each client's care.	National Outcomes Measures (NOMs) data elements EBP utilization rate	Quarterly	Provider Oversight Committee, Governance Council
Efficiency – the maximum use of resources with minimal waste and duplication.	Rate of residential readmissions within 30 days of discharge Average Cost per case	Quarterly	Governance Council
Safety – an environment that ensures, to the greatest extent possible, that all unnecessary dangers to clients are mitigated and eliminated.	Adverse and sentinel events analysis Recredentialing denial rate	Quarterly	Provider Oversight Committee, Governance Council
Quality of client/provider relationship	Percent of providers with a complaint resulting in a sanction Client satisfaction survey	Annually	Provider Oversight Committee

Reporting

BPA will begin reporting on all areas of the CQIP upon full access to and formal training on SSRS, the reporting tool for WITS. Reporting capabilities will be based on what is available in SSRS through BPA's logins. CQIP Reports will be delivered via email to the Partners by the 20th of the month following the end of each quarter.

7. Program Integrity

Idaho Response:

The Division of Behavioral Health has a three-pronged approach to program integrity. They are fiscal planning, services delivery and quality assurance. As indicated in previous responses, the Division has separate systems for the delivery of mental health and substance use disorders services. For both systems, the first step in ensuring program integrity if fiscal planning. Each state fiscal year, after budget appropriations have been made, the Division's leadership staff meet with the Bureau of Financial Services to develop the Division's budget. Integral to this process is a review of relevant state and federal requirements. Based on these requirements funds are allocated to support services to priority populations, required initiatives and statewide service delivery.

At a minimum, this budget is reviewed quarterly to evaluate compliance with the budget expenditure plan, federal and state expenditure requirements and emerging needs. Based on this review, corrective actions are taken, when indicated, to ensure compliance with federal and state requirements as well as areas of emerging needs.

The second prong of the plan focuses on ensuring intermediaries, relevant providers and state staff are knowledgeable about state and federal program requirements, state initiatives and priority populations. For state staff this is done by providing guidance documents, on required populations and services, including, but not limited to: state and federal code; policies, protocols and procedures; manuals; and standard tools. This also includes formal and informal training, technical assistance and mentoring.

When contractors are used, either as intermediaries or as direct services providers, the process begins with a Request for Proposals (RFP). The Division drafts a scope of work detailing the tasks to be completed under the contract including the population(s) to be served. State and federal requirements, for which the contractor will be responsible, are always referenced in the RFP Scope of Work, and as appropriate, included in the RFP document. The RFP, is the foundation for the contract, so the Division is very careful to ensure that any requirement the contractor is addressing is fully outlined in the RFP. As requirements are modified, the RFP or resulting contract are amended to reflect the change. It is important to note, that the Division is generally responsible for requirements that are best addressed at the state level and the contractor is responsible for requirements that need to be implemented at the community level. This includes detailing requirements in contracts, providing guidance documents, information on trainings whether web-based, in person or recorded and technical assistance.

The third prong of the Division's covers contract compliance monitoring, quality assurance evaluation, contract invoice review and client demographic data. For services delivered directly be state staff, the Division has a quality assurance unit, separate from the service delivery system that reviews client files for compliance with Division policies and procedures, program/practices requirements and service documentation. In either case, failure to comply with requirements will result in a corrective action plan. Also attached to this response is the Division's Quality

Program that details the Division's activities to support the delivery of effective, equitable services.

The Division has a multi-layer approach to fiscal monitoring. Budget review is conducted jointly by program managers and the Department of Health and Welfare's Bureau of Financial. This is done officially on a quarterly schedule. At this time the total expenditures are reviewed for compliance with federal and state requirements as well as the established annual budget. If modifications need to be made to the budget to comply with state and federal requirements., they are also made at this time. At the claims level, all invoices are submitted to the relevant contract monitor to evaluate compliance with the contract and allowed expenditures. Once the review is completed, the contract monitor assigns a payment code and authorized the payment. At this point, invoices are entered into the state accounting system, the accounting department processes the invoice and makes a second review of the invoice to confirm the costs are allowable under the contract and funding sources. At this time the invoice is returned electronically to the Division's leadership team for final approval and then is sent to the State Controller's Office for payment.

As indicated above, compliance reviews occur at multiple levels. Compliance with state and federal requirements, contract scope of work or program requirements are reviewed during quality assurance and contract monitoring site visits. Any problems identified during the site visits are documented and initially, addressed informally. If the problem persist, a corrective action plan is required and punitive steps may be taken. Compliance with program expenditures are reviewed, as indicated above, when the invoice is received and paid, during contract monitoring site visits and during quarterly budget reviews. Contract monitoring site visits include a review of services funded, quality of services delivered and services invoiced. This is done to ensure that the contractor is in compliance with all elements of the contract scope of work and cost/billing procedure. As with other contract compliance issues, when problems are found, they are documented and addressed as appropriate for the level of the problem. If fraudulent records or fraudulent invoicing are identified, the entity is required to reimburse the Department for any payments made and based on the terms of the contract may be subject to additional penalties. If a federal or state audit indicates that payments to the contractor fail to comply with applicable federal or state laws, rules or regulations, the contractor must refund and pay to the Department any compensation paid to the contractor arising from the noncompliance, plus costs, including audit and collection costs.

The Division of Behavioral Health uses two primary mechanisms for disbursement of funds. The mental health funds are used to pay state staff who deliver adult and children's mental health services. The attached Quality Assurance Program 2 outlines activities undertaken by the Division to ensure appropriate, sufficient and effective services are delivered in a timely manner. The remainder of the mental health funds are used to contract with governmental and private agencies for the delivery of services not provided by state staff such as community-based care in areas where the Division does not have local offices, for specialized outpatient care and support services. The Division also uses mental health block grant funds to contract with organizations such as the Idaho Office of Consumer and Family Affairs and the Federation of Families to support consumer education and advocacy services. Contracts which fund services to individuals are set-up as fee-for-services instruments. The contractor gets paid after an allowable

service is delivered and invoiced. Consumer advocacy contracts are set up as agency support contracts which pay for staff and program administration to deliver a broad range of consumer support services.

The Division's Substance Use Disorder treatment services are solely delivered by a statewide network of providers managed by an intermediary. All services delivered must be entered into the Division's Web Infrastructure Treatment Services (WITS) data system in order to be invoiced. The Division establishes compliance standards, including state and federal requirements, in the contract with the intermediary. The Division evaluates compliance with these contract elements, during contractor site visits, invoice reviews and during facility approval site visits conducted by Division staff.

If fraudulent records or fraudulent invoicing are identified, the entity is required to reimburse the Department for any payments made and based on the terms of the contract may be subject to additional penalties. If a federal or state audit indicates that payments to the contractor fail to comply with applicable federal or state laws, rules or regulations, the contractor must refund and pay to the Department any compensation paid to the contractor arising from the noncompliance, plus costs, including audit and collection costs.

Client encounter data is used to compare actual client need/service expenditures to budget allocations to determine the need increase outreach activities or re-allocation of funds. It is used to evaluate treatment completion rates to identify areas/providers in need of specialized training or technical assistance. It is also used to identify high-cost clients to evaluate client's needs, determine what can be done to better serve the client and identify community resources that could support their recovery.

Audits are conducted at three levels. First level audits are conducted by the intermediary on their network providers . A copy of the intermediary's audit tool is attached to this response as is their CQI plan. The Division conducts conducts performance monitoring on the intermediary during weekly contractor meetings. These sessions review compliance with the contract scope of work and the cost/billing procedure. Session records are maintained and the contractor is required to provide weekly updates on corrective action plans/improvements to the system. The Division has the capacity to audit any service, invoiced by the intermediary, by auditing the client record entered into the WITS data system. This process enables the Division to review client records as they are entered into the system and identify problem areas without traveling to the intermediary or provider site. If fraudulent records or fraudulent invoicing are identified, the entity is required to reimburse the Department for any payments made and based on the terms of the contract may be subject to additional penalties. If a federal or state audit indicates that payments to the contractor fail to comply with applicable federal or state laws, rules or regulations, the contractor must refund and pay to the Department any compensation paid to the contractor arising from the noncompliance, plus costs, including audit and collection costs.

Finally, the Legislative Audits Division of the Legislative Services Office, under the direction of the Legislative Council, is charged with the responsibility to audit the State of Idaho´s Comprehensive Annual Financial Report (CAFR) and perform the annual Federal Single Audit required by federal regulations. The Audits Division is also performs management reviews of

each executive department of state government at least once in a three year period. Management reviews include evaluation of internal controls over financial and program activities and other matters related to the department´s operations. All reports produced by the Audits Division are delivered to the co-chairs of the Joint Finance-Appropriations Committee (JFAC) for review and approval prior to release for public distribution. The Co-Chairs of JFAC may, at their discretion, conduct hearings related to any report and seek input and testimony prior to or after reports are released and distributed. If a report contains any findings and recommendations, the Audits Division contacts the agency approximately 90 days after the report was issued to determine the current status of the corrective actions. A "90-Day Follow-up Report" is then prepared and released for public distribution.

The Division employs three payment methods for the distribution of community mental health services and substance abuse prevention and treatment block grant funds. Funds used for staff salary are distributed in accordance with state accounting procedures. The Division of Human Resources within the Idaho Department of Administration is responsible for setting salary ranges based on required knowledge, skills and physical abilities needed to complete the tasks required for each specific job classification. Salary ranges are set by the Idaho's salary structure consists of 19 pay grades with minimum, policy, and maximum rates. Idaho uses the Hay methodology per Idaho code in order to determine appropriate pay grades for classification of state positions. Compliance with this system is evaluated during Legislative audits. This system ensures state staff are paid fairly and are evaluated annually for job performance and compliance with state and federal requirements.

For some activity-based contracts required under the block grants, such as consumer advocacy and family support, the Division uses a line-item contract which defines the costs to be covered, such as personnel, travel and reports. These line-items are established through a competitive request for proposals (RFP) process. Based on the quality of the proposal and the proposed costs, a contract is awarded for the period of one year. The contract may be extended for up to three additional years. The Division employs the invoice payment process described above on these contractors. Contractors are paid upon submission on an invoice, in compliance with the cost/billing procedures, and scope of work.

The third type of payment method employed by the Division is a fee for service system. Under this system, the Department can establish rates that will be paid for each service or they can allow agencies bidding to propose a fixed rate(s) for the service(s) to be delivered under an RFP. With either of these method a rate is set for each type of service to be delivered. In general, rates are set at a daily level for residential, halfway house, day treatment, etc.; and at an hourly or portion thereof, for services such as group, individual, education and case management, etc. As with the activity-based contracts, the Division employs the invoice payment process described above on these contractors. Contractors are paid upon submission on an invoice, in compliance with the cost/billing procedures, and scope of work.

The state has given high priority to supporting regional mental health staff utilize evidence-based programming and practices. Two main methods were used to facilitate this movement. The first was to provide regionally-based training on evidence-based program most effective for the populations served in Idaho. The second was to send regional staff to state or national trainings

on evidence-based programs. Now the Division is focusing on the use of national and state webinars and video conferencing to make training available in a state where distance and geography make face to face trainings costly. For contractors, whether mental health or substance use disorders, the Division has given priority funding to entities proposing to use evidence-based program, provided funding for training and evidence-based materials, accessed federal assistance for onsite training and as with Division regional staff, employed national and state webinars and video conferencing to facilitate access to evidence-based programs and practices trainings. Compliance is evaluated during annual staff reviews, reviews of client files, contract monitoring and invoice auditing.

As indicated in multiple sections of this document, the state employs two main methods of delivering community mental health services and substance abuse prevention and treatment block grant funded services. A financial qualification process, including review of insurance/ Medicaid coverage is conducted for all individuals receiving mental health and substance use disorders treatment services. The Division only covers services for individuals who have no other funding source or whose funding source does not cover all the services they need. In the case of the second scenario, the Division will only cover the services not covered by their insurance or Medicaid. The Division of Behavioral Health

The Division of Behavioral Health transfers to the Office of Drug Policy annually, not less than 20% of the substance abuse prevention and treatment block grant for the purposes of funding primary prevention services. The compliance with federal requirements, management and delivery of these services, including reporting, is solely the responsibility of the Office of Drug Policy.

The Division of Behavioral Health collects data on all individuals receiving mental health and substance use disorders services at intake and discharge regardless of service(s) delivered. As a part of this data collection national outcome measures data are collected. The Division is developing a plan to utilize outcome data to identify service needs specific to Idaho's regional populations, select evidence-based programs to serve these populations and identify areas in need of training and technical assistance.

8. Tribes

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[74] 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 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

TRIBAL CONSULTATION AGREEMENT BETWEEN THE NEZ PERCE AND THE IDAHO DEPARTMENT OF HEALTH AND WELFARE

SECTION I

Consultation Policy Statement

The United States government has a unique legal relationship with American Indian tribal governments as set forth in the Constitution of the United States, treaties, statutes, presidential orders and court decisions. The Idaho Department of Health & Welfare (hereafter referred to as the Department) acknowledges this unique relationship and recognizes the right of Indian tribes to self-determination and self-government. This special relationship constitutes a government-to-government relationship between American Indian tribes and federal and state governments. The relationships between governmental structures can only be built through trust and mutual respect. As separate sovereign governments, the Nez Perce Tribe and the State of Idaho must work together to develop mutual respect for the sovereign interests of both parties.

It is the intent of the Department to consult on a regular, on-going basis with the Nez Perce Tribe (hereafter referred to as the Tribe) on matters relating to Department programs and services, which have a direct effect on Native Americans and Indian Social Service and Health Programs. This process ensures that the Tribe as a Federally Recognized Tribal government in Idaho is included in decision making when changes in Department programs place a direct compliance cost or impact on the Tribe social service or health programs as prescribed by federal or state law or rule. This process also preserves the right of the Department to make appropriate decisions based upon the needs of all program beneficiaries. The process of communication, collaboration and consultation between the Department and the Tribe shall be as outlined in this document as well as any applicable rules, policies or negotiated contractual obligations.

BACKGROUND

The 1996 requirement under title IV-B and 1978 ICWA law (amended in 2003) establish Tribe/Department collaborative and communication obligations regarding Indian Child Welfare activities. The Indian Child Welfare Advisory Council (ICWAC) was established to assure operational compliance and a forum for communication around these issues. Quarterly meetings have historically taken place. Both the Tribe and the Department have representation on ICWAC and participated in drafting the By-Laws as amended in 2008.

On July 1, 2009, Congress passed the American Recovery and Reinvestment Act of 2009 (Recovery Act), which amended §1902(a) (73) of the Social Security Act to require that a state's Medicaid State Plan must, "in the case of any State in which one or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which they seek advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Health Organizations and that a) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and b) may include appointment of an advisory committee and of a designee advising the State on its State plan under this title."

MUTUAL RESPONSIBILITY

To assure success in executing a policy regarding tribal consultation it is noted that a good faith effort on both the Department Executive Leadership and Nez Perce Tribal Executive Committee is necessary to assure staff resources and processes exist to: (1) identify issues for potential consultation; and (2) provide timely notification so that both parties can effectively participate.

SECTION II

OBJECTIVES OF CONSULTATION

1. Assure that the tribal government understands the technical and legal issues necessary to make an informed policy decision;

2. Assure state actions are not interfering or affecting federal compliance with treaty and trust obligations, as well as other applicable federal laws and policies impacting tribal culture, religion, subsistence, and commerce;

3. Improve policy-level decision-making of both tribal government and Department of Health and Welfare;

4. Bilateral decision-making among two sovereigns;

5. Ensure compliance with tribal and state laws and policies;

6. Develop and achieve mutual decisions through a complete understanding of technical and legal issues; and

7. Improve the integrity of state-tribal decisions.

SECTION III

NOTIFICATION TO TRIBE

Engaging tribal leadership prior to policy, rule or formal process development is critical for consultation to effectively take place. Simple notification (Dear Tribal Leader Letter) will not meet the spirit of the requirement to involve the Tribe for input, negotiation, cooperation and mutual decision-making prior to a change in policy, rule or State Medicaid plan amendment. Although the Tribe may elect not to participate in consultation surrounding a specific change, assurance of proper notification prior to establishment of Department policy is important so the decision can be made timely.

The Department agrees to provide the Tribe with notice of planned changes to policy, rule or formal processes that may affect Nez Perce Tribal programs or members. The Department agrees to include at least the following information in its notification:

a. Purpose of the proposal/change.
b. Anticipated impact on Native Americans or Tribal programs.
c. Method for providing comments/questions.
d. Timeframe for responses.

The Tribe's Executive Committee agrees to review the Department's notice in a timely manner and respond to the Department, identifying in writing its issues with the proposed changes, within forty-five (45) days of receipt of the Department's notice.

The Department agrees to reply in writing within thirty (30) days of receipt of the Tribe's response.

If the Tribe chooses to request formal Consultation, it may do so in writing within forty-five (45) days of receipt of the Department reply.

OPERATIONAL & EXECUTIVE COMMUNICATION

It is noted that many changes to policy or rule are very technical in nature. An ability to involve affected operational staff for both the Department and the Tribe early on in the consultation process is important so leadership has a clear understanding of the issue being presented and its anticipated effect on tribal programs, services or clients.

The Tribe has a complex organizational structure for Social Service delivery (for example, separate Departments for TANF, Indian Health, Child Welfare, Child Support and Child Care); and the Department is structured into Divisions of Welfare, Medicaid, Family Children's Services, Health and Behavioral Health. Each Tribal Department or Department Division has its own management hierarchy and operational leadership. Because Tribal and Department programs intersect at so many levels it is important to recognize the technical expertise needed by either Department Division Administrators or the Tribe's Executive Committee members within each sub-management structure. So that tribal council leadership understands the issue of Department changes being proposed to them, input from these technical experts is critical.

Communication is therefore needed at two levels; one, at an operational level with Tribal Department and Department Divisional leadership and staff; and two, at upper management level between the Department Executive Leadership Team (ELT) and the Tribe's Executive Committee.

COMMUNICATION FORUMS

Forums exist for operational communications which engage tribes with collaboration, communication and cooperation. These processes are described below and recommended for ongoing tribal technical support and review:

a. Quarterly Tribal/Medicaid Meetings between Tribal Health leadership and Medicaid Division leadership;
b. Quarterly TANF Meetings between Tribal TANF program leadership and Division of Welfare leadership;
c. Quarterly Indian Child Welfare Advisory Council Meetings between Tribal Social Service and Family and Children's Service leadership;
d. Monthly Child Support conference calls between individual tribal program leadership and Division of Welfare Child Support management; and
e. Division of Health has a cultural liaison who participates in a number of the meetings described above.

SECTION V

CONSULTATION PROCESS

The Department and the Tribe agree to the following process to facilitate open and continuous exchange of information to attain mutual understanding and informed decision-making.

1. The Department agrees to designate a single point of contact for the Director to be known as the "DHW Consultation Facilitator" (Facilitator).
2. The Tribe agrees to designate a single point of contact for the Tribe's Executive Committee to be known as the "Tribal Consultation Initiator" (Initiator).

3. The Department and the Tribe agree that the respective designees will attend (preferred) or review the minutes from the above-described communication forums.
4. The Department and the Tribe agree that the respective designees keep the Director and the Tribe's Executive Committee informed of any and all major program issues identified in the communication forums.
5. The Tribe agrees to identify in writing to the Department Facilitator any issues it seeks consultation on within forty-five (45) days of receipt of written Reply from the Department or within forty-five (45) days of a communication forum meeting.
6. The Department agrees to set up a Consultation Meeting between the Tribe's Executive Committee and the Director within thirty (30) days of receipt of the Tribe's request for consultation. The Consultation Meeting may be conducted by telephone, video-conference or in person.
7. The Department and the Tribe agree that the goal of any Consultation Meeting shall be to gain a mutual understanding of the potential impact changes in policy, rule or procedure may have on tribal programs, services or clients.
8. The Director shall develop an annual conference call with the Tribe's Executive Committee chair to review the Consultation process.

DISCLAIMER

Each of the parties respects the sovereignty of the other party. In executing this agreement, no party waives any rights, including treaty rights; immunities, including sovereign immunities; or jurisdiction. This agreement does not diminish any rights or protections afforded other Indian persons or entities under state or federal law. Through this policy, the parties strengthen their collective ability to successfully resolve issues of mutual concern. While the relationship described by this agreement provides increased ability to solve problems, it likely will not result in a resolution of all issues. Therefore, inherent in their relationship is the right of each of the parties to elevate an issue of importance to any decision-making authority of another party, including, where appropriate, that party's executive office.

Both parties agree that in instances where federal mandates dictate State regulatory or rule action, Consultation may not be appropriate at the State/Tribal level. However, notification and communication between the parties of this agreement shall still occur in these circumstances. Although the State and the Tribe agree to try to meet the timeframes outlined herein, unforeseen future federal or state changes in the law could affect the ability of either party to comply.

Effective Date

This agreement is effective upon signing by Nez Perce Tribal Executive Committee Chairman and Secretary and Department Director reflected below:

Authorized Signatures

Silas C. Whitman, Chairman Nez Perce Executive Tribal Committee — Date: 04-29-13

Anthony D. Johnson, Secretary Nez Perce Executive Tribal Committee — Date: 4/29/13

Richard Armstrong, Director, Idaho Department of Health and Welfare — Date: 4-29-13

8. Tribes

Idaho Response

Six federally recognized tribes are located in Idaho. They are the Shoshone Bannock, the Northwest Band of the Shoshone, the Nez Perce, the Coeur d'Alene, the Kootenai and the Duck Valley (Shoshone Paiute) Tribes. Located in the Idaho Department of Health and Welfare, the Division of Behavioral Health is covered under the formal consultation agreements the Department has established with two of these tribes. The Department is working to establish consultation agreements with the remaining four tribes. An example of a tribal consultation agreement is attaches. A a part of this agreement tribal representatives sit on the State Behavioral Health Planning Council. .

The Division formally identified a representative to serve as an active liaison to leaders of Idaho tribes. This liaison works with the Department of Health and Welfare's Tribal Relations Manager to build relationships with tribal leaders from each tribe, and to invite ongoing input into behavioral health planning and service implementation. The liaison and representatives from the Division of Medicaid meet quarterly with tribal leadership.

Currently, the one tribally-owned provider is participating the Division of Behavioral Health's Substance Use Disorder treatment network is the Benewah Medical and Wellness Center in northern Idaho (Plummer). The Division's Idaho Tobacco Project continues to consult with tribal representatives and provide access to resources tribes can use to implement programs to prevent underage access to tobacco. The Project has worked with representatives of the Shoshone Bannock Tribe to discuss sharing of resources to implement a program to prevent minors' access to tobacco products.

An e-mail was sent to each tribe with an invitation to access an external website that provided a survey opportunity to provide input into the narrative categories of the Idaho 2016-2017 Combined CMHS/SAPT Block grant application. No concerns about the combined block grant application were raised by the six tribes.

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG 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 abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:

- ***The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);***
- ***The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and***
- ***The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).***

Idaho has an established State Epidemiological Outcomes Workgroup (SEOW) which meets monthly to examine alcohol, tobacco and other drug-related archival data to determine the scope and level of substance abuse, and any associated problems. The SEOW currently has 18 members representing 9 different agencies including the Idaho Department of Corrections, the Idaho National Guard, the Office of Drug Policy, the Idaho Department of Education, the Idaho Department of Juvenile Corrections, the Idaho Department of Health and Welfare, the Idaho Supreme Court, Boise State University, and the Idaho Statistical Analysis Center. The SEOW's mission is to promote the strategic use and dissemination of data for informing and guiding Idaho's substance abuse prevention and behavioral health promotion policy and program development, decision-making, resource allocation and capacity building.

The Idaho SEOW does not collect data, but instead compiles data from multiple sources in the state. Data regarding consumption and consequences of alcohol, tobacco, marijuana, and prescription drug usage are used in the State of Idaho Substance Abuse Prevention Needs Assessment. Additionally, in 2014, the SEOW assisted the Office of Drug Policy in creating a school survey called the Idaho Youth Prevention Survey (IYPS). Items on the IYPS asked about a number of intervening variables.

Data that is used by the SEOW is compiled from multiple state sources, resulting in a large population for which data are available. In regard to survey data, the IYPS and YRBS are sources of information for youth. Additionally, because ODP owns the data from the IYPS, parceling out differences among minorities and rural regions of the state is possible. The BRFSS is used by the SEOW to obtain data from older and younger adults. The BRFSS recently refined demographic variables, making it possible to analyze data based on gender and sexual orientation.

Agencies that provide data to be used in the State of Idaho Substance Abuse Prevention Needs Assessment include U.S. Census Bureau, Bureau of Labor Statistics, Idaho State Liquor Division, Bureau of Vital Records and Health Statistics, and Idaho Department of Transportation. Additionally, other data sources contributing to identifying needs in Idaho regarding substance abuse prevention include the Idaho Youth Risk Behavior Survey (YRBS), Idaho Behavioral Risk Factor Surveillance System (BRFSS), Incidence Based Reporting System, National Survey on Drug Use and Health (NSDUH), the Idaho Youth Prevention Survey (IYPS) and Treatment Episodes Data Set (TEDS).

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

Needs assessment data is used to make decisions about the allocation of SABG primary prevention funds at both the local and state level. Beginning in fiscal year 2014, prevention providers across the state were required to utilize the SPF model when applying for SABG funding. Providers were educated through webinars, trainings, e-mail communications, site visits, etc. regarding the completion of local needs assessments designed to identify local conditions associated with their identified problems.

The state needs assessment data is used to guide SABG funding decisions by providing specific priority areas on which the state is focused. In Idaho, the priorities identified are prescription drug abuse and misuse, alcohol health outcomes, and marijuana use. We ensure those programs funded with SABG monies address these issues. We also use data regarding priority subpopulations from the needs assessment to ensure there are funded programs focusing on and available to these subpopulations. Finally, the needs assessment adds to our understanding of community challenges and strengths as well as assisting to identify gaps in resources to address those challenges.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

While Idaho's current prevention system is solid, there are identified areas that would benefit from further development. The state intends to build the capacity of its prevention system, including the capacity of its prevention workforce, by: 1) building and sustaining local community coalitions; 2) encouraging the implementation of evidence-based environmental strategies; 3) prioritizing workforce development; 4) identifying and adapting programs/strategies to fit rural and frontier communities and subpopulations; and, 5) continuing to expand and improve our data collection and evaluation systems.

Developing and sustaining local community coalitions to mobilize and build capacity is an ongoing process. In 2009, Community Coalitions of Idaho (CCI) was created to facilitate collaboration and encourage cooperation among Idaho community coalitions. This "coalition of coalitions" was tasked with providing a forum for community coalitions to promote prevention efforts, establish a strategic prevention plan, and increase the number of prevention coalitions in Idaho. Since its inception, the number of CCI substance abuse prevention coalition members has grown from 13 to 30. With the award of a SPF-SIG grant in 2013, ODP funded eleven (11) community coalitions to date, with an additional six (6) coalitions selected to receive funding in FY2016. All SPF SIG grant sub-recipients will participate in the National CADCA Coalition Academy, a comprehensive training program developed to promote sustainability, cultural competence, assessment, prevention planning and strategies for success.

The implementation of evidence-based programs and practices has similarly been a focus area for building capacity. One hundred percent of the direct service programs funded in Idaho with SABG funds are identified as evidence-based programs. Environmental prevention strategies designed to change the community, as well as the social and economic contexts in which individuals access alcohol, tobacco, or other illicit drugs have more recently been introduced. Increasing the delivery of EBPs and environmental strategies in Idaho is a statewide priority for FY2016.

Developing the substance abuse prevention workforce in Idaho is a high priority for ODP. Several efforts have been initiated to improve training and technical assistance available to prevention providers, especially those in rural and frontier areas. After analyzing data from a survey of current providers, ODP identified that there was a large need for program specific training of instructors. Of the 32 respondents, over 21% reported that they had never received program specific training for the program they were currently instructing. Although ODP is attempting to meet the need by arranging for these trainings, there is still room to improve. In addition, Idaho is currently determining the feasibility of requiring all sub recipients to obtain the Certified Prevention Specialist certification through IC&RC to ensure the prevention workforce has the requisite knowledge and skills to implement successful prevention efforts.

Adapting evidence-based programs to meet the needs of Idaho's individual communities is another area of focus. ODP has established an Evidence-Based Practices Workgroup consisting of 11 members, including state agency staff, local experts, community providers and Advisory Council members. Idaho plans to utilize the Workgroup to build its capacity in using evidence-based practices in a variety of prevention areas.

Finally, ODP continues to focus on the development of a strong data infrastructure system capable of both collecting and extracting required data for local, state and federal reports and producing outcome data to guide resource decisions and best practices. ODP contracts with KIT Solutions (KITS), LLC to provide a web-based Data Collection, Reporting and Evaluation System for substance abuse prevention programs. The KITS system

was implemented in April 2014. Training of ODP staff and prevention providers was conducted throughout SFY2014. The KITS format follows the Strategic Prevention Framework model, and allows providers to enter Needs Assessment, Capacity, Planning, Implementation, and Evaluation data related to prevention programs and activities delivered. Additionally, the system is used to collect data on participant demographics, attendance, pre/post test scores, providers/staff and staff training, and service costs. Required block grant and NOMS data is also recorded in the data management system. There are currently forty eight (48) providers using the KITS data management system to track SABG funded community substance abuse prevention services. This system can be viewed at: https://idprev.kithost.net/idprevent2014/.

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;
b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
c. A formal mechanism to assess community readiness to implement prevention strategies.

Currently, Idaho has no statewide licensing or certification program for the substance abuse prevention workforce.

The coordination of training and technical assistance for the prevention workforce is the responsibility of ODP's grant project directors and staff. Historically, SABG funds have been utilized to provide scholarships to the Idaho Conference of Alcohol and Drug Dependency (ICADD) and the Idaho Prevention Conference. Most recently, ODP is partnering with the Center for Application of Prevention Technologies (CAPT) and Community anti-Drug Coalitions of America (CADCA) to develop both on-line and in-person training opportunities designed to increase the number of Certified Prevention Specialists in the state. Idaho currently has a total of 3 CPS registered by the Idaho Board of Alcohol/Drug Counselor Certification (IBADCC). A recent assessment of prevention providers indicated a large range of both experience and expertise. Efforts to standardize provider training and improve system quality are in process. ODP intends to develop a written plan for the process of certification.

At this time, Idaho does not have a formal mechanism to assess community readiness to implement prevention strategies. Readiness and capacity to implement prevention strategies is currently determined through the competitive grant application process. Applicants are required to provide a community assessment, information about their organization's capacity, and detailed plans for implementation and evaluation. The Regional Review Committees then determine the applicant's readiness to implement the proposed strategies based on their submitted application materials.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

The Idaho Office of Drug Policy (ODP) assumed oversight of the delivery of substance abuse prevention services in Idaho effective July 1, 2013. At that time, ODP introduced the *Strategic Prevention Framework* (SPF) principles as the foundation for substance abuse prevention strategies and programs. The SPF model is data-driven. The process of establishing priorities, identifying gaps in resources, and choosing evidence-based practices to address specific needs are all based on available data and local conditions.

ODP, with the assistance of numerous partners, utilized data on substance use consumption patterns, consequences of use, and risk and protective factors to compile an annual substance abuse prevention needs assessment. This completed assessment serves as the basis for the identification of primary prevention services that are needed. The *Idaho State Epidemiological Outcomes Workgroup* (SEOW) implemented a four step process to determine appropriate indicators to inform prevention efforts:

> Step 1: Review Data Indicators. An examination of existing information was conducted, establishing a comprehensive list of over 150 possible state-wide indicators grouped by substance and construct type. From this initial list, statewide priorities were identified.

Step 2: Incorporate Criterion. Driven by the interest of requiring data sources that would reflect a statewide scope, the workgroup assigned 6 criterions to refine the above mentioned list to 40 indicators.

Step 3: Identify Relevance and Record Type. Using a scale of one to three, with 1 being *Very Relevant* and 3 being *Not Relevant*, all indicators were scored by SEOW members and classified based on the data source, administrative (A) or survey-based (S).

Step 4: Score. A hybrid Delphi method was employed by the SEOW workgroup to further define indicators. The resulting indicator list is composed of 12 constructs and 38 indicators. The resulting trends from the remaining indicators were used to determine areas of need in the state.

In addition to the annual Needs Assessment, and with the support of the State Epidemiological Outcomes Workgroup staff, the Office of Drug Policy began an update of Idaho's Prevention and Treatment Research (PATR) website. Currently, the site focuses on substance abuse prevention data. The data is being transitioned to incorporate use and consumption information obtained through both the *Idaho Youth Risk Behavior Survey* (IYRBS) and the *Behavior and Risk Factors Surveillance System* (BRFSS). The site also includes a variety of archival and survey data reported at the state and county level. The goal is to provide the resources and data that individual providers and community coalitions could use in community planning as well as grant applications. The PATR web address is: http://patr.idaho.gov/. Further expansion of the site is planned to include behavioral health data and information.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Idaho's Substance Abuse Strategic Prevention Plan was developed by ODP with the assistance of the Idaho SPF Advisory Council, SEOW, EBP, Idaho State Priority Scoring Subcommittee, and the Boise State University Evaluation team. It was drafted and submitted in the spring of 2014 and is used to guide decisions about the use of the primary prevention set-aside of the SABG. The three overarching goals of the strategic plan are to: 1) Prevent the onset and reduce the progression of substance abuse, including underage drinking; 2) Reduce substance abuse related problems in communities; and 3) Build prevention capacities and infrastructure re at the state/tribal and community levels. The plan is based on the Strategic Prevention Framework and incorporates implementation of each of the five steps of the model.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

Idaho has an active Evidence-Based Practices Workgroup. Programs that are listed on the Idaho Evidence-Based Program List are considered evidence-based and, therefore, may be used by prevention providers across the state. Programs that are listed on the National Registry for Evidence-Based Programs and Practices (NREPP) are also deemed evidence-based. However, if the program is not on NREPP, the program must be reviewed by the Idaho Evidence-Based Practices Workgroup to identify if there is evidence of effectiveness.

The Workgroup is composed of research professionals from several state agencies. For a program to be reviewed by the 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 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.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

All specific recurring primary prevention programs, practices and strategies funded with SABG prevention set-aside dollars must be on Idaho's approved list of evidence-based programs (this list can be found at: http://odp.idaho.gov/grants/sabg.html). Decisions to include an evidence-based program on the list are based on National Registry of Evidence- based Programs and Practices (NREPP) ratings and/or Idaho outcome data. National registry-listed programs that have shown positive outcomes with Idaho populations which do not meet NREPP ratings requirements may be provisionally funded in areas where the program has proven effective, if approved by the Evidence-Based Practices (EBP) Workgroup.

The identification of evidence-based environmental strategies has proven to be a bit more challenging, as few are listed on National Registry of Evidence-based Programs and Practices, and even fewer have comprehensive implementation materials that are comparable to the recurring education programs. Currently, Idaho funds media campaigns/media advocacy; community town hall meetings and awareness/education activities; youth projects related to substance abuse prevention or education; responsible server training; and, prescription drug take back events.

Idaho ensures that SABG dollars are used to purchase primary substance abuse prevention services by implementing a statewide partnership with multiple agencies. The Office of Drug Policy has established multiple workgroups to build a substance abuse prevention infrastructure in Idaho.

The specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies include the following:

CSAP Prevention Strategy Type	**Prevention Program Name**	**Program Type**
Information Dissemination	RADAR Information Center	Public Awareness
	Statewide Resource Directory	Public Awareness
	Underage Drinking Media Campaign	Public Awareness
	Lock Your Meds Media Campaign	Public Awareness
Prevention Education	Project Alert	Classroom-based Skills based for youth
	Nurturing Parenting Program	Parent/Family based Education/Support
	Strengthening Families Program	Parent/Family based Education/Support
	Second Step	Classroom-based Skills based for youth
	Al's Pals	School-based Skills based for youth
	Life Skills Training	School-based Skills based for youth
	Guiding Good Choices	Parent/Family based Education/Support
	Positive Action	Curriculum-based Skills based for youth
	Class Action	Curriculum-based Skills based for youth
	Project Towards No Drug Abuse	Curriculum-based Skills based for high school youth
	eCHECKUP TO GO	Skills based for high school youth

Alternatives		
	Cross Age Mentoring Program	Youth and adult leadership activities
	Positive Action/Prime Time for Kids	After-School Program Community service activities /
	Youth Leadership Conference	Youth leadership activities
Community-based Process		
	Community and Volunteer Training	Skills based
	Coalition Development	Skills based
Environmental Strategies		
	TA to communities	Skills based
	Reality Parties	Community-based/Environmental Strategies
	Prescription Medication Take-back Programs	Community-based/Environmental Strategies
	Responsible Beverage Server Training Programs	Community-based/Environmental Strategies
	Youth Sticker Shock Campaigns	Information Dissemination/ Environmental Strategies
	Social Host Ordinances	Community-based/Environmental Strategies
Problem Identification and Referral		
	Active Parenting/Families In Action	Prevention Education, Problem Identification and Referral
	Towards No Drug Abuse+	Prevention Education, Problem Identification and Referral
	Strengthening Families Program	Prevention Education, Problem Identification and Referral

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

To avoid duplication of prevention efforts, Idaho has now moved oversight of all Federal substance abuse prevention dollars to the Office of Drug Policy (ODP). This ensures that all SAP efforts are coordinated through one state office and reduces the possibility of duplication of efforts. However, there are some state agencies that occasionally fund what can be considered substance abuse prevention programs. Because of the strong relationships we have built with these agencies, we work together to stay informed of these programs and ensure that we are not duplicating efforts. In addition, 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.

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

The state will collect process data on participants served by prevention programs, as well as sub recipient providers. Data such as number of participants served, demographics, attendance data, and pre/post data will be collected on participants. Regarding sub recipients, ODP will collect: the number and distribution of grantees across the state, the funding amounts awarded to the grantees, the number of grantees that provide accurate pre-

post data on their program's outcome measures, the number of certified prevention specialists, the number of grantees that work with SPF SIG funded coalitions, the number of evidence-based programs used, and the number of people served by the programs administered by the grantees.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to college on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?
Please indicate areas of technical assistance needed related to this section.

At the state level, Idaho collects data on the following indicators:

- Percentage of people 12 and over needing but not receiving treatment for alcohol dependence
- Rate Idaho gallons sales per capita
- Percent of students grades 9-12 reported use of alcohol past 30 days
- Percent of adults 18 and older reporting use of alcohol past 30 days
- Percent of students in grades 9-12 reporting five or more drinks in a row within a couple of hours in the past 30 days
- 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
- Percent of adults aged 18 or older binge drinking of alcohol in past 30 days
- Rate of alcoholic liver disease deaths per 100,000
- Rate alcohol-induced deaths per 100,000
- Deaths sustained in alcohol-related vehicular crashes per 10,000
- Alcohol-related arrests per 1,000 per 1,000 population
- Driving under the influence (DUI) arrests per 1,000 population
- Underage alcohol-related arrests per 1,000 population
- Alcohol-related treatment admissions in which alcohol was reported as the primary substance of use upon treatment entry
- Percentage of adults who have smoked at least one cigarette in the past 30 days
- Percentage of adults ever using smokeless tobacco
- Percentage of 9th-12th grade students who smoked cigarettes on 20 or more days in the last 30 days
- Nonmedical use of prescription pain relievers in the past year per 1,000 population
- Prescription drug seizures per 100,000 population
- Percentage of students in grades 9-12 reporting marijuana usage one or more times during the past 30 days
- Marijuana as a primary substance of use upon treatment entry per 100,000
- Illicit drug use other than marijuana past month per 1,000 population
- Other drug trafficking arrests per 100, 000
- Other drug possession arrests per 1,000
- Other drug seizures per 100,000

This data assists the state in keeping our needs assessment current as well as determining progress being made in each priority area. By tracking this data, Idaho can build on successes and make adjustments in strategies when necessary.

At the community level, all grantees administering programs will deliver pre-post surveys to assess their progress on their goals. Items on the pre-post surveys are contingent on the population the program serves and assess domains such as refusal skills, usage, and perception of harm, parent-child communication, and parenting practices. This data will assist Idaho in determining if the EBP's being implemented are delivering the desired outcomes. If reported outcomes are less than desired, ODP will work with providers to endure the program is being delivered with fidelity, if there is a program that is better suited to the population served, or if additional training or technical assistance is required.

Environmental Factors and Plan

10. Quality Improvement Plan

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.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Quality Assurance Program

Division of Behavioral Health

Submitted by Candace Falsetti- CO 3rd, 4-24-2015, #2

2015

Idaho Department of Health and Welfare

Quality Assurance Program

Quality Assurance Program

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Quality Assurance Program

Revisions:

Title	Date	Revision #	Notes
Quality Assurance Program	**March 16, 2015**		
“”	**March 27, 2015**	**1**	**Added definitions Clarified role of Qa Checked BPA QA description Checked IYTP description**
Same	**April 24th, 2015**	**2**	**Clarified role of QA compared to Contract Monitors**

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): 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: A program for 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

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.

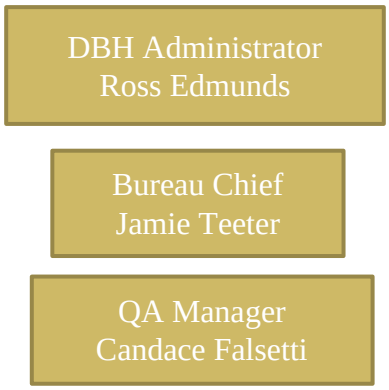
A set of key outcome/performance measures that will be used for evaluation are in development. The measures will be identified based on the following philosophy:

- 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.

A list of possible 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.

Once key indicators of performance and outcome measures have been identified the process for reporting of outcomes will be developed. Outcome measures will be utilized to evaluate the impact of the QAP.

DBH QA Management Structure



Quality Assurance Program

Quality Assurance Methodology

The Quality Assurance (QA) methodologies that will be employed will include review of State operated and contractor records, reports, policy and procedures, site visits, direct interviews, and surveys. QA findings will be assessed and addressed as quality improvement (QI) through various quality techniques such as Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis.

QAP Functional Areas

QAP identifies the areas of responsibility specifically assigned to the Quality Assurance Unit. These functional areas are listed below.

Idaho Behavioral Health Plan (IBHP)

Managed Services Contractor (SUDS)

19-2524

Preadmission Screening and Resident Review (PASRR)

Continuous Quality Improvement (CQI)

Facility Approval

Critical Incident

Jeff D – Quality Management Improvement Activity (QMIA) plan Development

Idaho Youth Treatment Plan (IYTP) Evaluator

Quality Improvement (QI) Work Plan

Performance Improvement Projects (PIPs)

A high level description of each functional area follows.

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

Quality Assurance Program

DBH QA monitors the IBHP progress toward the goals for transformation through:

i. Evaluating targeted IBHP responsibilities and processes to ensure they are within an acceptable range meet state and federal laws, requirements and standards.

   IBHP responsibilities that DBH QA will evaluate include, but are not limited to:

   a. Transformation
   b. Care Management:
      i. Authorization and Denials
      ii. Records of ICM, Discharge Coordination
      iii. Care Coordination with PCP
   c. Provider Network:
      i. Provider credentialing
      ii. Provider audit findings, action plans
      iii. Provider training plans
   d. Quality Assurance:
      i. Member Rights
      ii. Member Satisfaction

ii. Assessing the impact of IBHP processes based on the quality aims set by the Institutes of Medicine (IOM) for quality assurance: effectiveness, efficiency, equitable, safe, timely, client centered.

   The impact will be measured utilizing identified key outcome measures

Managed Services Contractor (SUDS)

In addition to, and in support of, contract monitoring central office 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.

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 ensure that consideration is given to the behavioral health needs as part of presentencing determination.

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. If the information is not adequate to develop a treatment recommendation the DBH clinician requests a full MHE. Information regarding treatment recommendations are communicated to the PSI and are notated in the final report.

In addition to the Utilization Management processes noted 19-2524 staff work with IDOC and 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 screening to develop recommendations, which may include a comprehensive MH evaluation. 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.

Quality Assurance Program

Facility Approval

In accordance with Idaho Statute and IDAPA all SUDs provider must have facility approval by the state authority. DBH QA staff designated lead completes all initial site certifications and monitors the work of the MSC.

DBH is in the process of developing IDAPA rule for Facility Approval for a Behavioral Health Agency.

Critical Incidents

Regional Programs report all Critical Incidents to central office administrators and QA. Critical incidents are also reported by the IBHP and 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

Jeff D Quality Management Improvement Activities (QMIA) Plan Development

DBH QA will work with the Jeff D implementation team to develop a Quality Management Improvement Activities (QMIA) plan that will define the QA processes to be implemented in regards to Jeff D Members.

Idaho Youth Treatment Program (IYTP) Project Evaluation

QA acts in the role of Project Evaluator for the grant for the Idaho Youth Treatment Program. The Project evaluator performs a variety of monitoring, evaluating and reporting functions as described in the IYTP Project Evaluation Plan.

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)

Systemic issues that are appropriate may be addressed through a PIP. A PIP 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.

Quality Assurance Program

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:

Quality Assurance Program

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

Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
Client/Family Centered (Engagement)	Parent/Family voice, choice, and preference are assured throughout the process	What proportion of cases involves caregivers and children in case planning and service delivery?	Number of cases in which client or family were involved in service planning Number of cases in which age-appropriate children were involved in case planning	Client satisfaction surveys Direct client survey (phone calls?)
		How do clients/family perceive the quality of the collaboration?	Client and family perception of collaborative service delivery	
	Collaborative Assessment of Environmental Factors	Are client and family strengths and needs integrated into treatment?		
	Services are maintained	Are clients 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 Clients have improved family mental health/substance abuse and relationship status	To what extent are family strengths and needs assessed and integrated into treatment?	Items from the *CANS*, CALOCUS, CAFAS , GAIN, LOCUS Measure for Social connectivity? Wellness Assessment (Optum's WA)	Results of outcomes tools
	High utilizers	Are clients and families receiving appropriate services?		Encounter data
Linkages	Evidence of Care coordination with other mental health providers	To what extent is the treatment plan coordinated with other agencies?	Treatment plan indicates coordination with other agencies as needed Client perceptions of service availability, access post-	

Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
			discharge	
	Evidence of Care Coordination with Primary Care	To what extent is treatment integrated?	Treatment plan indicates coordination with other primary care	
	Evidence that physical health issues are assessed	To what extent are physical health issues assessed?		
Safety	Risks are identified and clients 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		

10. Quality Improvement Plan

Idaho Response

Because the Division of Behavioral Health employs multiple service delivery methods and transfers management of primary prevention funds to the Office of Drug Policy, there are multiple quality improvement/quality assurance plans. The Office of Drug Policy response will be submitted in a separate document.

For the delivery of mental health services and state level oversight of substance use disorders services, the Division has established the "Quality Assurance Program" manual. This document addresses the Division's priorities and commitment to quality care. The Division of Behavioral f Health is committed to reducing the impact of substance abuse and mental illness on Idahoans and to Idaho's communities. To support this goal the Division of Behavioral Health DBH has developed a Quality Assurance Program .The goal of the this program is to build a structure 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 critical to the Division of Behavioral Health Each operational unit in the Division 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.

The Division's Quality Assurance Program manual is included in the attachments responding to this section.

The Division of Behavioral Health requires their substance use disorders services intermediary, Business Psychology Associates, to have a quality improvement specific to the state-funded provide network. While the Division does not write or implement this plan, Division staff do review and approve the plan.

The Business Psychology Substance Use Disorder Treatment and Recovery Support Services Network Continuous Quality Improvement Program is also included in the attachments responding to this section.

Substance Use Disorder Treatment and Recovery Support Services Network

Continuous Quality Improvement Program

January 27, 2013

Submitted by:

Business Psychology Associates

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Introduction

Partnerships with clients living with substance use disorders and their families, stakeholders, and the provider networks are essential in meeting the changing needs and choices with service provision. This important aspect of recipient empowerment and choice drives Business Psychology Associates' (BPA) Substance Use Disorders system's (SUD) Continuous Quality Improvement (CQI) program. BPA is committed to working with the Partners to provide quality services to our SUD clients. This commitment mandates an interactive system that involves clients and their families, providers in the network, BPA staff, and stakeholders. This quality system must function as a collaboration to set quality standards, identify system problems, require corrective action, and recommend solutions.

This document will be updated annually to reflect any changes to the BPA CQI program as a result of system changes and agreements between the Partners and BPA.

Purpose

BPA is the management services contractor (MSC) for the State of Idaho's Substance Use Disorder's (SUD) system of care. BPA directly manages multiple funding streams that include state and federal block grant funding. BPA maintains ongoing efforts toward seeking opportunities for and making continuous improvements in the quality of healthcare services and the health status of the populations served. A comprehensive Continuous Quality Improvement (CQI) program directs BPA's efforts.

The scope of the CQI program is designed to ensure the accessibility of services, availability of the network and the quality and appropriateness of services provided to our clients. Input and feedback into the CQI process from the clients, Partners, providers, and stakeholders are valuable components of the quality improvement program.

The CQI program encompasses all aspects of care delivered by providers as determined by each Partner's benefit plan. These services can include substance use disorders services, which are

provided in outpatient, residential, social, detoxification, and community-based settings. In addition to continuous assessment of the clinical elements of healthcare, the CQI program looks at administrative and service issues that affect the delivery of care.

This CQI Program description is designed to ensure BPA's efforts meet state and federal regulations and national accreditation standards.

Goals

The Quality Management Program aims to improve the health of the people we serve, enhance the patient experience of care, and promote quality access, while controlling or lowering per capita costs. Our program works towards achieving these aims by applying strategic focus on improvements in the following dimensions of care and services:

1. Accessibility
2. Appropriateness
3. Timeliness
4. Continuity
5. Effectiveness
6. Efficiency
7. Safety
8. Quality of client/provider relationships

Additional information on these quality domains is provided in the CQI Measures and Reporting section of this program description.

The BPA Quality Management Program achieves these aims by:

1) Assuring that services are always designed and delivered in a manner that safeguards member safety
2) Promoting member rights and regulatory protections
3) Monitoring the clinical competence of our network and service providers

4) Monitoring that the clinical care provided to members is consistent with recognized standards of care in accordance with best practices and/or evidence-based practices
5) Improving member (patient) health outcomes
6) Identifying areas for improvement and designing interventions or redesigning procedures that will lead to positive change
7) Ensuring member satisfaction with services rendered

CQI Structure and Accountability

Overview

BPA is committed to ensuring that customers and clients receive the highest quality health care and the most effective, efficient service from our employees and our providers. The BPA Quality Management (QM) Program is grounded in the concepts of consumer-driven recovery, resiliency, and results. The QM Program considers consumer and family, provider, and stakeholder involvement as an integral component to our quality assessment and performance improvement programs.

The BPA treatment and service delivery strategy is to drive and support recovery, which is defined by SAMHSA as, *a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential*.[1] BPA recognizes that recovery, resiliency and ultimately self-management must be the common, recognized outcome of the services we provide.

Culture of Quality

The BPA QM program adheres to a Continuous Quality Improvement (CQI) philosophy through which we monitor and evaluate appropriateness of care and service, identify opportunities for improving quality and access, establish initiatives to accomplish agreed upon improvements, and monitor resolution of problem areas. Our philosophy is an ongoing process that spans

[1] http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

every aspect of our program operations and unites our organization, members, providers and other stakeholders in a continuous upward spiral of quality improvement through planning, action, and evaluation.

The Quality Management Committee (QMC) oversees the QM program. The QMC and designated quality committees utilize an analytic framework to establish departmental and organizational measures that includes, but is not limited to the following components: (1) the Triple Aim established by the Institute for Healthcare Improvement (IHI) and (2) the Model for Improvement[2].

The BPA QM program follows the framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. This model asserts that healthcare improvements must be developed to simultaneously pursue three dimensions, called the "Triple Aim". Below are the three dimensions of the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

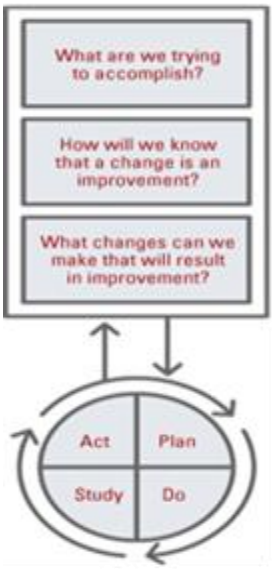
BPA's QM program utilizes the Model for Improvement to guide improvement activities. The Model for Improvement is a simple yet powerful tool for accelerating improvement[3]. Below is a description of the Model for Improvement:

- **Forming the Team**

[2] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

[3] Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

Including the right people on a process improvement team is critical to a successful improvement effort. Teams vary in size and composition. Each organization builds teams to suit its own needs.



- **Setting Aims**

  Improvement requires setting aims. The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

- **Establishing Measures**

  Teams use quantitative measures to determine if a specific change actually leads to an improvement.

- **Selecting Changes**

  Ideas for change may come from the insights of those who work in the system, from change concepts or other creative thinking techniques, or by borrowing from the experience of others who have successfully improved.

- **Testing Changes**

  The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

- **Implementing Changes**

  After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team may implement the change on a broader scale — for example, for an entire pilot population or on an entire unit.

- **Spreading Changes**

  After successful implementation of a change or package of changes for a pilot population or an entire unit, the team can spread the changes to other parts of the organization or in other organizations.

Comprehensive Outcome Measures Program

The BPA QM program acknowledges national excellence in service delivery within both health and behavioral health models through our embedded Comprehensive Outcomes Measures Program (COMP). The BPA COMP employs standardized, reliable, and valid industry measures for all outcomes tracking and reporting. Our Program utilizes all applicable Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as SAMHSA's National Outcomes Measures (NOMs) and Treatment Episode Data Set (TEDS) methodology for assessing system outcomes. The QM Program promotes the use and ongoing evaluation of additional National Quality Forum (NQF) measures for inclusion in the COMP. For more details, please refer to the Comprehensive Outcome Measures Program document.

Structure

BPA's internal Quality Management structure provides an objective, systematic and continuous process for assessing, monitoring and improving the quality of all our functions including the behavioral health services provided to clients. The QMC reports activities to BPA's Board of Directors at least annually. The QMC also provides feedback to all sub-committees, advisory groups and all ad hoc work groups and task forces acting as data feeds into the QMC. Subcommittee reports include a summary of activities performed and recommendations for action.

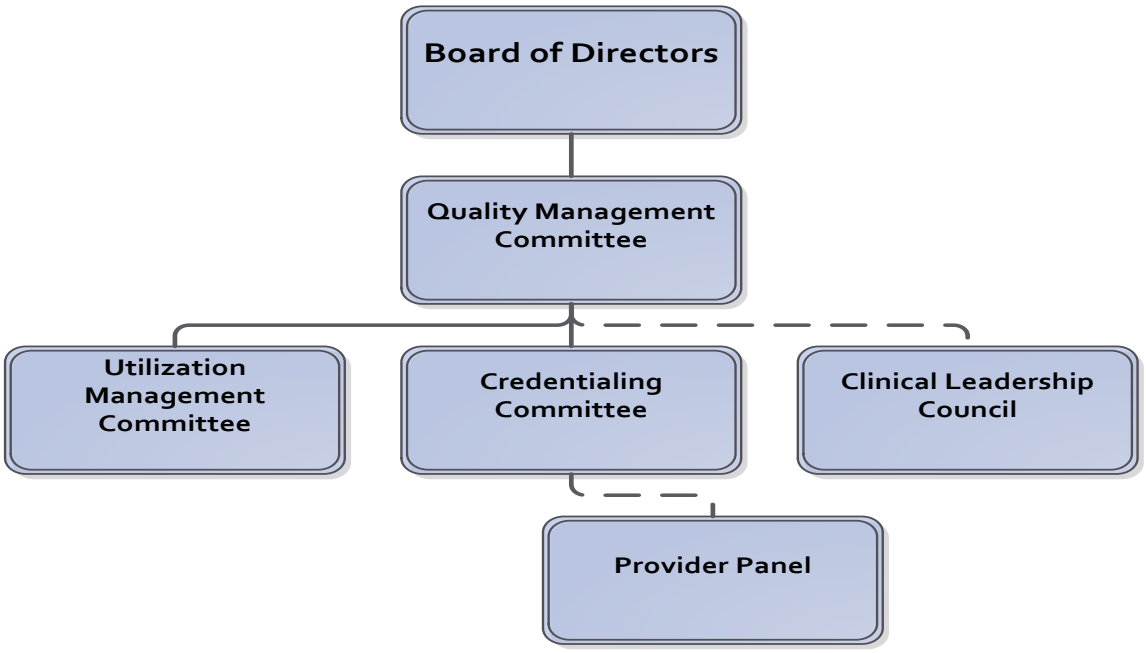
Subcommittees:

- **Utilization Management Committee (UMC)** The Quality Management Committee has delegated oversight of the utilization management function to the UMC. The UMC has responsibility to recommend policies for development; review and approve, and deny, or recommend revisions to policies related to UM activities; review utilization issues (cases) as requested by the Medical Director; review quarterly utilization reports and make recommendations for improvement, review and approve studies, standards, clinical guidelines, trends in quality and utilization management measures and outcomes.

- **Credentialing Committee** The Quality Management Committee (QMC) has delegated decision-making authority to the Credentialing Committee. This committee, chaired by BPA's Medical Director with membership that includes providers, is responsible for credentialing and re-credentialing providers who deliver services to clients. This committee is also responsible for conducting professional review activities involving the providers whose professional competence or conduct adversely affects, or could adversely affect, the health or welfare of clients. The credentialing committee's major responsibilities are: (1) receive and review, at a minimum, health practitioner/professional and provider credentials that do not meet BPA's credentialing criteria (that are not complete, "clean" as defined by BPA, and approved by the BPA Medical Director); conduct peer review evaluations; and make decisions regarding actions on the credentialing or re-credentialing information presented.

In addition to the above committees, the QMC invites input from stakeholders to gain expert clinical recommendations and valuable stakeholder feedback. The QMC advisory panels include the Clinical Leadership Council (CLC) and the Provider Panel. The Clinical Leadership Council provides a multi-disciplinary clinical roundtable to support BPA's internal improvement and business activities. The Provider Panel is an advisory committee composed of behavioral health practitioners whose role is to advise BPA on organizational wide clinical, operational and quality activities. The Provider Panel meets at least quarterly.

The graph below reflects the structure of BPA's CQI/QM Program:



Oversight

The QMC meets no less than quarterly and is chaired by the President or appropriate designee. The committee is comprised of the following participants: President, appropriate Clinical and Operational leadership as designated by the President, Chief Financial Officer, Manager of Clinical Services, the Director of Provider Networks, and the Quality Support Supervisor. Because BPA strongly believes that quality management should be embedded in the entire organization, the QMC appoints ad-hoc members including staff, providers, customers, and members/clients.

The Executive Team is represented on the QMC. The QMC reports to the BPA Executive Team through the committee minutes. The Executive Team is responsible for ensuring that the organization provides the necessary resources for the Quality Management Program to achieve its objectives and the activities of the QMC are consistent with the organization's overall goals and objectives. The Executive Team is also responsible for reporting on quality improvement to the BPA Board of Directors.

Quality Management Committee Responsibilities

The QMC is responsible for the following:

1) Developing and maintaining the quality management program
2) Tracking and trending key indicators of:
    a. Compliance
    b. Member safety including access
    c. Clinical quality including provider performance
    d. Efficiency
    e. Stakeholder satisfaction including member satisfaction
3) Identifying and prioritizing annual quality initiatives
4) Identifying and prioritizing new quality initiatives during the year as issues of critical importance are identified
5) Implementing quality improvement projects based on items 1 through 4 (above)
6) Including provider input
7) Reporting routinely to the BPA Management Team and staff
8) Developing a semi-annual report to the Board of Directors
9) Assuring an appropriate and effective credentialing function by overseeing the Credentialing Committee
10) Assuring appropriate and effective care management by overseeing the Utilization Management Committee
11) Ensuring that appropriate training, resources and support are provided to the organization to achieve our quality aims
12) Development of an Annual Plan, to include:
    a. Designation and monitoring of core quality indicators
    b. Measuring, tracking, and trending core indicators
    c. Designation of at least one new quality improvement project based on:
        i. Data from core indicator measures
        ii. Identification of one or more areas of concern regarding a meaningful quality indicator that the committee determined require(s) improvement
        iii. Customer requirements
        iv. Company-wide quality initiatives

13) Annual review and assessment of program activities and achievements
14) Review of any critical incidents or critical quality of care concerns and development of action plans to address those as appropriate
15) Ongoing development and oversight of activities tailored towards improving quality of life or quality of care for members

Collaboration with Partners and other Stakeholders

BPA leadership will work collaboratively with the Partners and other stakeholders to ensure continuous quality improvement activities are effective and beneficial to clients and the system of care. The Governance Council, jointly comprised of BPA and Partner leadership, will provide oversight and direction for quality activities, including the Comprehensive Outcome Measures Program.

Contractor Regulatory and Contractual Compliance

In an effort to ensure BPA's compliance with applicable state and federal regulations, the Quality Support Supervisor (QSS) or their designee will continuously monitor legislative activities, and will make changes to the CQIP and related activities as needed. The QSS or their designee will conduct a regulatory compliance audit at least annually. The QSS will evaluate quality deliverables in conjunction with contract monitoring efforts at least annually. Results of each will be included in each annual CQIP evaluation and any necessary changes to the CQIP will be made in the annual CQIP update.

Provider Network Regulatory and Contractual Compliance

To ensure provider compliance with contractual and regulatory requirements, BPA will conduct compliance audits on the following schedule:

	Facility Review Audit	Initial Compliance and Training Audit	Client Record Audit	Clinical Oversight Audit	Evidence Based Practice (EBP) Audit	Client Assessment of Care Survey
Treatment	At	w/in 90	Annually	Annually	Fidelity audits	Annual

Network	renewal for all BPA network providers	days of contracting w/BPA			are conducted quarterly during implementation and annually thereafter	
Recovery Support Services (RSS) Network	At renewal for all BPA network providers	w/in 90 days of contracting w/BPA	Annual desktop audits	Case Management only	NA	Annual

Facility Review Audit

Regional field staff staff will conduct this audit for renewal of facility approval, ensuring that the provider meets requirements of Section 130 or Section 135 of IDAPA 16.07.20, as appropriate. BPA understands that our responsibility to conduct facility review audits is limited to providers that are in the BPA network at the time of renewal. BPA will work with IDHW to coordinate the audit schedule so that facility approval standards can be reviewed at the time of another scheduled on-site audit, if those audits fall within a mutually agreed upon window.

Initial Compliance and Training Audit

Clinical regional staff will conduct this audit within 90 days of provider entering the network. Providers are introduced to the standards and trained to the tools used by BPA to assess compliance within the provider's respective network.

Member Record Audit

Clinical regional staff will conduct this audit annually. Providers are audited to adherence to well-documented treatment records, facilitation of communication, coordination and continuity of care, to promote efficient and effective treatment.

Clinical Oversight Audit

Clinical regional staff will conduct this audit annually. Providers are audited to adherence to clinical supervision standards utilizing the "How to Manual", per IDAPA standards. In addition, providers reporting the use of EBP will be audited to ensure compliance to the EBP standards.

Evidence Based Practice (EBP) Utilization Audit (Fidelity Audit)

BPA's Provider Oversight Committee will review quarterly network, regional, and individual provider reports to assess and monitor adoption of and adherence to accepted best practices within the network. These reports will be valuable in establishing our understanding of provider EBP utilization rates, patterns and frequency of use within the SUD treatment network.

Member Assessment of Care Survey

This is a standardized survey that asks clients to report on and evaluate their experiences within the system of care and services. It will be designed to capture client perspectives on health care quality. The Member Assessment of Care Survey will be administered at time of discharge and annually at the date to be established by the Partners.

CQI Quality Domain Measures

The eight quality domains are detailed below. The Governance Committee will determine acceptable levels at a date to be determined.

Required Quality Domain	Assessment	Analysis Frequency	Review, by
Accessibility – the accessibility of services for clients.	Provider adequacy analysis Call Standards: -transfer rate -drop rate -abandoned rate -average hold time	Quarterly	Provider Oversight Committee, Governance Council
Appropriateness – the correctness of the treatment decisions of a provider for any one client.	Clinical decisions: -denial rate -appeal rate -overturned rate (appeals)	Quarterly	Provider Oversight Committee, Governance Council

Timeliness – the timeliness of services that is optimal for the benefit of the client	Treatment initiation rate Treatment engagement rate Complaints response rate	Quarterly	Provider Oversight Committee, Governance Council
Continuity – the provision of SUD services within a framework of a holistic approach to the behavioral health system in Idaho.	Claims payment comparison to authorized RSS Residential discharges receiving outpatient services within 30 days of discharge (excluding against professional advice) Average Length of episode	Quarterly	Provider Oversight Committee, Governance Council
Effectiveness – the effectiveness of the treatment to meet the identified outcomes for each client's care.	National Outcomes Measures (NOMs) data elements EBP utilization rate	Quarterly	Provider Oversight Committee, Governance Council
Efficiency – the maximum use of resources with minimal waste and duplication.	Rate of residential readmissions within 30 days of discharge Average Cost per case	Quarterly	Governance Council
Safety – an environment that ensures, to the greatest extent possible, that all unnecessary dangers to clients are mitigated and eliminated.	Adverse and sentinel events analysis Recredentialing denial rate	Quarterly	Provider Oversight Committee, Governance Council
Quality of client/provider relationship	Percent of providers with a complaint resulting in a sanction Client satisfaction survey	Annually	Provider Oversight Committee

Reporting

BPA will begin reporting on all areas of the CQIP upon full access to and formal training on SSRS, the reporting tool for WITS. Reporting capabilities will be based on what is available in SSRS through BPA's logins. CQIP Reports will be delivered via email to the Partners by the 20th of the month following the end of each quarter.

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SUBSTANCE USE DISORDER PROVIDER MANUAL

Welcome

Business Psychology Associates, on behalf of the State of Idaho Department of Health & Welfare and partnering governing bodies, would like to welcome you to the Substance Use Disorder (SUD) Provider Network. BPA staff looks forward to supporting your successes as a SUD Provider in your local communities through the consistency and expertise of our Provider Network Management team of professionals. We believe personal contact maintains strong links to providers especially when dealing with sensitive matters. Our staff are trained and dedicated in the importance of positive and professional dealings with all clinicians and facilities in all areas of need. To meet these expectations we encourage one-on-one contact between our Regional Coordinators, Medical Director, or Clinical Director and your agency whenever necessary.

How to use this manual

The impetus for the development of this training manual for the SUD Provider Network is to provide a basic framework and definitions for program development for new providers as they integrate into the network. We believe whether you are a seasoned provider or new to the industry the information assembled in this manual will help to alleviate some of the complexities associated with providing SUD treatment (TX) and Recovery Support Services (RSS) in Idaho's evolving behavioral healthcare system. The BPA Provider Network Management team strongly encourages the utilization of our staff whenever necessary to assist in your development through consultation, problem-solving, and advocacy.

The content of this manual is intended for use by every member of your clinical treatment and administrative support teams. By design, we have presented the necessary information as less prescriptive in nature wherever possible in terms of providing recommendations or suggestions for implementation of clinical quality and best practice interventions in your provision of SUD services.

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Dual Diagnosis Capability in Addiction Treatment (DDCAT) Tools
Clinical Supervision How to Manual
Qualified Substance Use Disorders Professional Manual

Business Psychology Associates Introduction

History

BPA began as a private practice named Psychological Associates. The company was among the first Employee Assistance Program (EAP) vendors in the Pacific Northwest. In 1974, the practice began providing EAP and related mental health and substance abuse assessment and therapy services to J.R. Simplot Co., an Idaho-based company with nationwide facilities and employees.

Since its founding, Business Psychology Associates (BPA) has achieved professional and financial success through a strategy of careful, steady growth. Business Psychology Associates was formed by founders of a large provider-owned clinical practice who wanted to focus resources and attention on the then-new field of Employee Assistance Program (EAP) services.

BPA provides premium EAP throughout the United Sates in addition to managed behavioral healthcare programs and substance abuse treatment for Idaho. We regularly work with customers to consult on plan design, cost containment strategies and quality assurance measures. In addition, we have solid experience developing and implementing mental health parity plans.

Mission

- We transform lives by improving behavioral healthcare delivery systems.

Beliefs

- The quality of each employee's lifestyle is of primary importance both at and away from work.
- BPA employees are entitled to the opportunity to maximize their individual and collective potential.
- Each employee is expected to utilize the opportunity to develop his/her potential.
- BPA's service must contribute to the welfare of both the individuals and organizations we serve and to society as a whole.
- BPA's efforts must reflect the highest standard of ethics and quality.

Purpose of BPA Provider Manual

The purpose of this manual is to provide specific and detailed information about Business Psychology Associates' (BPA) service delivery system. The manual contains explicit statements regarding our mission, our managed care philosophy, and our commitment to total quality management. Our goal is to build a strategic partnership between BPA and the mental health/substance abuse providers who manage, provide, and coordinate behavioral treatment services for us. We will strive together to meet the objectives of our corporate mission.

We hope this manual provides you with a clear understanding of our treatment philosophy and of the policies and procedures that must be observed when providing treatment services to clients on behalf of BPA. We are committed to providing support to help assure your success in the behavioral health care environment. We look forward to working with you and hope that you find your relationship with BPA a satisfying and rewarding one.

Provider Responsibilities

The substance use disorder treatment provider provides evidenced based modalities to all eligible clients. In order to receive BPA referrals providers must contract and credential with BPA.

To comply with the BPA contract agreement BPA providers agree to the following:

- Provide covered services authorized by a BPA representative. Covered services shall be provided in accordance with generally accepted practices and standards prevailing in the professional community at the time of treatment and in accordance with Idaho Administrative Procedures Act (IDAPA) 16.07.20 *et seq.* and applicable plan documents. Provider shall ensure that all personnel providing services to clients under this agreement provide such services in an ethical and professional manner, and in compliance with all applicable laws and regulations, including state licensure boards.
- Complete and maintain clinical records on eligible clients, to whom services are rendered, as required by the State of Idaho for providers as specified in IDAPA 16.07.20, 375 and 376. BPA shall have the right to access and copy records of eligible clients for a period of five (5) years after termination of this Agreement.
- Maintain an active State Facility Certificate of Approval to receive SUD funding as defined by IDAPA 16.07.20.
- Not discriminate against eligible clients on the basis of source of payment, race, color, creed, sex, ethnicity, nationality, age, state of health, place or residence, disability or perceived disability, or any other basis prohibited by law.
- Maintain professional liability insurance coverage in an amount of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) aggregate. Provider shall also (a) supply upon reasonable request a copy of the face sheet reflecting any changes in insurance coverage prior to their effective date; (b) supply copy of the face sheet for each annual renewal of the provider's professional liability insurance. Provider shall immediately notify BPA in the event of termination or non-renewal of such insurance.
- Unless prohibited by law, promptly notify BPA of the initiation of litigation by any third party or the initiation of any state or federal investigation and of any facts or circumstances which indicate the possibility that a third party has a cause of action or will initiate litigation, with respect to any act or omission of provider or BPA, or any employees, agent, or contractor of provider or BPA.
- Consents to the listing of his/her name in BPA's directory or in the directory or other publications of any organization with which BPA has contracted to arrange for the provision of behavioral health care services or Idaho Department of Health & Welfare funded substance use disorder services.
- Not advertise or distribute material, which refers to BPA without BPA's prior written consent.
- Comply with all reasonable administrative policies and procedures of BPA relating to the delivery of covered services including, but not limited to timeliness standards and procedures to request additional services beyond those initially authorized.
- Agree that during the course of this agreement and at all times thereafter, he/she shall hold confidential all information concerning BPA, BPA providers and eligible clients.
- Comply with all IDHW and BPA required standards as outlined in IDAPA 16.07.20 and BPA Provider Manual.
- Agree to accept eligible clients upon referral from a BPA representative. If provider cannot meet the requirements of the referral, the provider must promptly notify BPA.
- Agree to allow appropriate BPA representatives, upon request, to inspect its facilities and its medical records of eligible clients.
- Agree to comply and cooperate with the BPA Quality Assurance Program including, but not limited to, Evidence Based Practice audits, outcomes and satisfaction assessment process, Continuous Quality Improvement (CQI), charitable choice requirements, co-occurring outcomes and the credentialing process. These elements will be pursuant to HIPAA and 42CFR privacy rules to ensure the limited purpose of evaluating for compliance, review competence and or qualifications of providers by evaluating their performance. These audits/reviews are not used for the purpose of any study or for direct client contact.
- Provider agrees to follow the Code of Ethics as adopted by the provider's license and/or certificate related national professional association.
    - Notify BPA within ten (10) working days from receipt of notice to the agency or any personnel providing services pursuant to this agreement termination, non-renewal, or restriction of license, certificate, registration, or other legal authorization to provide any behavioral health services.
- Submit appeals and complaints using BPA's Appeals & Grievance Policy and Procedure, available on the BPA website and in the Provider Manual.

- SUD Faith Based Providers must comply with Charitable Choice laws as outlined in the Federal Community Services Block Grant and Substance Abuse and Mental Health Services.
- Notify BPA thirty (30) days prior to any service site relocation or addition of new service site. Any new service sites must go through BPA's established application and credentialing process.
- Comply with required provider trainings
- Report adverse incidents as outlined in the Adverse Incident Reporting Policy and Procedure and reporting form available on the BPA website.
- Maintain HIPAA compliance for electronic claims submission.
- Comply with the requirements of the GAIN/WITS interface as outlined by IDHW and BPA.
- Ensure that all personnel providing services to eligible clients under this agreement are properly trained and qualified per IDAPA 16.07.20 to render the services they provide. Provider shall arrange for continuing education of personnel rendering services under this agreement as necessary to maintain such competence and satisfy all applicable licensing or other legal or regulatory requirements.
- Provider nor any person providing services to eligible clients shall have been barred or excluded from participating in any federal health care program, including Medicaid.

See also Credentialing and Contracting

Cultural Competency

Within the BPA network Cultural Competency is defined as a set of congruent behaviors, attitudes, and policies that combine to work effectively in cross-cultural situations.

BPA is devoted to the development and strengthening of effective and healthy provider/member relationships. Clients have a right to appropriate and quality care. When cultural differences are disregarded clients are at risk for poor quality of care. Clients are less likely to communicate their needs in an indifferent environment, limiting effectiveness of the health care process.

Part of the credentialing and site visit process is to assess the cultural competency level of network providers and provide access to training to help develop cultural competent and culturally proficient practices.

Network Providers must ensure:

- Client knowledge of access to signers, client interpreters, and TTY services to facilitate communication without cost to them;
- Consideration of the clients' language, ethnicity/race and its influence of the clients' health
- Culturally competent office staff that routinely come in contact with clients participate in ongoing cultural competency training and development;
- Administrative staff attempts to collect race and language specific client information;
- Treatment plans use consideration of race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process;
- Office sites have posted and printed materials in English, Spanish, and other prevailing languages within the regions.

Understanding the Need for Culturally Competent Services

Research shows that a person has better health outcomes when they experience culturally appropriate interactions with providers. Developing cultural competency begins with self-awareness and acceptance that cultural competency is ongoing. The experience of a client begins at the front door. Failing in being culturally and linguistically competent could cause the following results for clients:

- Feelings of being insulted
- Reluctance and fear of making future contact with the office
- Misunderstanding and confusion
- Non-compliance
- Feelings of being uncared for, looked down on and devalued
- Parents' resisting to seek help for their children
- Missed appointments
- Provider's misdiagnosis
- Increased grievances or complaints

Preparing Cultural Competency Development

BPA encourages the recognition and acceptance of the value of meeting the needs of your clients.
Here are some questions to keep in mind as you provide care to clients:

- How are cultural differences impacting your relationship with your clients?
- What do you know about your client's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- What are your own cultural values and identity?

Cultural Competency Training

BPA encourages providers to continuously train their staff on cultural competency. Our trainers will also ensure that all trainings include cultural competency objectives to increase participants' understanding, appreciation, acceptance, and respect for cultural differences and similarities. BPA is committed to the development, strengthening, and sustaining of healthy provider-client relationships that reflect cultural competence in the services provided by both the provider network and BPA staff. We believe that a client has a better outcome when they experience culturally appropriate interactions with treatment and RSS providers.

Clinical Practice Guidelines

Clinical practice guidelines offer research-based suggestions to treating a variety of disorders. Practice guidelines differ from treatment guidelines in that practice guidelines are more general suggestions for assistance rather than specific treatment requirements. The suggested practice guidelines include an assessment of the strength of the current scientific evidence for each recommendation.

The American Psychology Association has Clinical Guidelines for Practitioners ranging from record keeping, healthcare delivery systems, to Guidelines for Assessment of and Intervention with Persons with Disabilities. The purpose of these guidelines is to help educate clinicians and give recommendations about professional conduct. Furthermore, this offers a place for clinicians to maintain and develop competencies and/or stay current with new practice areas.

Additional Resources:

- Institute of Behavioral Research, Texas Christian University http://www.ibr.tcu.edu
- The Change Company, http://www.changecompanies.net

Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual by Mary Velasquez, Gaylyn Gaddy Maurer, Cathy Crouch and Carlo C. DiClemente (July 15, 2001).

Motivational Interviewing and Stages of Change: Integrating Best Practices for Substance Abuse Professional by Kathyleen M Tomlin and Helen Richardson.

Substance Abuse Treatment & the Stages of Change: Selecting & Planning Interventions by Connor, Donovan and DiClemente.

Client Records

Client records include results of examinations and laboratory tests, encounters, referrals, mental health screenings and tests, contacts about the client, and any other clinical information that pertains to the care and treatment of the client. Records are to be prepared, maintained and stored as directed in Idaho state rules and regulations, and signed by the professional providing service.
Accurate and complete client records will assist providers in delivering the highest quality healthcare. They will also enable BPA to review the quality and suitability of services rendered. To ensure the clients' privacy, client records must be kept in a secure location.

Client Records Release
Client's records shall be confidential and not released without the written authorization of the covered person or the covered person's legal guardian. When the release of client records is appropriate the extent of that release should be based upon client necessity or on a need to know basis. Each client record release needs to be documented in compliance with HIPAA and 42 CFR part 2 regulations.

Required Information
Providers must maintain complete client records in accordance with the following standards:

- Client's name and/or client record number on all chart pages
- Personal/biographical data is present (i.e. employer, home telephone number, spouse, etc.)
- All entries must be legible
- All entries must be dated and signed (can be electronic) or dictated by the provider rendering the care
- Significant illnesses or client conditions are documented
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the client record. If no known allergies exist, that must be documented
- Appropriate subjective and objective information pertinent to the client's presenting complaints is documented in the record
- Past treatment history is easily identified and includes any psychiatric hospitalizations
- Working diagnosis is consistent with assessment
- Treatment plan is appropriate for diagnosis
- Risk assessments for suicidal and homicidal ideation at every session
- Confidentiality of client's information and records protected
- Progress note for each session
- Discharge Plan
- Discharge Summary

Provider Audits

Once providers have received facility approval from IDHW a BPA Regional Coordinator will conduct a new provider training. This training will familiarize providers with required documentation and BPA audit tools for Clinical Chart Audits, Clinical Supervision Audits, and Evidence Based Program Audits.

Training Review

Within 90 days of this training, providers will undergo an initial review to establish a baseline understanding and application of network requirements. The results of this review are not reported to IDHW however, it will be used to determine the timeframe of the next scheduled Clinical Chart and Clinical Supervision Audits.

Scheduled Audits

A score of 80% or above on the Clinical Chart and Clinical Supervision audits places the provider on an annual audit schedule. Clinical Chart or Clinical Supervision Audit scores lower than 80% places the provider on a 90 day audit schedule for the next audit.

To clarify:
Clinical Supervision Audit **≥** 80% = Annual schedule for Clinical Supervision Audit
Clinical Supervision Audit **<** 80% = 90 day schedule for Clinical Supervision Audit

Clinical Chart Audit **≥** 80% = Annual schedule for Clinical Chart Audit
Clinical Chart Audit **<** 80% = 90 day schedule for Clinical Supervision Audit

> In the event of a score less than 80% the provider will be required to submit a Corrective Action Plan within 10 days upon receipt of the audit results. The Corrective Action Plan is then approved by the Regional Coordinator and the deadline for the next audit is set for approximately 90 days.
> If the Regional Coordinator identifies a consistent deficiency and the score is above 80% a Performance Improvement Plan is requested and due for approval 10 days upon receipt of the request. The Performance Improvement Plan is then sent to the Regional Coordinator for approval and the provider remains on the annual timeline.

For Cause Audits

If BPA receives a complaint or identifies a problem or potential problem with a provider, BPA may determine an audit is necessary to ensure compliance.

Facility Renewal

BPA conducts Facility Renewal Audits and provides a recommendation to the Idaho Department of Health & Welfare for the length of the approval. This audit consists of a facility walk through, review of policy and procedures, personnel records, and uses the Clinical Supervision and Clinical Chart Audit data (if done within 6 months prior to the Facility Renewal Audit).

Audit Scheduling and Procedure

Audits are scheduled the month prior to the deadline. Regional Coordinators will make every effort to schedule audits at the provider's convenience prior to the deadline. To fulfill our contractual obligations to IDHW we cannot schedule audits past the deadline.

Once the audit is complete the Regional Coordinator is available to review the findings of the audit. In each region a Regional Coordinator is available to schedule technical assistance training.

Utilization Management Program

Business Psychology Associates' (BPA) Utilization Management (UM) Program provides a structure and process by which clinical appropriateness of behavioral health services are defined, continuously monitored, and improved over time. Because BPA believes quality is an organizational value synonymous with performance, the UM Program is highly integrated with the Quality Management Program, which continuously monitors program data, evaluates clinical and consumer satisfaction results, and takes focused actions when opportunities for improvement are identified.

The UM Program activities are based on a commitment to consumer driven services, our provider network, and Continuous Quality Improvement (CQI). UM activities are integrated throughout the organization, involving every department, system, and employee.

BPA does not currently delegate UM functions; however, should this occur in the future, oversight will be conducted in accordance with regulatory and accreditation requirements. BPA's UM Program is URAC accredited.

Purpose and Goals

The purpose of the UM Program is to provide easy and equitable access to quality behavioral health services, which focus on individualized treatment strategies that promote the principles of recovery and resiliency. The BPA UM Program is designed to evaluate the cost, quality of services, and transitions of care and services provided to our consumers. BPA strives to build strong, working relationships with our network providers.

The goal of utilization management is to create a system that facilitates necessary communication with the providers serving our consumers in order to produce efficiency in the authorization process and access to services. The UM Program assures appropriate utilization, which includes evaluation of potential overutilization, underutilization and timely access to services. Review of services is based on medical necessity in accordance to BPA's Clinical Review Criteria policies and standard operating procedures.

The following are the goals of the Utilization Management Program:

- Assure services rendered are medically necessary and furnished in an amount, duration and scope that address the needs of the consumer, using written, objective, clinical review criteria based upon professionally recognized resources and established with input from clinical staff members and substance use disorder professionals.
- Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity according to the Prospective, Concurrent, and Retrospective Review Policies & Procedures.
- Establish the process used to review and approve the provision of behavioral health services, including an appeal system for non-certifications including; service denials, reduction in services request, or termination of coverage.
- Enable clients to access behavioral health services in a timely manner, based on turnaround of all UM decisions and timely notification about decisions to consumers and/or providers.
- Establish accountability structures and processes for communication and integration of a comprehensive plan of care across providers, settings, and the continuum of care.
- Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and with applicable state and federal laws that govern the utilization management process.
- Protect the confidentiality of consumer and provider information and records.
- Explore opportunities to create and innovate in health care management and delivery with consumers and providers.

Oversight

BPA's Medical Director or clinical designee will provide leadership, direction and guidance for all aspects of the

UM Program and will be responsible for ensuring all clinical and non-clinical services are administered in a manner consistent with accepted standards of care. The Utilization Management Committee (UMC) meets at least quarterly and is chaired by the Medical Director or their appropriate clinical designee. The membership of the UMC includes representation from cross-functional areas such as Clinical, Quality Support, Utilization Management, and Member Services departments. A quorum consists of four of five members present with one clinical voting member present.

The UMC reports utilization management activities and performance data to the Quality Management Committee (QMC) at least quarterly.

Staff Roles and Responsibilities

The Manager of Clinical Services and Frontline Team Supervisor oversee the day-to-day activities of the Utilization Management Program. The UM Department utilizes non-clinical and clinical staff members. UM staff performs functions that ensure consumers get the right care at the right time based on the applicable benefit eligibility structure. These functions include care coordination activities that promote the consumer's safe transition between providers and care settings.

Customer Support Specialists (CSS) are non-clinical employees responsible for review of service requests for completeness of information, collection and transfer of non-clinical data, collection of structured clinical data, conducting initial screening to determine benefit eligibility, triage of crisis calls, placing initial assessment authorizations, and creating or modifying authorizations based on current processes. CSS have clinical oversight available at all times.

The Care Management team is comprised of health professionals. Utilization Management Client Service Coordinators (UM CSC) are clinical staff that are licensed, masters level behavioral health professionals with clinical and utilization management experience. Care Managers perform clinical reviews for prospective, concurrent, and retrospective authorization requests using specified clinical review criteria.

The Medical Director makes non-certification determinations based on medical necessity for services involving urgent care and residential treatment, in accordance with BPA policy. If initial clinical review indicates a potential medical necessity issue or quality of care concern, the care request will be referred to an appropriate clinical peer reviewer. UM CSCs perform brief assessments and provide referral services for clients who present in crisis.

Decision Making Criteria

Clinical review criteria are used to ensure that all care management decisions (a) are made in a standardized and consistent manner, (b) will determine the most appropriate care available, (c) meet the needs for safety, health, and general wellbeing of the populations we serve, (d) are based in scientific literature pertaining to established clinical guidelines and organizational practices, both locally and nationally, and (e) will have regular oversight and reexamination by BPA staff. These criteria are reviewed annually both internally and externally, to ensure that our assessment and determination tools are based on the latest scientific evidence and professional standards. The Care Management team is trained on clinical review criteria as part of their orientation and at least annually thereafter. During the course of day-to-day utilization management activities, UM staff will have readily available access to the appropriate criteria sets and clinical oversight for reference in clinical decision-making.

Information Used for UM Decision-Making

Utilization management staff uses standardized tools and procedures to review information when making decisions about medical necessity. BPA accepts information from the provider and/or other collateral sources that will assist in making an informed decision about the medical necessity of care. BPA will collect only the information that is necessary to certify the admission, procedure or treatment, length of stay, frequency or duration of services.

Information obtained during the UM decision making process is confidential and will be managed in accordance

with BPA policy.

Credentialing and Contracting

To request a copy of your contract please send us an email. Click here if you would like a credentialing application.

BPA Credentialing Requirements

Credentialing and re-credentialing of BPA network providers is designed to ensure that providers within our networks meet BPA credentialing standards. The goal of this policy includes:

- Ensure each BPA provider is qualified by education, training, licensure and experience to deliver quality behavioral health services
- Maintain only competent and qualified providers through appropriate parameters of credentialing and application of performance standards without discrimination based on race, age, color, religion, national origin or sex
- Provide a means to address issues of professional conduct, physical and psychological health status and current clinical competence

As designated by the Quality Management Committee (QMC) the Credentialing Committee (CC) has responsibility and authority for credentialing and re-credentialing the BPA provider network. The Clinical Director is designated to review and approve credentialing and re-credentialing applications. The Clinical Director may conduct additional review and investigations of credentialing applications where the credentialing process reveals factors that may impact the quality of care or services delivered to clients.
Membership or provisional status in the provider networks of BPA shall be extended only to professionally qualified practitioners who:

- demonstrate their current competence,
- continuously meet and satisfy the qualifications, standards and requirements set forth,
- practice in a geographic area determined by BPA to be advantageous to its clients and
- who possess the necessary physical and mental health to provide quality behavioral health services.

The credentialing and re-credentialing process shall be completed within 60 days of the receipt of the provider application and required documents. Prior to review, BPA will accept additional information from providers to correct incomplete, inaccurate, or conflicting credentialing information.

BPA will send written notification to the provider informing them of the determination of the credentialing application within 60 days of the determination.

Qualifications and Criteria for Decision Making for SUD Network Membership:

- Facility Approval
  - The provider agency must have current State of Idaho Department of Health & Welfare Alcohol and Drug Abuse Treatment Program Certificate of Approval.
    - If the provider does not have an IIDHW certificate of approval BPA rejects the application.

- Qualified Staff
  - The clinical staff at the provider agency must meet conditions of a Qualified SUD Professional, or Qualified SUD Trainee as determined by the Idaho Department of Health & Welfare.
  - The provider agency must employ a Clinical Supervisor who meets qualifications as determined by the Idaho Department of Health & Welfare

- Professional Liability Insurance
  - SUD treatment providers - $1,000,000.00 per occurrence and $3,000,000.00 aggregate
  - SUD standalone case management providers- $1,000,000.00 per occurrence and $3,000,000.00 aggregate

- Commercial General Liability Insurance
  - SUD housing provider - $1,000,000.00 per occurrence and $2,000,000.00 aggregate
  - SUD alcohol and drug testing providers - $1,000,000.00 per occurrence and $1,000,000.00 aggregate

- Auto Insurance
    - SUD transportation providers - $1,000,000.00 per occurrence and $1,000,000.00 aggregate

- Training Requirements
    - Provider agency must complete WITS Training with the IDHW WITS Helpdesk and New Provider Orientation with a BPA Regional Coordinator prior to activation in the network(s).

Application Process

Unless otherwise specified, applicants must first complete a BPA application for participation in the network. The application may be submitted electronically or hard copy.

Each application is reviewed and must include the following minimum requirements:

- Complete, signed and dated BPA application;
- Current IDHW Certificate(s) of Approval;
- Current liability insurance in compliance with minimum limits; professional liability claims history including any pending professional liability actions;
- Listing of all sanctions or penalties within the past five years;
- Documentation of any voluntary or involuntary relinquishment of privileges to practice in a facility or jurisdiction;
- Attestation of history of loss of license and /or clinical privileges, disciplinary actions, and /or felony convictions;
- Disclosure of any physical, mental, or substance abuse problems that could impede the provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of clients without reasonable accommodation;
- Attestation to the correctness/completeness of the application;
- Signed and dated Release of Information Form.

Applicants submitting incomplete applications or submitting the incorrect application materials will be contacted in writing and given the opportunity to complete the application process or re-file using the corrected application. On identification of erroneous information the applicant will be notified in writing and given the opportunity to correct the information.

If any application is signed and dated by the provider more than 180 days prior to the credentialing committee review, it will be returned to the provider for updates.

BPA may conduct additional review and investigation of credentialing applications where the credentialing process reveals factors that may impact quality of care or services delivered to consumers.

BPA will conduct primary source verifications of providers. Primary source is defined as the organization or entity that originally conferred or issued an element used in credentialing or the data bank(s) to which those organizations report.

Credentialing Committee

As designated by the Quality Management Committee (QMC) the Credentialing Committee (CC) has responsibility and authority for credentialing and re-credentialing the BPA provider network. The Credentialing Program will be reviewed and modified as necessary, at least annually by the QMC.

The Credentialing Committee's primary responsibilities include:

- To apply established, nationally recognized criteria for both initial credentialing and re-credentialing;
- To analyze Provider Network Management reports to determine network development needs and adequacy as part of credentialing recommendations;
- To ensure the ongoing use of quality review information in making credentialing and re-credentialing recommendations;

- To receive and integrate provider concerns and feedback on the Credentialing Program into ongoing credentialing activities;
- To recommend changes in the credentialing and re-credentialing criteria to ensure compliance with changes in federal, state, professional, accreditation, and payer guidelines;
- Explore provider concerns as they relate specifically to credentialing criteria;
- Discuss whether providers are meeting reasonable standards of care;
- Accesses appropriate clinical peer input when discussing standards of care for a particular type of provider;
- Evaluates and reports to the Quality Management Committee (QMC) the effectiveness of the credentialing program;
- Review and approve Credentialing Policies & Procedures and program description at least annually.

The Credentialing Committee has overall responsibility for administering credentialing and re-credentialing decisions related to or affecting providers and organizations in a BPA provider network. The Committee reviews credentialing and re-credentialing activities and makes recommendations concerning provider sanctions. Committee members include the Medical Director, Clinical Director, and Director of Provider Networks. The credentialing committee includes at least one participating provider who has no other role at BPA.

The Credentialing Committee is authorized to review the scope of clinical practice as well as the professional conduct and clinical performance of each provider. The Credentialing Committee must approve all credentialing applicants that are not "clean files" before a provider or facility is designated as a participating provider within the plan's network.

The Credentialing Committee has an exceptions process that can be used if it is necessary to credential a provider given a client's needs. Providers also can be provisionally credentialed if necessary to make them available prior to completion of the full credentialing process. Provisional credentialing status is time-limited and can only be granted once for a given provider (See Provisional Credentialing below).

In addition to credentialing and re-credentialing providers the Credentialing Committee can also terminate (e.g., due to lapsed licensure) or restrict or limit a providers clinical privileges (e.g., based on quality of care and/or services issues). In these situations the provider can enter into the Provider dispute resolution process as defined in the Provider Termination & Sanctioning Policy.

The Credentialing Committee shall meet bi-monthly and on an as-needed basis based on credentialing files that may necessitate off-cycle review as determined by the Medical Director.

The Medical Director, which shall be a physician licensed in the State of Idaho, has been designated to review and approve credentialing and re-credentialing applications and shall be the chairperson of the Credentialing Committee. The Medical Director may conduct additional review and investigations of credentialing applications where the credentialing process reveals factors that may impact the quality of care or services delivered to consumers. The Medical Director has final authority on the credentialing and re-credentialing of files. Any exceptions to BPA's credentialing policies must be approved by the Medical Director.

Provider Rights

- Providers will be informed via initial application packet letter of: 1) their right to review the information obtained to evaluate their credentialing decision, attestation, or CV; 2) the process and provider's right to be informed of the credentialing decision; 3) provider's right to correct erroneous information (see below); 4) the appeal process for actions taken against providers (see below and Provider Termination & Sanction Policy).
- Providers have the right to review information obtained by BPA to evaluate their (re)credentialing applications except where disclosure is protected by peer review or prohibited by law
- Discrepancies of information:
    - For information obtained during verification from primary sources providers have the right to correct discrepant or erroneous information by working directly with the reporting entity or listing agency.
    - If the credentials verification process reveals information that varies substantially with the information supplied by the provider on the (re)credentialing application the provider is notified by a

staff member of BPA and given the opportunity to respond to inconsistent information on the (re)application. The provider will have ten calendar days to provide a response in writing. The provider's response and corrected information is documented in the credentialing file. It is the responsibility of the provider to contact the primary source if the provider feels that the primary source data is incorrect.

- Status of credentialing application
  - Providers have the right to request the status of their application at any time.

Adverse Action

Decisions made which are unfavorable to the provider will be reported to National Practitioner Data Bank and state licensing board(s) as required after the provider has exhausted all their appeals. If the provider does not agree with decisions or actions the provider is entitled to a review under the appeals process. BPA will provide written notification to the provider when a professional review action has been brought against the provider, the reason for the action and a summary of the appeal rights and process.

Credentialing Decision Appeals

Providers who have received an adverse action from the Credentialing Committee are afforded an opportunity to appeal the decision. The provider has the right to review and correct credentialing information and may do so during the appeals process. BPA allows the provider to request a hearing within 30 days of receipt of the adverse determination. The written appeal must be mailed or faxed to BPA. The provider may be represented by an attorney or another person of their choice. When appeals are identified, BPA adheres to the provisions as outlined in the Provider Termination & Sanctioning Policy.

General Billing

SUD funding in the BPA provider network uses the electronic health record Web Infrastructure for Treatment Services (WITS). All billing is done through WITS however; BPA will manage billing appeals and use WITS to audit client files. WITS training required for providers prior to being credentialed into the network.

Client and Provider Appeals and Complaints

Client and Provider Complaints
BPA's Complaint Resolution Policy conforms to URAC's Health Utilization Management (HUM) accreditation standards. BPA will provide a copy of this policy to our clients, providers, stakeholders and the public, upon request. This policy is also available on our website at: www.bpahealth.com.

BPA believes that anyone has the right to make a complaint and express a concern about our programs and services. A client may designate a representative to file complaints on their behalf. There is no statute of limitations for the filing of a complaint. BPA welcomes complaints and considers them as valuable opportunities to learn, adapt, and improve the services we provide our clients and customers. BPA will not retaliate or take any discriminatory action against any individual, facility or organization due to filing a complaint. BPA categorizes each complaint into one of the following categories:

- **Administrative Complaint**: dissatisfaction related to inadequate or poor performance and/or management of business operations
- **Quality of Care Complaint**: dissatisfaction related to an alleged violation of established clinical care guidelines
- **Regulatory Complaint**: dissatisfaction related to an alleged violation of contractual or regulatory standards

The following activities describe the complaints process:

Initiating a Complaint
The following are acceptable methods for submitting a complaint with BPA. However, any employee may take a complaint and forward it to the Appeals Coordinator for investigation:

a. Phone BPA at 1-800-726-0003 to speak directly to a Customer Support Specialist (CSS).
b. Mail written complaints directly to the attention of:
   Business Psychology Associates
   C/o Appeals Coordinator
   380 E. Parkcenter Blvd, Suite 300
   Boise, ID 83706
c. Fax to 1-208-344-7430

BPA will:
- Address complaints quickly and courteously, treating all complaints equally and seriously
- Record all complaints, keep clients and customers informed of the progress, and record the action taken to address the complaint.
- Respond to complaints within **five (5) days** from receipt and resolve them within **thirty (30) days** from receipt.

Client and Provider Appeals
BPA's commitment is to provide our clients with safe and timely access to medically necessary and clinically appropriate services. This commitment also includes service requests which result in a non-certification (denial) determination. Any client or provider rendering services has the right to appeal a non-certification decision.

BPA ensures the following appeal activities:

- Notification of non-certifications sent to providers includes instruction on how to appeal the non-certification determination.

- The client, authorized representative and/or provider must submit an appeal request within 180 days of notice of non-certification.

- BPA will provide assistance to any client, authorized representative or provider needing assistance with an appeal request.

- Standard or all non-expedited appeal requests will be resolved or responded to in writing within 30 days of receipt.

- Expedited appeals will be resolved or responded to within 24 hours of receipt with immediate verbal notification that is followed by a written notification within 24 hours of receipt. Expedited appeals are defined as any pre-service claim or request for authorization during pre-certification or concurrent review involving an urgent/emergent need for treatment due to the potential risk of:
    - Seriously jeopardizing the life or health of the client or the ability of the client to regain maximum function; or
    - Subjecting the client to severe pain that cannot be adequately managed without the treatment that is the subject of the claim, in the opinion of the provider with the knowledge of the client's condition.

- The client, authorized representative and/or provider will have three (3) opportunities to have a non-certification decision reviewed for reconsideration.

- Standard appeal requests must be submitted in writing. Expedited appeal requests can be submitted verbally or in writing.

- A copy of BPA's Appeals Policy is available, upon request, to any client, authorized representative or provider rendering services.

- The client, authorized representative, or provider may submit additional information in their effort to overturn the original denial of certification. BPA will take the submitted information, and all the information originally submitted into account when rendering an appeal determination.

- The client, authorized representative or provider rendering service has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

- Each peer clinical reviewer, for each clinically reviewed appeal, must attest to meeting the following:
    - is licensed or certified in a field that typically manages the clinical issue under review and
    - have current and relevant knowledge and/or experience to render a determination for the services being reviewed

- BPA will support a decision by the appeal reviewer to overturn a previous denial of certification. BPA reserves the right to pay even if the reviewer upholds the denial, as dictated by the funding benefit

Appeal Requests
The client or service provider must submit standard appeal requests in writing within 180 days from non-certification of services. Standard appeal requests must include the following client information:

- Client name
- Client date of birth
- Client WITS ID, if applicable
- Service type and dates of services being contested
- Explanation of why non-certification determination is being disputed
- Any additional documentation needed to support the appeal

BPA's Quality Support Department manages the appeals process. When an appeal is received verbally or in writing by a BPA staff member, the appeal is immediately routed to an Appeals Coordinator.

Quality Assurance Program

BPA is committed to providing quality programs and services to our clients, families, and customers. As such, we place great emphasis on the quality of our provider networks. BPA considers each network provider to be an integral part of the Quality Management Program and expects each provider to participate in BPA's Provider Quality Assurance Plan. The Provider Quality Assurance Plan sets forth BPA's provider network quality standards along all lines of business to ensure clients are receiving high quality care and providers' treatment environment and operations.

BPA's provider performance standards are assessed, monitored and maintained through the following quality monitoring activities:

- Provider credentialing and re-credentialing
- Quality of care concerns
- Site visits
- Satisfaction surveys
- Corrective action plan compliance
- Terminations and sanctions monitoring

Structure

The Provider Quality Assurance Plan is governed by the Quality Management Committee (QMC) and overseen by the Provider Network Management Department. All pertinent provider quality monitoring data is reported to the appropriate quality committee per BPA policies.

Primary Activities

The Director of Provider Networks oversees the daily operations of the provider quality assurance activities. These activities include the following:

- Overseeing the monitoring functions;
- Tracking and trending key indicators of:
  - Provider compliance with plan
  - Internal quality compliance to plan and adherence to nationally recognized criteria.
- Submission of an annual provider quality report to QMC and the Credentialing Committee;
- Ensuring ongoing use of quality review information in making credentialing and re-credentialing decisions.
- Identifying and prioritizing new quality initiatives during the year as issues of critical importance are identified;
- Implementing provider quality improvement projects;
- Collaborating with providers on initiatives;
- Recommending changes in the credentialing and re-credentialing criteria to ensure compliance with changes in federal, state, professional, accreditation, and payor guidelines;
- Ensuring that appropriate training, resources and support are provided to providers and throughout the organization to achieve quality goals.

Primary Monitoring Activities

The BPA Provider Quality Assurance Plan includes the following primary monitoring activities:

- Provider credentialing and re-credentialing:
  - The Provider Quality Assurance Plan monitors and assesses provider credentialing and re-credentialing criteria and ensures BPA internal quality metrics comply with national standards.
  - BPA credentials providers within our networks who are licensed to practice independently according to rigorous criteria that reflect professional and community standards as well as applicable laws and regulations. All providers and/or agencies are required to participate in the credentialing process as the basis for ensuring BPA's providers meet our quality standards.
  - The re-credentialing process is a robust provider quality monitoring program that includes gathering pertinent data from client concerns, complaints on site review results, treatment record review results, quality of care issues, and quality improvement activities. In addition, BPA conducts ongoing monitoring of provider sanctions, complaints and quality issues. When issues are identified, BPA adheres to the provisions as outlined in the Provider Termination & Sanctioning Policy.
- Quality of Care Concerns

    - The Provider Quality Assurance Plan monitors appeals, complaints and adverse incident data to ensure consistent quality of service to our clients. Pertinent data is reported to the appropriate quality committee per BPA policies.
- Site Visits
    - The Provider Quality Assurance Plan ensures BPA meets national quality accreditation standards for conducting on-site reviews of all BPA's network providers. The site visits conducted are conducted in accordance with BPA policy.
- Satisfaction Surveys
    - Satisfaction surveys are utilized as a way to gather client and provider feedback regarding quality concerns. Data from the survey may trigger a complaint investigation.
- Corrective Action Plan Compliance
    - A Corrective Action Plan (CAP) is utilized as a mechanism to engage the provider in a performance improvement process as outlined in the Corrective Action Plan Policy
- Terminations and Sanctions Monitoring
    - A provider can be denied credentialing/re-credentialing, sanctioned, or terminated from providing services to BPA clients based upon accordance with the Provider Termination & Sanctioning Policy.

Recovery Support Services

Recovery Support Services (RSS) promote client engagement in the recovery process and provide services needed for support of a client's continued recovery. Recovery support services are initiated with the client at the earliest possible point in the individual planning and service delivery process. Ideally, RSS are identified at the outset of treatment as part of the development of the individual treatment plan. It is expected that the client's needs will change during course of treatment so recovery support is an ever-evolving plan. Organizations collaborating in order to provide RSS are expected to maintain linkages with the primary service provider in order to fully assess the effectiveness of on-going services and to determine if additional services are needed.

State-Funded Recovery Support Services include:

- Case Management – Basic and Intensive
- Adult Staffed Safe & Sober Housing
- Alcohol & Drug Testing
- Transportation
- Life Skills
- Child Care

NOTE: A Certificate of Approval is required for a RSS program to be included on the Idaho Department of Health & Welfare's (IDHW) list of programs which meet the standards specified in this manual. Programs must be on the list in order to receive referrals and to receive state reimbursement. A director or owner of a program must submit a completed application to IDHW on forms provided by IDHW 90 days prior to the date of the initial approval or expiration of the certificate of approval.
Website:http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/RecoverySupportServices/tabid/381/Default.aspx

NOTE: ALL IDAPA applicable SUD standards for policies and procedures must be met.

Case Management

Case Management services are assessing, planning, linking, coordinating, monitoring, and advocating for clients and their families to ensure that multiple services, designed to ensure their needs for care, are delivered in a coordinated and therapeutic manner to meet the goals of treatment outcomes. For additional information please see RSS Resources:
http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/RecoverySupportServices/tabid/381/Default.aspx

Case Management to be provided by Qualified Substance Use Disorder Professional or trainee as defined in IDAPA rules subsection 013; a person with a - Bachelor's Degree in Human Services or related field or higher from a nationally-accredited university or college, or an ISAS as defined in IDAPA rules subsection 012. The case manager must have a clinical supervisor as required in the IDAPA rules. It is the agency's responsibility to ensure that the case managers meet the IDAPA rule requirements and evidence that in the clinical supervision and/or personnel record.

The Case Manager is to complete a comprehensive service plan that addresses the needs of the client as identified through the assessment process. It is expected that the Case Manager will include information from the assessment and the treatment plan as they assess the client's needs. A comprehensive plan is anticipated to include current medical needs, legal needs, financial, transportation concerns, mental health issues, housing status, job potentials, client strengths and limitations, family concerns that may impact the client and other areas that may influence the client's success with completing treatment and being successful in the community. A written comprehensive case management service plan is to be completed within 30 days of the first client visit and to be updated at least every 90 days thereafter. To the maximum extent possible, this plan is to be a collaborative process involving the client and other support and service systems.

It is recognized that while assisting a client, phone calls or other contacts may be of short duration. Each day's billable times may be included into one note for the total time, provided the note delineates the times for each activity.

Reimbursable services include: face-to-face contact with client, client's family, legal representative, primary caregivers, service providers or others directly involved with the client's recovery; telephone or email contact with

the individuals listed above; paperwork completed to obtain services (client must be present); and documenting services for Idaho Department of Correction (IDOC) requirements.

Non-reimbursed services include missed appointments, attempted contacts, travel to provide service, leaving a message, transporting clients, documenting services (IDOC is the only exception), group case management, or mental health services provided by the Case Manager.

Life Skills

Life Skills (LS) programs are designed to enhance personal and family skills for work and home, reduce marriage/family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community.

The goal of Life Skills services is that through advocacy, teaching, role modeling, educational, social service and groups, clients and consumers in recovery will find and adopt the various tools they will need to become productive members of society. Life Skills activities may include activities that are culturally, spiritually or gender specific.

Below is a list of IDHW approved subjects for (LS) programs. This list provides examples of possible topics that may be addressed as well as online resources for building a curriculum. This is only a guideline and providers may address additional topics as long as they are related to the list of approved curriculum subjects**.**

Per IDAPA 16.07.20 section 720, any provider wanting to provide LS for any of these approved subjects must submit a basic curriculum outlining topics that will be addressed. IDHW may also request additional information and materials in addition to the curriculum.

Life Skills activities for recovering individuals may be provided on an individual basis or in a group setting and shall consist of one or more of the following objectives:

- Money Management - Budgeting and savings, balancing a checkbook/checking account, improving/fixing credit issues
- Employability Skills - Resume formats and content, filling out a job application, interviewing skills
- Healthy Relationships - Family relationships, marital/romantic relationships, friends/co-worker relationships, communication skills
- Nutrition and Cooking - Outline of a balanced diet, how to read and understand food labels, how unhealthy foods affect the body, meal planning, food shopping/creating a grocery list
- Stress and Anger Management - Relaxation techniques, coping skills, involvement in leisure activities
- Parenting Skills - Understanding basic child development, methods of disciplining children, how substance abuse affects parenting skills
- Adolescent Independent Living Skills - Apartment hunting, managing finances and paying bills, employability skills, applying for financial assistance/college loans, meal planning and food shopping
- Pastoral Counseling - Recognizing addiction, how substance abuse affects families and communities, the role of a “higher power" or religion in recovery, appropriate pastoral roles and interventions

Safe & Sober Housing

Adult Safe and Sober Housing (SSH) programs provide a safe, clean and sober environment for adults with substance use disorders who are transitioning back into the community.

Staffed Safe and Sober Housing facilities may include either or both of the following:

- Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living is typically provided for 3-6 months and can be offered in congregate settings that may be larger than residences typically found in the community.

- Long-term housing that provides stable, supported community living or assists the client in obtaining and maintaining safe, affordable, accessible, and stable housing.

Statutes regulating transitional housing can be found at 42 U.S. Code 11384 (b) and implemented at 24 CFR 583. Statutes for Safe and Sober Housing can be found in the federal Anti-Drug Abuse Act of 1988.

The Fair Housing Act prohibits discrimination in housing because of race, color, national origin, sex or familial status (families with children), or handicap.

Safe and Sober Housing programs afford the following community living components:

a) Regular meetings between the staff and clients.
b) Opportunities to participate in typical home activities.
c) Linkage to healthcare when these needs are identified.
d) Daily access to nutritious meals and snacks.
e) Opportunity of choice by the persons served as to room and housemates.
f) Opportunities to access community activities including but not limited to: cultural activities, social activities, recreational activities, spiritual activities, self-help groups, and necessary transportation.

Safe and Sober Housing programs shall not bill rent to clients receiving State Substance Use Disorder funding for housing but may impose a "program fee" to cover the following expenses:

- Basic Utilities—electricity, gas, water, sewer, trash, etc.
- Telephone Service
- Cable/Satellite T.V.
- Internet services (if available to client)
- Amenities Fund—Covers wear and tear on home living items such as furniture, bedding, curtains, washer and dryer, cookware, dishes, appliances, etc.
- Cleaning supplies (if supplied by provider)

Drug Testing

Alcohol and drug testing results are objective measures of treatment effectiveness, as well as a source of important information for periodic review of treatment progress. Alcohol and drug testing helps support positive treatment outcomes and provides accurate and reliable data supportive of other data collection efforts.

An accurate testing program is the most objective and efficient way to establish a framework for accountability and to gauge each client's progress. Methods of testing may include the use of urine specimens or oral swabs.

In addition to the general requirements for RSS providers outlined in IDAPA, alcohol and drug testing programs must meet the following requirements:

- Alcohol and drug testing policies and procedures are based on established and tested guidelines. Licensed contracted laboratories analyzing urine or other samples are also to be held to established standards.

- Testing will be provided at the provider location and may be administrated randomly or at scheduled intervals.

- Frequency of testing will vary depending on a participant's progress.

- The scope of testing is sufficiently broad to detect the participant's primary drug of choice as well as other drugs of abuse, including alcohol.

- Elements contributing to the reliability and validity of a testing process include, but are not limited to:

    - Direct observation of sample collection;
    - Verification temperature and measurement of creatinine levels in urine samples to determine the extent of water loading;

    - Specific, detailed, written procedures regarding all aspects of sample collection, sample analysis, and result reporting;
    - A documented chain of custody for each sample collected;

- Quality control and quality assurance procedures for ensuring the integrity of the process, and;
- Procedures for verifying accuracy when drug test results are contested.

A RSS program can provide alcohol or drug testing under the following conditions:

- Train provider staff to administer alcohol and drug testing utilizing elements contributing to the reliability and validity of such testing.
- Onsite alcohol and drug testing utilizing elements contributing to the reliability and validity of such testing.
- All employees shall be instructed in the precautions to take when handling specimens and who has direct responsibility for supervising this activity.
- Employees responsible for collection and testing shall be provided with protective apparel.
- Provision shall be made for storage and disposal of samples and testing chemicals.
- A department, service or staff member shall be assigned responsibility for developing these policies and procedures and for documenting their implementation.

Child Care Services

Child Care programs provide care and supervision to a client's child(ren) while the client is participating in clinical treatment and/or recovery support services. This includes care, control and supervision provided by an individual, other than a parent, during part of a twenty-four (24) hour day to a client's child(ren), less than 13 years of age, while the client is attending a treatment appointment or recovery support service.

- Child care providers must be licensed and meet the Idaho Administrative Procedures Act (IDAPA) Rules 16.06.02 *Rules Governing Standards for Child Care Licensing* (Sect. 300)
- Child Care programs will be expected to provide the following services and perform the following tasks:
  - Provide services at a time and location that is suitable for the client to attend clinical treatment or recovery support services;
  - Provide a setting that promotes and ensures the health, well-being and safety of the child(ren) in care.

Transportation Services

Transportation services are provided to clients who are engaged in treatment and/or recovery support services and who have no other means of obtaining transportation. Reimbursement is not available for transportation services to and from employment.

Individual Transportation refers to any individual providing transportation who does not meet the definition of public or Agency Transportation and provides only transportation services to an eligible client.

Please Note—only Individual Transportation providers who are approved by the Bureau of Substance Use Disorders and have a Provider Agreement with the BPA can be reimbursed.

Public Transportation refers to any entity in the business of transportation that is organized to provide and actually provides transportation to the general public

Public Transportation may include:

- Taxis
- Intra-city or inter-city buses or vans
- Airlines
- Intrastate or interstate buses (such as Greyhound) or vans

Agency Transportation refers to an entity whose employees or agents provide transportation services in addition to one or more other TX or RSS services to the same eligible client.

Please be advised that clients not funded by Medicaid may utilize transportation services for any SUD funded treatment and RSS that are defined in IDAPA. SUD clients may also use authorized transportation to any services/appointments that are directly related to any goals documented on the client's Comprehensive Case Management or RSS Service Plans.
This may include but is not limited to:

- Medical appointments
- Dental services
- Probation appointments
- Employment assistance services
- Idaho Division of Vocational Rehabilitation appointments/services
- Client case staffing
- Mental health services

Any transportation requests to recovery-oriented services not defined in IDAPA require documented confirmation of the appointment/service for which the client is receiving transportation services. Examples of documented confirmation could include a physician's note, appointment receipt, transport record, etc. Treatment providers and Case Managers should consider requirements regarding transportation services outlined in IDAPA 16.07.20 Section 730 and the transportation benefit limits when requesting client transportation.

BPA Contact Information

Provider Network Management……..(800) 688-4013
Provider Network Email Contact…….providerrelations@bpahealth.com
For questions regarding contracts, facility service information, authorized levels of care and provider status and changes

Claims……(208) 947-1275
Claims Email Contact…….claims-dept@bpahealth.com
For questions regarding claims payment, denial, submissions etc., not for submission of claims

Care Management……..(800) 922-3406
For questions regarding service vouchers, service authorization, and to speak to a Care Manager for clarification

Care Management Screenings……(800) 922-3406
Care Management Email Contact……sacare@bpahealth.com
For clients calling to complete eligibility screenings.

BPA Regional Coordinators
Communication and education liaisons between the provider and BPA, a resource to providers and community stakeholders/referral sources for the State of Idaho Substance Abuse Treatment Delivery System.

Nancy Irvin, Clinical Regional Coordinator Region 1…….(208) 964-4868
Email: Nancyi@bpahealth.com

Dean Allen, Clinical Regional Coordinator Region 2……..(208) 305-4439
Email: Dean.Allen@bpahealth.com

LaDessa Foster, Clinical Regional Coordinator Region 3 & 4……..(208) 284-4511
Email: LaDessa.Foster@bpahealth.com

Kim Dopson, Clinical Regional Coordinator Region 5……..(208) 539-5090
Email: kim.dopson@bpahealth.com

Doug Hulett, Clinical Regional Coordinator Region 6 & 7 …….(208) 921-8923
Email: Doug.Hulett@bpahealth.com

Idaho Department of Health & Welfare
Division of Behavioral Health - Central Office Staff Contact Information

Rosie Andueza, Program Manager, Operations Unit…….……..(208) 334-5934
Email: anduezar@dhw.idaho.gov

Ryan Phillips, Program Specialist……..... ……..(208) 334-6610
Email: phillipr@dhw.idaho.gov
Facility Approval
DUI Evaluators

Deborah Bailey, Administrative Assistant……..……..……..(208) 334-0642
Email: baileyd@dhw.idaho.gov
Tobacco Permits
Web Site Updates
DUI Evaluator Licensing

John Kirsch, Program Specialist……..…….(208) 334-6680
Email: kirschj@dhw.idaho.gov
QSUDP(T) Approval
Clinical Supervisor Approval
GAIN Training

Terry Pappin, Program Specialist……..(208) 334-6542
Email: pappint@dhw.idaho.gov
Prevention
Prevention Intervention

Crystal Campbell, Project Coordinator…….…….(208) 334-6506
Email: campbelC@dhw.idaho.gov
ATR

Denise Williams, Information Systems Coordinator…….……...(208) 334-4940
Email: williamsd@dhw.idaho.gov
WITS Help Desk (208) 332-7316
WITS GAIN SUD Access

Definitions / Acronyms

42 CFR, Part 2: Federal confidentiality rules that prohibit the disclosure of information concerning a client in alcohol or drug treatment unless further disclosure is expressly permitted by the written consent of the person who it pertains or otherwise permitted by 42 CFR, Part 2. Please note that to reduce stigma associated with substance abuse, this rule defines the required confidentiality and privacy for substance abuse treatment across the country. It is far more restrictive with regard to disclosure than HIPAA.
Website: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&rgn=div5&view=text&node=42:1.0.1.1.2&idno=42

Adverse or Sentinel Event: A sentinel event is including, but not limited to, any event or events that threatens the safe and efficient operations of any provider or of the Contractor, or any event involving violence or serious injury at a provider site or during a provider sponsored activity, involving a client who received services within the last thirty (30) days. Such events are called "sentinel" because they signal the need for immediate investigation and response. Sentinel events will include, but not be limited to the following:

1. Death that is related to client's condition, such as a motor vehicle accident, accidental overdose or medical condition that is related to substance use disorder
2. Suicide
3. Serious suicide attempt while receiving treatment services in a residential or inpatient facility
4. Actual, alleged or suspected cases of violence, abuse or neglect of a patient/client
5. Any facility or provider related event that will substantially interfere with care
6. Any facility or provider break-in resulting in missing or stolen client files
7. Improper use or disclosure of patient records covered under CFR 42 and HIPAA
8. Major disaster or accidents affecting the location or well-being of clients
9. Employee criminal activity resulting in arrest, detention, or involvement with law enforcement

American Medical Response (AMR): AMR is the contracted transportation brokerage assigned to administer, coordinate, and manage all non-emergency transportation for eligible Idaho Medicaid participants.
Website:http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/MedicalTransportation/tabid/704/Default.aspx

American Society of Addiction Medicine Patient Placement Criteria (ASAM): The ASAM criteria helps clinicians, counselors, and care managers develop patient-centered service plans and make objective decisions about patient admission, continuing care, and transfer/discharge for individuals with addictive, substance-related, and co-occurring conditions. Through their multidimensional assessment and the continuum of care, the criteria can improve patient outcomes. The third edition was released in 2013; The Patient Placement Criteria second edition revised (PPC-2R) was released in 2001. Website: http://www.asam.org/publications/patient-placement-criteria

Assessment: The collection of data necessary to identify areas of concern and functioning and may be used to develop an individualized treatment strategy aimed at eliminating or reducing alcohol/drug consumption utilizing a thorough evaluation of the person's physical, psychological, and social status, a determination of the environmental forces that contribute to the alcohol/drug using behavior, and examination of the person's support systems and resources.

NOTE: For clients receiving state-funded treatment, the required minimum assessment tool is the Global Assessment of Individual Needs-CORE (GAIN-CORE) or GAIN-I when court ordered. The GAIN-CORE must be administered by an individual trained and certified as a site administrator. Additional tests/measurements may be used to assist in defining the needs to be addressed (e.g., BECK depression scale, mental health screenings, ASI, SASI, and Socrates).

Assessment Building System (ABS): The GAIN Assessment Building System (ABS) is a HIPAA-compliant, web-based system hosted by Chestnut Health Systems that allows for computer-based and interactive administration of the GAIN instruments. Individuals utilizing this system must have authorization to access through WITS and be certified and approved by IDHW in GAIN administration. Website: http://www.gaincc.org/abs

Authorization Change Request (ACR): The documentation required to submit a utilization review in WITS including initial clinical reviews, concurrent reviews, change to service(s) request, request for a new service(s),

updates to authorization span and units. Some ACRs require ASAM documentation accompany in order for a clinical determination to be made by the UM team. Some ACRs do not require ASAM documentation.

Business Psychology Associates (BPA): Managed Behavioral Health Organization that serves as the Management Services Contractor (see MSC definition) for the State of Idaho Substance Abuse Treatment System. Website: http://www.bpahealth.com/

BPA Care Manager: Healthcare professional delivering utilization management (UM) services defined as: Evaluation of the medical necessity, appropriateness, and efficiency of use of health care services. UM encompasses prospective, concurrent and retrospective review as well as any review of services where authorization is required in which clinical criteria are applied to a request. Care Managers are also responsible for care coordination activities.

BPA Recommended Forms: Refers to those Word documentation examples produced by BPA as having the required
IDAPA and ASAM elements. Providers have the option to utilize these forms in their current format or reformat them to fit their respective agency or EHR needs. **NOTE:** The elements in the recommended forms must remain intact to meet IDAPA Standards.

BPA Required Forms: Refers to those PDF documentation examples produced by BPA that cannot be edited. These documents can be found on our website.

Bureau of Substance Use Disorders: A program within the IDHW Division of Behavioral Health that is responsible for the statewide delivery system of substance abuse clinical treatment and recovery support services.

Case Management (CM): "Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes." Definition from Case Management Society of America (CMSA).

Charitable Choice: The general term for several laws that were enacted during the period 1996-2000. These laws are designed to give people in need of services choice among charities offering them services and apply to projects funded by seven Federal agencies including the Substance Abuse and Mental Health Services Administration. These laws clarify the rights and responsibilities of faith-based organizations that receive Federal Funds.

Client: A person/consumer/individual receiving services from the program for substance use disorders (SUD) services. This term may be used interchangeably with eligible recipient (see definition of eligible recipient).

Client ID Number: WITS generated identification number to identify clients within WITS. Can be used on hard copy clinical files.

Clinical Chart Audit: Review of client charts for compliance with IDAPA standards.

Clinical Supervision Audit: Review of staff supervision files for compliance with IDAPA and/or additional identified standards.

Clinical Supervisor (CS): A clinician having first met the requirements as a Qualified Professional (QP) and having met the qualifications of the supervisory staff which must be verified through written documentation of work experience, education, and classroom instruction as described in IDAPA 16.07.20, Sections 216 & 218.

Comprehensive Case Management Service Plan: A comprehensive service plan is based upon a current approved assessment that addresses the medical, social, psychosocial, legal, educational, and financial needs of the client for Case Management services. The Comprehensive Case Management Service Plan provides for the coordination of services across multiple need domains.

Co-occurring Disorders (COD): The occurrence of a mental health and substance related disorder(s) as defined in the current DSM and diagnosed by someone with the licensed capacity to assess and diagnose. Also referred to as dual diagnosis.

Customer Support Specialists: Primary contact point for all BPA interactions with providers and clients. The Customer Support staff is responsible for conducting initial telephonic screenings and determining funding eligibility, answering questions regarding service vouchers, service authorization, and triaging calls to the correct department for resolution. Customer Support staff can be reached at *1-800-922-3406 (this number also provides 24 hour access to crisis counselors).*

Dual Diagnosis Capability in Addiction Treatment (DDCAT): A fidelity instrument for measuring addiction treatment program services for persons with co-occurring (i.e., mental health and substance related) disorders. The DDCAT provides definition and standards to determine levels of structure and clinical quality to assist providers in developing treatment programs to meet the needs of the COD population.
Website: http://www.samhsa.gov/co-occurring/ddcat/

Domains: Specific bio-psycho-social assessment areas as defined by ASAM; six (6) dimensional criteria: acute intoxication and/or withdrawal potential; biomedical conditions and complications; emotional, behavioral, or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and, recovery/living environment.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The manual is published by the American Psychiatric Association and covers all mental health disorders for both children and adults including Substance Abuse and Dependence. It is used to better understand illnesses and potential treatment.

Eligible Member: An individual who qualifies to receive SUD funded services through the contracted services of BPA. Also referred to as a client.

For-Cause Audit: Mandatory audit in suspected cases of abuse or other serious violations of state and federal regulations

Global Appraisal of Individual Needs (GAIN): State Approved assessment tool as identified in IDAPA Code 16.07.20. Website: http://adminrules.idaho.gov/rules/current/16/0720.pdf OR http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/InformationforProviders/IDAPAAdministrativeRules/tabid/1002/Default.aspx

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information. Website: http://www.hhs.gov/ocr/privacy/

Idaho Administrative Procedures Act. (IDAPA): IDAPA rules serve as the Administrative Rules for all state agencies. Administrative rules have the force and effect of law and as such are subject to a comprehensive process that includes review and approval by the Idaho Legislature to become final and enforceable.
Website: http://adminrules.idaho.gov/

Intensive Outpatient (IOP): An organized service delivered by addiction professionals or addiction-credentialed clinicians, which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a structured program, for a minimum of 9 hours of treatment per week for adults and 6 hours of treatment per week for adolescents (not including Recovery Support Services). *NOTE: IDOC authorizations for IOP differ dependent upon Stages of Treatment Benefits plan– additional information on plan limitations are noted in the IDOC Rate Matrix.*

Level of Care (LOC): A level or modality of care is a step in the client's treatment process. A level of care

includes clinical services, and may also include care coordination and recovery support services. Each time a client moves from one level of care to another, the clinician will be required to document the clinical observations justifying the change.

Life Skills (LS): Life Skills programs are designed to enhance personal and family skills for work and home, reduce marriage/family conflict, and develop attitudes and capabilities that support the adoption of healthy, recovery-oriented behaviors and healthy re-engagement with the community.

Management Services Contractor (MSC): Organization that contracts with Idaho Department of Health and Welfare Bureau of Substance Use Disorders to manage the statewide delivery system of substance abuse clinical treatment and recovery support services. Responsibilities of the MSC include: utilization review and care management services, quality management and outcome assessment, management reporting, account management, claims processing, data collection and managing the provider network.

Not to exceed (NTE): Not to exceed service limits (weekly/authorization) identified in the Rate Matrix.

Outpatient (OP): An organized nonresidential service, delivered in a variety of settings, in which addiction and mental health treatment personnel provide professionally directed evaluation and treatment for substance-related, addictive, and mental disorders. This also includes the services of an individual licensed practitioner (8 hours or less of treatment per week for adults and 5 hours or less of treatment per week for adolescents, not including RSS services) *NOTE: IDOC authorizations for OP differ dependent upon Stages of Treatment Benefits plan– additional information on plan limitations are noted in the IDOC Rate Matrix.*

Pre-Treatment: IDOC's early intervention treatment modality to determine readiness and appropriateness for entering/engaging in treatment. Pre-Treatment period is not to exceed 60-days without clinical justification and coordination with Probation/Parole.
***NOTE**: Applies to IDOC populations only.*

Protected Health Information (PHI): Individually identifiable health information: (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; (ii) Maintained in any medium described in the definition of electronic media at Sec. 162.103 of this subchapter; or (iii) Transmitted or maintained in any other form or medium. (2) Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity in its role as employer. (67 Fed. Reg. at 53,267 (Aug. 14, 2002); 65 Fed. Reg. at 82,805 (Dec. 28, 2000) (to be codified at 45 C.F.R. pt. 164.501)).

Provider Notification: BPA electronic notification process for the delivery of timely information to the SUD Provider Network.

Provisional Voucher (PV): An authorization (aka: voucher) entered by a provider to refer services to an agency other than themselves. This request is placed in a provisional status until reviewed by the MSC. If the request is approved then an authorization is created. If the request is denied then the authorization is never sent to referring agency. Some Provisional Voucher requests may be required to be accompanied by an ACR with ASAM documentation.

Rate Matrix: Reimbursement and CPT code schedule for all funding streams including frequency, duration and maximum allowable services.

Recoupment: Process of repaying claims for items of over payment, incomplete billing, unsubstantiated billing, or other concerns where payment in excess of authorized and appropriate payments have been made

Recovery Support Services (RSS): Approved non-clinical substance abuse services designed to engage and maximize the ability of Eligible Recipients to be successful in their recovery, and to live productively in the community. Recovery support services are initiated with the client at the earliest possible point in the individual planning and service delivery process.
Website:http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/RecoverySupportServices/tabid/381/Default.aspx

Regional Field Staff / Regional Coordinator (RC): BPA clinical employees that mentor behavioral healthcare facilities, act as a liaison with BPA offices, provide training as developed, and assist in problem solving. Regional Coordinators monitor the requirements of the provider contracts with BPA and the State agencies contracting for the SUD services.

Release of Information (ROI): Required documentation signed by the client and/or representative for the release of specifically identified information. See 42 CFR, Part 2 / HIPAA regulations.

Secure Email: Email system that meets all HIPAA and 42 CFR, Part 2 Federal requirements for the secure transmission of PHI and/or related information to/from BPA and/or any other entity requesting such communication.

Specialty Provider: SUD Provider that has met additional specific requirements and is authorized to provide services to specific populations (e.g., Pregnant Women & Women with Children (PWWC)).

Substance Abuse and Mental Health Services Administration (SAMHSA): The Federal agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Website: http://www.samhsa.gov

Substance Use Disorder (SUD): Substance use disorder is marked by a cluster of cognitive, behavioral, and psychological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems. SUD is the new term for what previously included substance dependence and substance abuse.

Service Plan: Per IDAPA "All clients receiving services must have an individualized service plan. The development of a service plan must be a collaborative process involving the client and other support and service systems." The Individualized Service Plan uses the IDHW approved comprehensive assessment (GAIN) for identified problem areas to develop goals, and treatment interventions specified for the client. IDAPA states that "The responsibility for the development and implementation of the service plan will be assigned to a qualified staff member." For more, refer to Section 380 of IDAPA.

Treatment Episode: A treatment period that begins with admission to clinical treatment and ends with the last authorized service date.

Treatment Provider: Organization approved by the Idaho Department of Health & Welfare Bureau of Substance Use Disorders to provide clinical treatment services to individuals with substance abuse disorders.

Authorization: A voucher in WITS identifying funding source (contract), service, allowable units for reimbursement, and allowable time frame to use units. Vouchers are provided to eligible recipients to pay for clinical treatment and recovery support services from a network provider. Vouchers are provider and site specific and are sent to the provider chosen by the eligible recipient.

Web Infrastructure for Treatment Services (WITS): WITS is a web-based application and database that serves dual purposes, a management information system (MIS) and clinical documentation tool. As an MIS tool, the system allows the Division of Behavioral Health to meet current and emerging state and federal reporting requirements. As a clinical documentation tool, WITS provides an agency the ability to create a full electronic health record compliant with HIPAA and 42-CFR part II standards.

Additional acronyms not otherwise defined:

Adult Protection Services (APS)
Child Protection Services (CPS)
Idaho Department of Health & Welfare (IDHW)
Evidenced Based Practices (EBP)
Idaho Board of Alcohol/Drug Counselor Certification (IBADCC)

Idaho Board of Occupational Licensing (IBOL)
Idaho Dept. of Correction (IDOC)
Idaho Dept. of Juvenile Corrections (IDJC)
Idaho Supreme Court (ISC)

Web Resources

The following website resources are the most commonly used in day-to-day business activities in Idaho. We have included website resources that providers may find useful in developing curriculum, staff training, policies and procedures and informational sites with coming changes in the SUD industry in Idaho and nationally. BPA encourages providers to bookmark the websites you use most often for easy reference. These websites have also been noted thorough this manual where applicable for additional information.

Idaho Department of Health & Welfare (IDHW)

IDHW Main Menu:
http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/tabid/105/Default.aspx

Links to all websites noted below and:
Treatment Provider Locator by Region
RSS Provider Locator by Region
RAC Websites
Pregnant Women and Women with Dependent Children (PWWC)

Idaho Criminal History Unit
https://chu.dhw.idaho.gov/

Information for providers:
http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/InformationforProviders/tabid/1915/Default.aspx

Facility Approval Application
SUD Newsletters
IDAPA FAQ's
Provider Training Calendar
IDHW SUDs Division contact information
Provider Updates
Life Skills Curriculum – IDHW Recommended
Idaho Tobacco Project

Recovery Support Services (RSS):
http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/RecoverySupportServices/tabid/381/Default.aspx

RSS Provider Locator by Region
Medicaid Approved Transportation Providers
E-Application for Program Approval
Idaho Application for Program Approval
IDAPA Rules
Use/Disclosure of IDHW Records

Qualified Substance Use Disorders Professional Lists and Clinical Supervision documentation:
http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/InformationforProviders/QualifiedProfessionalsCaseManagers/tabid/1004/Default.aspx

Qualified Substance Use Disorder Professional List
How to Manual for Clinical Supervision, check lists, required QSUDP forms, learning plans
IDAPA Rules for Clinical Supervision and Staff Requirements
Additional links to GAIN information and User eManuals

Pregnant Women and Women with Dependent Children (PWWC):
http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/FindTreatment/PregnantWomen/tabid/1001/Default.aspx

Approved PWWC Facilities List
Informational Resources

Administrative Rules – IDAPA:

http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/InformationforProviders/IDAPAAdministrativeRules/tabid/1002/Default.aspx

Alcohol and Drug Treatment Rules
Adolescent Residential Treatment Rules

Regional Advisory Committees (RAC):
http://healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/RegionalAdvisoryCommittees/tabid/198/Default.aspx

7 Regional Advisory Committee sites
American Society of Addiction Medicine (ASAM)
2-1-1 Idaho Care Line
Prevention Idaho – Benchmark Research and Safety
National Institute on Drug Abuse
Northwest Frontier Addiction Technology Transfer Center
Safe and Drug Free Schools
Substance Abuse and Mental Health Administration (SAMHSA)

State Government Telephone Directory
http://www.idaho.gov/government/gov_phone.html

Telephone and email contact information for State of Idaho employees by agency (e.g. IDHW, IDOC, ISC and IDJC)

WITS/ABS Websites & Reference Manuals

Idaho WITS Training Website
https://idaho-training.witsweb.org/

SUD Provider E-manual
http://healthandwelfare.idaho.gov/portals/_rainbow/manuals/WITS/nethelp/Sud%20eManual.htm#!Documents/treatmentplan.htm

WITS FAQ
http://wits.idaho.gov/Portals/0/Medical/SUD/NetHelp/WITS%20FAQ.html#!Documents/audits.htm

WITS Production Site:
http://idaho.mountain-witsweb.org

SUD WITS eManual
http://healthandwelfare.idaho.gov/portals/_rainbow/manuals/wits/nethelp/IDHWPilotProjecteManual.htm

Global Appraisal of Individual Needs - Initial (GAIN-I) – Printable Paper version
http://www.healthandwelfare.idaho.gov/Portals/0/Medical/SUD/GAIN-I%20Global%20Appraisal%20Individual%20Needs.pdf

Business Psychology Associates (BPA)

BPA Provider Main Menu:
http://www.bpahealth.com/providers/home

SUD Provider Network (*Menu Tab*):
http://www.bpahealth.com/providers/provider-network/substance-use-disorder-provider-network
SUD Treatment & RSS Provider Listings by Region

Licensing/Certification Websites

Idaho Board of Alcohol/Drug Counselor Certification (IBADCC):
http://ibadcc.org/
FAQ's
Certification Applications
Professional Staff Listing
Code of Conduct
Event Calendar

Idaho Board of Occupational Licensing (IBOL):
http://www.ibol.idaho.gov/IBOL/Home.aspx
Professional Staff Listings
Administrative / Licensing Rules
Licensing Application/Renewal
Public Records – Adjudicated Complaints

National Resources – Curriculum, Staff Training, & Program Development

Addiction Technology Transfer Center Network
http://www.attcnetwork.org/index.asp

Motivational Interviewing Assessment; Supervisory Tools for Enhancing Proficiency (MIA: STEP)
Main Menu
http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/miastep/
MIA: STEP Manual PDF
http://www.nachc.com/client/Motivational%20Interviewing%20Manual_A-STEP.pdf

Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful
http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/txplanningmatrs/

M.A.T.R.S Media PDFs
http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/txplanningmatrs/product_materials.asp

DSM-5: The Future of Psychiatric Diagnosis
http://www.dsm5.org/Pages/Default.aspx

Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit
http://www.samhsa.gov/co-occurring/ddcat/

Understanding Evidenced-Based Practices for Co-Occurring Disorders
http://www.samhsa.gov/co-occurring/topics/training/Evidence-BasedPractices(OP6).pdf

Evidenced Based Curriculum and Program Development Strategies
National Research Institute - *Evidence-Based Practices*
http://www.nri-inc.org/reports_pubs/pub_list.cfm?getby=Evidence%2DBased%20Practices

A SAMHSA guide to evidence based practices

Institute of Behavioral Research, Texas Christian University:
http://www.ibr.tcu.edu/pubs/trtmanual/manuals.html

Evidenced –Based Practices, tools, training materials
http://medecine.forumed.org/pdflike.php?search=www.ebp

Mental Health Evidence Based Practices (EBPs) in Washington State
http://www.dshs.wa.gov/pdf/dbhr/mhtg/EBPs_in_WA.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov

SAMHSA's National Registry of Evidenced-based Programs and Practices
http://www.nrepp.samhsa.gov/ViewAll.aspx

Useful Links

WITS - Agency & User Set Up Instructions

Minimum Case Management Standards Manual **(see page 74)**

Recovery Support Services Additional Resources

IDAPA 16.03.09 IDHW– SUD Medicaid

SUB AREA: SUBSTANCE ABUSE TREATMENT SERVICES
(Sections 690 - 699)

IDAPA 16.05.06 IDHW Criminal History & Background Checks

Dual Diagnosis Capability in Addiction Treatment (DDCAT) Tools

The “How to” Manual for Clinical Supervision in Idaho

Qualified Substance Use Disorders Professional Manual

SUD Provider Manual Attestation Statement

I _____, hereby attest that the BPA SUD Provider Manual has been reviewed by my agency_____ on _____. I understand the contents of the manual and have been given the opportunity to ask questions to clarify any of the content.

Sincerely,

_____ _____

Signature Title

BPA: Providing behavioral healthcare solutions that help people improve their lives.

Email this completed form to BPAProviderRelations.com

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

75 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.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

11. Trauma

Idaho Response:

It is the policy of the Division of Behavioral Health that all clients be screened for trauma and that any issues related to trauma be addressed, at the level the client determines, in the treatment plan. The Division is in the process of developing minimum standards for care for all services funded. These standards can be found on the internet at http://healthandwelfare.idaho.gov/Portals/_Rainbow/Manuals/Mental%20Health/BHStandardseManual/NetHelp/index.html. Standards for Trauma-Informed care are scheduled to be drafted this year.

As stated in other sections, the Division of Behavioral Health has different models of service delivery for mental health and substance use disorders. Via the Department of Health and Welfare's online Knowledge and Learning Center, have access to training on trauma informed care. Likewise, providers in the Business Psychology Associates network, have access to training on trauma informed care through their online Provider Education system. Because Idaho is a large and mountainous state and because substance use disorders treatment services are delivered using a fee-for-service system, providing online training increases access and reduces burden of staff down-time for training.

Trauma informed care is a foundation piece in the delivery of behavioral health services. Both clients with mental illness and substance use diagnoses are very likely to have experienced trauma in childhood as well as in adulthood. It is the Division's expectation that all state and private providers delivering behavioral health services address trauma as a part of a comprehensive treatment plan and in discharge planning.

12. Criminal and Juvenile Justice

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 substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG 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. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths 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.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

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 mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

Idaho Response:

Question: Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

Response: Idaho has chosen not to expand Medicaid at this time. This includes no expansion for those involved in or at risk of of involvement in the justice system.

Question: Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

Response: Any individual may contact the Idaho the Division's substance use disorders treatment 800 number for screening and referral to treatment, regardless of their involvement in the criminal justice system. Authorization and provision of services is based on clinical and financial need.

Adults convicted of felony charges are screened for mental health and substance use disorders prior to sentencing. Further assessment may be ordered prior to sentencing if indicated. Services are then provided post sentencing.

Youth placed in juvenile detention are screened for mental health or substance use disorders. Any service recommendations are passed on to parents, juvenile justice staff and the courts. The court has the authority to have any youth under court jurisdiction assessed for mental health issues if the court believes that mental health issues are interfering with the youth's ability to comply with the directives of the court. The court may then order the SMHSA to provider needed/recommended services. The juvenile court may also order a substance use assessment during the sentencing phase and incorporate any treatment recommendations into the sentencing order.

Question: Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

Response: The Division of Behavioral Health collaborates with the adult and juvenile correction and judicial branch systems on the development and management the State of Idaho's managed care contractor, Business Psychology Associates. All services are delivered by the same provider network that delivers Division of Behavioral Health-funded services.

There are several mental health specialty courts for adults and children in which SMHA coordinates with the court and justice personnel regarding an individual's care and treatment. The court has the authority to have any youth under court jurisdiction assessed for the youth's ability to comply with the directives of the court. The court may then order the SMHSA to provide needed/recommended services. Services are delivered and coordinated with the family and juvenile justice personnel. Additionally, SMHA staff participate in screening teams as part

of a diversion process for youth being considered for commitment to the state juvenile corrections facilities. SMHSA staff also participate in discharge planning for youth leaving state juvenile justice custody when invited by the family to participate in after-care planning.

SMHA does not participate in the provision of services for individuals in adult or youth correctional facilities.

Question: Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system.

Response: Trainings specific to substance use disorders clinical and recovery support services are made available to all staff delivering mental health and substance use disorders services regardless of the population they serve. Trainings are delivered in person, via webinars and through colleges and universities in Idaho.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. 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. SMHAs and SSAs should collaborate with their state's 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan:

13 State Parity Efforts

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Narrative Question: Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. 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. SMHAs and SSAs should collaborate with their state's 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. **What fiscal resources are used to develop communication plans to educate and raise awareness about parity?**

   The Division of Behavioral Health has not dedicated any resources to the development of a communications plan for awareness and education regarding parity. The Division is in the process of evaluating possible options for addressing parity awareness and education and is considering incorporating requirements for parity education and awareness into the next contract with the Office of Consumer and Family Affairs.

2. **Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?**

   The State of Idaho does not currently coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law. However, when working with individual clients, staff attempt to inform clients of their rights under parity as it relates to their individual circumstances and needs. The Division of Behavioral Health is planning to add an element of parity awareness and education to the next contract with the State Office of Consumer Affairs contract.

3. **Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?**

   The State of Idaho does not currently coordinate across public and private sector entities to increase awareness and understanding of the parity law with health plans or health insurers.

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

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for 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 medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. 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.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with 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, advocacy with state payers)?

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

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

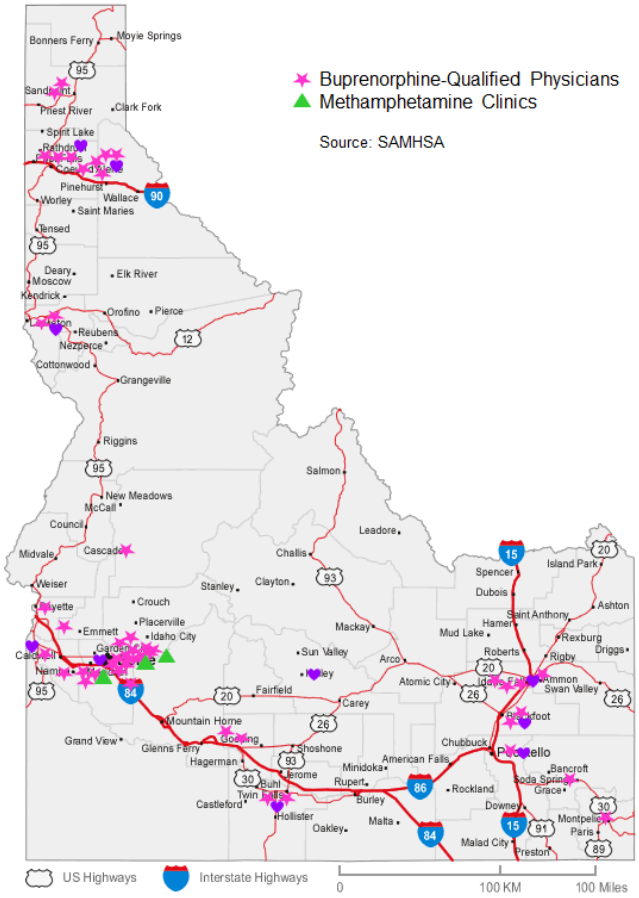
Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Medication Assisted Treatment

Idaho Response

No publicly-funded MAT services have been initiated by the Division of Behavioral Health at this time. The State of Idaho is conducting research to evaluate the efficacy of implementing MAT services for the population currently receiving publicly-funded substance use disorders treatment; relevant survey and archival data to evaluate the need/demand for these services; and means to fund implementation and maintenance for MAT services. One concern is the limited number of physicians qualified to deliver MAT services in rural and frontier area as depicted in the map below.



The Division has posted information about MAT services on the Substance Use Disorders webpage to educate medical and behavioral health professionals as well as the general public. (http://www.healthandwelfare.idaho.gov/Medical/SubstanceUseDisorders/tabid/105/Default.aspx) The Division is also working with the Idaho Office of Drug Policy to make resources materials available. (http://radar.boisestate.edu/?q=Medication+assisted+treatment&site=boisestate.edu)

The Division has already begun foundation work for the implementation of MAT services. Staff are in the process of revising Substance Use Disorders rules and incorporating mental health providers to create a system for Behavioral Health Facility. The draft rules include provision for MAT services. They are posted on the Division's Substance Abuse and Mental Health websites. (http://healthandwelfare.idaho.gov/Portals/0/Medical/SUD/Proposed%20New%20IDAPA%20Chapter%20BH%20Program%20Approval.pdf) In addition, the Division has drafted minimum standards for the delivery of MAT services. When completed, they will be posted on the Division of

Behavioral Health's e-manual.
(http://healthandwelfare.idaho.gov/Portals/_Rainbow/Manuals/Mental%20Health/BHStandardseManual/NetHelp/index.html)

Within Idaho, the Division of Medicaid has initiated a program to pay for Buprenorphine and Naltrexone to treat opioid addiction. The Division is watching this initiative to enable us to better plan for areas of need and forecast costs.

At this time, the Division has not identified technical assistance needs. As we develop an implementation process our SSA may submit a request.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

[89]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 use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

15. Crisis Services

Idaho Response

With the creation and passage of Title 39 Health And Safety Chapter 31 Regional Behavioral Health Services, the Idaho Legislature assigned the development of **c**ommunity family support and recovery support services which include, but are not limited to:
(a) Community consultation and education;
(b) Housing to promote and sustain the ability of individuals with behavioral health disorders to live in the community and avoid institutionalization;
(c) Employment opportunities to promote and sustain the ability of individuals with behavioral health disorders to live in the community and avoid institutionalization;
(d) Evidence-based prevention activities that reduce the burden associated with mental illness and substance use disorders; and
(e) Supportive services to promote and sustain the ability of individuals with behavioral health disorders to live in the community and avoid institutionalization including, but not limited to, peer run drop-in centers, support groups, transportation and family support services.

Due to this legislation, Idaho's Regional Behavioral Health Boards, not the Division of Behavioral Health, have been tasked with implementation of crisis services. This system ensures the services are accessible and effectively integrate existing community resources with the crisis center services.

In State Fiscal Year 2013, the Idaho Legislature appropriated funds to serve as seed money for the development a crisis center in Idaho. The Legislature's intent was to evaluate the resources needed to build a crisis center, community ability to sustain the service without state funds and the benefit of crisis centers before supporting the implementation of a statewide system. The money was appropriated to the Division of Behavioral Health to allocate the funds to a community based on the support for, and readiness of, the community to develop a crisis center. Based on responses, Region VII, which is located in southeast Idaho, was chosen. The community has established a comprehensive crisis resource center known as the "Behavioral Health Crisis Center of East Idaho."

Since the purpose of the crisis center to help people resolve crises, individuals are allowed to stay up to 23.75 hours. If they need more intensive care, they are then referred to a residential mental health provider or hospital. Individuals can return to the center whenever they need the services. There is no cost to the individual for these services.

The crisis center fills a healthcare gap by providing assessment, referral, and case management services to individuals in a behavioral health crisis - either mental health disorders, substance abuse disorders or both co-occurring together. A brief nursing assessment is completed to ensure more comprehensive medical care is not necessary. The goal of the crisis center is to keep individuals out of emergency rooms and jails. The Crisis Center provides a safe environment to meet the needs of individuals experiencing a behavioral health that do not need hospitalization or incarceration. Care received early in a crisis, helps individuals to achieve

stability, prevent future hospitalizations, and develop the vision and hope of recovery. At this point the Crisis Center is supported solely by community and local government support.

Based on the continued community support, financial investment and outcomes of this crisis center, the Idaho Legislature appropriated seed monies to implement a second crisis center. This center will be located in Coeur d'Alene in north Idaho. The funding was made available at the start of Idaho's state fiscal year, July 1, 2015, and it is anticipated this crisis center will be open and ready to deliver services by January 1, 2015.

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. 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.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

Idaho Response:

1. Does the state have a plan that includes:
a. the definition of recovery and recovery values,

The Division of Behavioral Health does not a formalized plan for recovery support. It is, however, supporting several critical initiatives to establish and sustain a recovery support system in Idaho. The efforts focus in two areas. The first is ingraining recovery planning in all treatment planning and establishing support from recovering peers as an essential part of the recovery process. To support that effort, the Division has implemented a training and certification systems for substance use disorders recovery coaches and mental health peer specialists and family support partners.

The Division has had in place, for over 2 years, processes to train substance use disorders recovery coaches and mental health peer specialists. During FY 2016, the Division is establishing systems a system for training family support partners to provide peer to peer support to families with children who have serious emotional disturbances.

To institutionalize these training systems, the Division has also established a certification systems for substance use disorders recovery coachers, mental health peer specialists and family support partners. The certification process of recovery coaches is being conducted by the Idaho Board of Alcohol/Drug Counselor Certification. The certification process for peer specialists and family support partners is currently being managed by the Division of Behavioral Health. The goal is to get the certification process standardized and ultimately move the certification to another certifying/ licensing body as was done with the recovery coach certification.

The Division also supports the statewide Recovery Community Organization. In the process of establishing its statewide Recovery Community Organization (RCO) in 2014, Idaho Behavioral Health stakeholders adopted a core value of recovery that will be implemented across Idaho's Recovery Community Centers and within the services provided by the state's Recovery Coaches: "You are in recovery when you say you are." Recovery Idaho, the state's RCO, was established during a meeting with stakeholders from across the state and facilitators from the Connecticut Community for Addiction Recovery (CCAR) in March 2014. Recovery Idaho received its 501 (c)(3) nonprofit status in January 2015. Recovery Idaho's mission is to provide advocacy, education and community-driven recovery support services for Idahoans seeking long-term sustained recovery from substance use disorders and mental illness. Recovery Idaho will be a key partner in the ongoing establishment and support of community-based Recovery Community Centers around the state. In Idaho, all pathways to recovery are supported, with the assistance of community, recovery support services, and traditional treatment. The state supports the definition that recovery is "the process that allows individuals to reestablish health and wellness, by utilizing a self-directed effort. Recovery is the gain of life, family, community, and opportunities lost." Recovery values and principles supported by the state and Recovery Idaho include:

- You're in recovery when you say you are

- Support all pathways to recovery
- We support the wellness of the full person
- Focus on recovery potential, not pathology
- Recovery is a gift. Expect to pay it forward
- The path of recovery is life-long
- Ongoing community support is vital to successful outcomes
- Everyone has a strength to share
- Client choice
- Peer Support
- The recovery community is vital to recovery
- Recovery includes wellness of the whole person.
- Recovery coaching/support and other supportive services are critical components of recovery

b. evidence of hiring people in recovery leadership roles,

The Division of Behavioral Health recognizes the critical role that people in recovery play in the design and delivery of SUD services and makes every effort to ensure that "authenticity of voice" is present in such discussions. Currently, the Program Manager who oversees the management of SUD services for DHW is in long-term recovery. She brings her own experiences with addiction and recovery to the table, in addition to her years of management experience with DHW. Central Office also employs a Certified Peer Specialist who is currently Idaho's lead on all things regarding recovery coaching. He has personally trained the majority of the state's recovery coaches, supports recovery coaches and peer specialists out in the field, and has worked on the establishment of recovery community centers in Idaho.

As indicated in other responses the Division has a separate system for the delivery of mental health services. The regional mental health offices, as well as the state hospitals have trained peers on staff provider a variety of support resources. Recovery coaching services are also a part of the Business Psychology Associates intermediary contract. The integration of recovery support services throughout the recovery system is an expectation established in their contract.

c. strategies to use person-centered planning and self-direction and participant-directed care:

The Division of Behavioral Heath takes person-centered planning and self-directed care very seriously. The Division's treatment planning policy, attached to this response, indicated the importance of the client and, as appropriate, their family's involvement in the development and ongoing updating of the treatment plan stating that the treatment plan shall be client-centered and family driven. All Division regional staff are required to comply with this policy and are evaluated on client satisfaction/engagement in care.

This commitment is further supported in Division's Quality Assurance Program, also attached to this response. Client/Parent/Family voice, choice, and preference are assured throughout the process is a key indicator that will be measured on an ongoing basis. This indicator is used to evaluate regional staff as well as contractors.

All treatment providers serving clients in the SUD program are expected to engage in person-centered planning to fully engage and maintain the client in their treatment under the Idaho Administrative Procedures Act (IDAPA). Through the state-approved GAIN Assessment, providers and clients are able to review life areas and develop treatment goals and interventions specific to client needs. Treatment plans include collaboration with community, family, and other support and service systems to develop a comprehensive, individualized treatment plan with the client. Case management services and life skills training services provide clients with opportunities to access and engage in community resources specific to client-identified needs. Treatment providers use a multi-dimensional approach to provide fully integrated and complimentary services to meet client-directed planning and goals.

d. variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?

The Division of Behavioral Health currently funds the following recovery support services for substance use disorders: recovery coaching, case management, drug/alcohol testing, safe and sober housing, transportation, child care, life skills, medical needs benefit for certain populations, staffing, interpreter services, aftercare, temporary housing and prenatal care. The Mental Health peer support program is designed to offer connection to a community of peers, encouragement and understanding, information on accessing resources and support through recovery. For mental health, Idaho supports the following recovery support services: peer to peer support, case management, safe housing, transportation, peer support groups, life skills, assistance accessing ancillary resources, crisis center services and advocacy.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

As indicated in the response above, recovery support services provide essential resources that enable the client to achieve stability and maintain recovery of time. It is the Division policy that recovery support services be integrated in each client's treatment plan. These services may be initiated at any time during the treatment episode and may continue after clinic services have been completed.

All clients entering the SUD system are given the GAIN assessment, which determines the diagnosis and level of care. The management services contractor, BPA, authorizes treatment and recovery support services based on the GAIN results. Once in treatment, the client and/or provider may identify additional supportive service needs. An authorization request is submitted via WITS and BPA then coordinates and manages the allocation of services.

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

The state not only recognizes, but also supports, the inclusion of peers and family members in all areas of service delivery, regardless of population. That said, some effort has been put into meeting needs of specific populations. Idaho's lead Recovery Coach Trainer, employed by DBH, is also trained in trauma informed care and has begun offering this 4-hour course to recovery coaches and recovery center volunteer staff. Recovery Coach training is also complimented by an 8-hour ethics course. On the Peer Specialist side of the system, Idaho was awarded a grant that offers the funding for Idaho to create and deliver "specialty endorsements" for certified peer specialists in the areas of Co-Occurring Disorders, Crisis Centers and Criminal Justice. We anticipate being able to utilize these new training modules and endorsements as a basis for potential replication in the area of Recovery Coaching.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

In 2013, the Division of Behavioral Health obtained a grant which allowed us to offer Recovery Coach (RC) training in Idaho. The initial training by CCAR resulted in Idaho's first 50 recovery coaches. Of those 50, 15 received additional training to become RC trainers, resulting in a cadre of trainers available to provide on-going training as needed. Since that time, more than 350 individuals have been trained as RCs in Idaho, with roughly 25% currently in paid employment. Many of the remaining RCs continue to offer their services on a volunteer basis.

At the same time, the Division initiated a peer specialist training program for individuals recovering from mental illness. The training was based on the curriculum developed by the Appalachian Group. A private contractor was responsible for both peer training and certification. Over 200 Idaho mental health peer specialists were trained and certified under this program. In state fiscal year 2015, the Division decided to split the contract. A private entity continues to delivery the peer specialist training, but the Division is now responsible for peer certification.

The Department received a Transformation Transfer Initiative (TTI) grant in the amount of $221,000 for the development and implementation of three endorsement curricula and trainings. The Division has secured a contractor who is responsible for facilitating stakeholder groups to develop participant and train-the-trainer curriculum for each endorsement area. The specialty endorsement curricula will address:

1. Criminal Justice
2. Crisis Center
3. Co-occurring Disorders.

The stakeholder groups are meeting currently and the curricula development process will be completed within the next nine months.

Finally, Idaho is implementing a Family Support Partner training and Agency Readiness training system. The goal of the this training is to educate potential certified family support partners in the basics of what a certified family support partner will do as part of the service team providing support to parents of children living with a mental illness or co-occurring mental illness and substance abuse disorders. This system will also include agency readiness trainings to assist the agency to prepare for the employment of certified family support partners, including the enhancement of services that will be provided by the certified family support partners and how to provide supervision to a certified family support partners.

a. Does the state have an accreditation program, certification program, or standards for peer-run services?

The Division has established separate processes for certifying mental health certified peer/family support staff and substance use disorders recovery coaches. The certification of mental health peer specialists and family support partners will be managed by Division staff for the time being. This will enable the Division to evaluate the certification process to ensure it results in qualifying individuals who have the knowledge, skills, resources and wherewithal to support other individuals and families dealing with mental illness. Once the evaluation phase is completed, the Division will seek an independent entity to manage this certification process. The standards for Certified Peer Specialist and Certified Family Support Partners are attached to this response.

Effective July 1, 2015, Certification for Recovery Coaches and Peer Recovery Coaches through Idaho Board of Alcohol Drug Counselor Credential (IBADCC) is now available. http://www.ibadcc.org/new_web/resources/news/news.shtml. The Department has also developed its own set of standards for all recovery coaches in Idaho, whether they are credentialed or not. The standard for Recovery Coaching is attached to this response.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

Not at this time.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

Idaho Code dictates membership to the State Behavioral Health Planning Council as well as that of Regional Behavioral Health Boards (RBHB) in each of Idaho's seven regions. For the Planning Council, that membership is required to include consumers, families of individuals with serious mental illness or substance use disorder and advocates for those with behavioral health issues. For the RBHBs, the membership must include the parent of a child with a serious emotional disturbance, a parent of a child with a substance use disorder, an adult mental health

services consumer, a mental health advocate, an adult substance use disorder services consumer and a substance use disorder services advocate.

The RBHBs are required to create a behavioral health Gaps and Needs report each year for submission to the Planning Council. The Planning Council uses these reports to then document this information for a statewide perspective, which is required to be delivered to the Department, the State Legislature and the Governor. In most cases, the RBHBs meet monthly within their regions and the Planning Council meets, at a minimum, three times a year, but more frequently if needed.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The Division of Behavioral Health used federal grant funding to provide a workshop on creating a recovery community organization in Idaho. One of our goals in identifying stakeholders to participate was to include at least fifty percent individuals who were in recovery, and that goal was met. At the end of the workshop, the foundation had been laid for Recovery Idaho. Since the workshop, Recovery Idaho has achieved 501 (c) (3) tax status, is establishing itself statewide as Idaho's recovery community organization, has been chosen as one of Idaho's partners to operate a recovery community center, and is currently in the process of hiring their first staff.

The DBH has been an active participant in finding funding for recovery community centers in four Idaho communities. We have met with the Idaho Association of Counties and individual counties to help tailor support unique to each county, in creating these recovery centers, and continue to meet with them on a monthly basis to deal with issues as they come up.

We employ a recovery coach trainer who we make available for training around Idaho. In the 23 months of his employment, he has participated in training 317 recovery coaches. We maintain a website that lists those recovery coaches who are available to provide services around the state as well. The Division contracts with Jannus for the training of peer specialists. Also, recovery support services are a covered service we provide to those who qualify for the services under the block grant.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

During the past year, Division of Behavioral Health engaged in some targeted outreach regarding PWWC services. Brochures were created and distributed to Health Districts and other entities which have direct contact with pregnant and parenting mothers with SUD issues. We closely watched the increase in enrollment in the PWWC program using WITS data. No other consumer outreach activities have occurred as funding limitations prohibit us from expanding services to more Idahoans.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

The Division of Behavioral Health is committed to supporting a holistic recovery process. That said, the Division is more committed to delivery client-directed care. Treatment plans, case management services and recovery support services address tobacco cessation, obesity and other co-morbid health conditions to the extent the client it willing to address them. All regional offices and substance use treatment providers prohibit smoking within their facilities and encourage clients to discontinue use, but the Division does not directly fund tobacco cessation or other health services. The Division does make available information on Idaho's tobacco prevention and cessation services managed by the Department of Health and Welfare's Division of Public Health. Information on their resources is located on the internet at http://projectfilter.org/.

Crystal 10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

The Division does not have a statewide plan to address housing needs of persons served in the Behavioral Health System. Due to the geography and population distribution within Idaho, many parts of the state are sparsely populated with limited resources. Rather than create a statewide program that is not reasonable for local needs, the Division's regional staff and contractors assist clients in accessing housing assistance. Clients receiving mental health services may receive funding for one-time rental or security deposit assistance. They may also access appropriate housing resources provided through federal programs that are administered by Idaho's Continuums of Care, the Boise City Ada County Housing Authority and the Balance of State.

On the substance use disorders side, individuals and families experiencing homelessness, both unsheltered and sheltered, may receive assistance through the Access to Recovery 4 grant. Under this program, community-based organizations working with the homeless individual or family will assist the client in calling BPA for a phone screening

11. Describe how the state is supporting the employment and educational needs of individuals served.

Life skills training is available to all mental health and substance use disorders client. In group or individual settings, life skills address such areas as employability skills, job search assistance, and communication strategies. Through case management services, providers work with clients on identifying specific life areas that have been impacted by substance abuse, then identifying existing available community resources and services. This includes assisting clients as they access employment and training programs through the Idaho Department of Labor services, State Vocational Rehabilitation programs, and coordination with public and private educational programs such as computer literacy courses and short-term, skill-specific training. Education

support, as indicated in the treatment plan, is also available to children and adolescents with serious emotional disturbances.

During the past year, Idaho has worked hard to establish recovery centers across the state. At the time of this writing, one center has already opened and three more are expected to do so this fall. These centers provide some job search assistance as well as referrals to educational institutions. Additionally, Recovery Coaches frequently assist customers in their job search and educational endeavors.

1.0 Certified Peer Specialist (CPS) Standards

1.1. Definitions

Rationale: A Certified Peer Specialist (CPS) is an individual in recovery from mental illness or mental illness with a co-occurring substance use disorder who uses his/her lived experience and specialized training to assist other individuals in their own recovery. The relationship between the CPS and the other recovering individual is one of mutual respect and support built on a connection and trust not obtainable through other service relationships.

1.1.1. Certified Peer Specialist has a mental illness or a mental illness and co-occurring substance use disorder diagnosis and at least one (1) year of lived experience receiving behavioral health services from a behavioral health service system.

1.1.2. Certified Peer Specialist completes the forty-hour Appalachian Group/DBSA (Depression and Bipolar Support Alliance) training.

1.1.3. Certified Peer Specialist passes the Appalachian Group/DBSA certification exam with a score of 70% or higher.

1.1.4. Certified Peer Specialist understands and lives by Idaho's Certified Peer Specialist Code of Ethics.

1.1.5. Certified Peer Specialist engages, educates, guides and supports recovering individuals to create new ways of seeing, thinking and doing in order to have healthy relationships and live successfully in the community. These new ways are determined by the individual being served.

1.1.6. Certified Peer Specialist is non-clinical and does not diagnose or offer primary treatment for mental health issues.

Special considerations: Eligibility to provide peer support services may depend on the nature of the employment and whether the CPS either passes a criminal background check or qualifies for a criminal background check waiver according to criteria outlined in IDAPA.

1.2. Qualifications

Rationale: The life experience of someone living with a mental illness or co-occurring diagnosis is most understood by someone who has also lived this sort of experience. Certain qualifications are needed to understand and know how to navigate the systems involved in creating a healthy and positive life. It is only ethical that the Certified Peer Specialist (CPS) meets certain criteria when working with individuals who may need support in working toward recovery.

1.2.1. Certified Peer Specialist (CPS) candidate has lived experience as someone who has a mental health diagnosis or co-occurring diagnosis and has at least (1) ongoing and continuous year of recovery as verified by a qualified health practitioner/behavioral health provider.

1.2.2. CPS candidate completes the Idaho Peer Specialist Certification Training Application which includes questions regarding one's lived experience.

1.2.3. CPS candidate submits two letters of recommendation with the training application.

1.2.4. CPS candidate completes 40 contact hours of training specifically designated for Idaho Certified Peer Specialists and approved by the State Behavioral Health Authority.

1.2.5. CPS candidate passes a post-training assessment established by the training entity and approved by the State Behavioral Health Authority.

1.2.6. A Letter of Completion is mailed to the CPS candidate. The letter states either approval for the individual to take the certification exam or it provides individualized recommendations for the candidate to complete before moving forward with the certification exam.

1.2.7. Work Experience and Education:

1.2.7.1. If the CPS candidate holds a bachelor's degree in human services (e.g. social work, psychology, education, sociology, social sciences), he/she documents 100 hours of work experience in the human services field within a year from completing the training. If the 100 hours of work experience are not completed within a year, a review is required by the certifying body.

1.2.7.2. If the CPS candidate does not hold a bachelor's degree in human services (e.g.. social work, psychology, education, sociology, social sciences), he/she must have a high school diploma or GED and documents 200 hours of work experience in the human services field within a year of completing the training. If the 200 hours of work experience are not completed within a year, a review is required by the certifying body.

1.2.8. CPS candidate completes 20 supervision hours with a designated Idaho CPS Supervisor within a year of completing the training.

1.2.9. CPS candidate passes the Idaho Certified Peer Specialist Exam with a score that meets the standard set by the certifying body authorized by the State Behavioral Health Authority.

1.2.10. Accommodations for the exam are provided as deemed necessary by the individual taking the exam. Examples of accommodations include, but are not limited to, extra time, a separate room, and use of a computer.

1.2.11. CPS Supervisor is a degreed professional in the field of human services who has supervisory capacity within the agency and is designated as a CPS Supervisor by the certifying body.

1.2.12. The CPS Supervisor obtains such designation by applying to the approved certifying body and following the approved process for said designation. The certifying body maintains a current list of approved Supervisors.

1.2.13. CPS maintains a working knowledge of current recovery trends and developments in the fields of mental health, substance use disorders, current research as it relates to behavioral health, wellness and recovery, ethical practices and peer support services by reading current journals, books, etc., attending webinars, workshops and conferences as they relate to these fields, and sharing with other CPSs.

1.2.14. CPS must be at least 18 years old.

1.2.15. To avoid role ambiguity and conflict, CPS does not fulfill other service roles (therapist, counselor, case manager, nurse, physician, clergy, etc.) to participants they are providing peer services to; nor do they practice outside the scope of their peer specialist training.

Special considerations: A clinician or professional person may hold certification as a CPS; however, a CPS working with a particular individual as a CPS provider cannot also be the clinician (i.e. other professional) who is providing any other services to that same individual. In other words, an individual cannot be the CPS provider and other professional provider of a participant at the same time.

Safety is an important concern, therefore background checks may be required by law and rule, but are the responsibility of the agency or place of employment, and are not part of the certification process.

1.3. Training

Rationale: Training equips the Certified Peer Specialist (CPS) with additional and necessary knowledge, understanding and skills. Documentation of trained Specialists establishes verification and credibility for agencies employing CPSs. Training adds to the participant's confidence and trust in the CPS's abilities with whom they are working.

1.3.1 CPS training includes, at a minimum, the following competency areas:

1.3.1.1 overview of mental illness and substance use disorders and their effects on the brain,

1.3.1.2 the stages of recovery and the role peer support plays in it,

1.3.1.3 the state behavioral health system and the role peers play within it,

1.3.1.4 advocacy for recovery programs and for the peers they serve,

1.3.1.5 the practice of recovery values: authenticity, self-determination, diversity, inclusion, etc.

1.3.1.6 how to use your recovery story to help others,

1.3.1.7 ethics (boundaries, confidentiality, HIPAA, etc.),

1.3.1.8 the identification of risk factors in participants' behaviors and how to respond in/to a crisis,

1.3.1.9 the use of interpersonal and professional communication skills,

1.3.1.10 effecting change,

1.3.1.11 work place dynamics and processes,

1.3.1.12 empowering others,

1.3.1.13 family dynamics,

1.3.1.14 the effects of trauma and use of a trauma informed approach,

1.3.1.15 wellness and natural supports,

1.3.1.16 maintaining one's wellness,

1.3.1.17 cultural sensitivity,

1.3.1.18 recovery plans, and

1.3.1.19 local, state and national resources.

1.3.2 Training is 40 hours of face-to-face instruction that is conducted by an IDHW DBH approved training entity. The training entity is separate from the certifying body. The certifying body is responsible for verifying competencies.

1.3.3 Curriculum includes all types of learning methods, including role-playing scenarios as a key element of building skills.

Special considerations: Any exceptions to the training as outlined here are reviewed by the certifying body.

1.4. Certification and Renewal

Rationale: Professional certifications lend credibility to the individual professional, as well as to the employer. Certification of Peer Specialists ensures that those who employ Certified Peer Specialists are employing individuals who have consistent experiences and qualifications. Certification provides employers and participants with evidence and documentation that the certificate holder has demonstrated a certain level of job-related knowledge, skills, abilities, and practical experience. Certification also empowers the holder via the knowledge and skills obtained, as well as by the fact that he/she has successfully accomplished the completion of all requirements.

1.4.1. Certified Peer Specialist (CPS) meets the qualifications as stated in section 1.2.

1.4.2. Persons claiming to hold certification status as a CPS hold documentation of said certification.

1.4.3. CPS certification is good for one year.

1.4.4. CPS professional renews his/her certification annually by:

1.4.4.1. completing at least 10 hours of continuing education approved by the certifying body for Idaho's CPS (e.g. trainings, workshops, webinars) per year and documenting said education. Continuing education topics can be from any of the competencies listed in the training competencies section in 1.3, AND

1.4.4.2. completing a renewal application, AND

1.4.4.3. maintaining a no-violations record regarding the CPS Code of Ethics

1.4.5. CPS follows the Certification Renewal Procedure put forth by the certifying body for Idaho's CPSs.

1.4.6. CPS is responsible for ensuring that the certifying body has all current documentation necessary for satisfying the certification criteria.

1.4.7. Employers of CPSs are responsible to check with the centralized certification body to ensure that the CPS which they wish to hire has current certification status as a certified CPS in Idaho.

1.4.8. The state's approved certifying agency tracks certifications and continuing education status of Idaho's Certified Peer Specialists.

Special considerations: Continuing education hours are approved by the certifying agency to renew certification.

1.5 Termination, Inactive Status & Reactivation

Rationale: Certification reveals to others that a person has reached a particular level of competency. If these levels are not maintained, a person's certification may be terminated or revoked. Termination can be due to, but is not limited to, deficient documentation or a Code of Ethics violation.

1.5.1 . Deficient documentation is the failure to submit on time requested documentation and application for certification and renewal, or any other requested materials from the certifying entity

1.5.2 . A Code of Ethics Violation is the failure to abide by the Certified Peer Specialist (CPS) Code of Ethics and/or providing false information on documents

1.5.3 . Inactive Status is when a CPS in good standing requests such status because he/she is unable to meet the requirements for recertification due to a decline in physical or mental health or an extenuating circumstance; such as: death of a close relative, divorce or marriage, long-term illness of family member, loss of employment, birth or adoption of a child, military deployment, or other circumstance that is approved by the certifying body.

1.5.4 . Reactivation is accomplished by submitting all required documentation, including a new application packet and verification of CEUs earned within one year of resubmission.

1.5.4.1. It is the applicant's responsibility to ensure that all documentation is completed and submitted.

1.5.4.2. If application is incomplete, a deficiency letter is sent to the applicant and applicant has 30 calendar days to mail all required documents. If 30 days go by and documents are not received by the certifying body, the applicant's certification expires and applicant will need to re-apply, submitting all certification documentation and a new application.

1.5.5. Applicants who have violated the Code of Ethics will, in addition to the documentation in 1.5.4, submit a report that details the nature of the violation, admission of the violation, corrective actions taken and insurance that the violation will not recur. The CPS Peer Review Board, which is defined by the certifying entity, will determine re-instatement based on the seriousness of the violation, applicant's report and the corrective actions taken.

Special considerations: Inactive status is not granted for the failure to comply with continuing education requirements or a reported Code of Ethics violation.

1.6. Reciprocity

Rationale: The time and effort that a person expends obtaining a Certified Peer Specialist (CPS) certification is valued. Idaho also values its certification process and therefore, reciprocity from another state's certifying board is permitted as long as certain conditions are met.

1.6.1. Applicant requesting reciprocity to provide services in Idaho must have completed the Appalachian Group/DBSA curriculum and passed the Appalachian Group/DBSA certification exam within the past 2 years.

1.6.2. Applicant submits an Idaho CPS application along with a copy of his/her certification and a copy of his/her current CPS certificate or equivalent from another state.

1.6.3. If Idaho's certifying agency finds the applicant deficient in any of Idaho's requirements, a letter explaining needed documentation will be sent to the applicant. The applicant has 30 calendar days to respond with an explanation as to how the requirements will be completed and 60 days to complete said requirements.

Special considerations: Safety is an important concern, therefore background checks may be required by law and rule, but are the responsibility of the agency or place of employment, and are not part of the certification process.

1.7. Reporting Changes

Rationale: Idaho values its Certified Peer Specialists (CPSs) and wants to maintain communication with each person. The best way to do this is to know how to reach each CPS to report CPS news, events and any changes to the certification requirements. It also aids in networking with all CPSs in the state. In addition, this allows IDHW to know how many CPSs are available in different parts of the state and who they are.

1.7.1. Certified Peer Specialist (CPS) reports changes in name, address, telephone number and email address.

1.7.2. CPS reports a change in supervisor's name.

1.7.3. CPS reports a change in employment status.

1.7.4. CPS reports a violation in Code of Ethics.

Special considerations: Failure to report changes may result in termination of certification or other disciplinary measure.

1.8. Grievance Procedures

Rationale: There are times when applicants will not agree with decisions made the certifying board. To be properly and fairly heard, a procedure has been identified for the applicant to voice his/her grievance.

1.8.1. Applicant may file a grievance when there is a valid factual reason to do so; such as, being denied certification, questioning the outcome of the review board, or applicant is subject to an action by the certifying board that he/she deems unjustified.
1.8.2. Applicant must file said grievance within 30 days of notice or action deemed unjustified to the certifying board.
1.8.3. Contracted entity reviews the grievance.

1.9. Provision of Peer Support Services

Rationale: Depending on the scope of work of the agency in which the Certified Peer Specialist (CPS) is employed, the tasks carried out by the CPS can vary. Generally speaking, the services that a CPS provides should be participant-centered, participant-driven, culturally sensitive, recovery-based and community-based with the participant's rights protected. These services broaden the continuum of care provided in the typical treatment setting; they are part of an array of services. Peer support services are partners to more traditional services, but should not be used as a substitute for clinical services when the need for clinical services is indicated. The purpose for these services is to complement treatment and help the participant feel less isolated and more empowered within their recovery and engaged in their community.

1.9.1. Certified Peer Specialist (CPS) services may be provided to all participants who are in need of such services.
1.9.2. Participant outcomes expected during and after a CPS works with a participant include, but are not limited to:
1.9.2.1. Ability to identify and use wellness tools;
1.9.2.2. demonstrated ability to live more independently;
1.9.2.3. re-engaging with support systems that had been lost;
1.9.2.4. increase in education, employment and/or volunteerism;
1.9.2.5. improved housing situation;
1.9.2.6. improved quality of life;
1.9.2.7. sense of purpose;
1.9.2.8. increased empowerment;
1.9.2.9. belief that recovery is possible;
1.9.2.10. increased self-esteem;
1.9.2.11. demonstrated ability to self-advocate; and
1.9.2.12. increased participation in community and positive activities.
1.9.3. Services are non-clinical and designed to help initiate and sustain the individual in his/her recovery. Services provided by the CPS are voluntary and include, but are not limited to:
1.9.3.1. peer mentoring;
1.9.3.2. facilitating support groups;
1.9.3.3. assisting participant in engaging or re-engaging with participant's natural supports (e.g. family, friends, other loved ones, neighbors);
1.9.3.4. facilitating job readiness training;
1.9.3.5. facilitating wellness and recovery seminars;
1.9.3.6. providing educational materials or programs;
1.9.3.7. assisting in the development of participants' goals;
1.9.3.8. assisting participant to develop self-advocacy and problem-solving skills;
1.9.3.9. role modeling behaviors, attitudes and skills that promote recovery and wellness that is needed for resiliency and coping;

1.9.3.10. assisting participants with identifying and utilizing their strengths;
1.9.3.11. role modeling the facilitation of collaborative relationships;
1.9.3.12. assisting participants in accessing community and social services, including self-help groups;
1.9.3.13. link participant to professional treatment when necessary;
1.9.3.14. assisting with the development of community supports;
1.9.3.15. assisting at peer and consumer operated programs;
1.9.3.16. assisting with substance-free physical and recreational activities; and
1.9.3.17. advocating for the needs of participants.

1.9.4. These services shall be delivered primarily face-to-face, and secondarily by telephone or social media.
1.9.5. Services are delivered individually and in group settings.
1.9.6. CPS shares his/her personal story when appropriate for the benefit of the participant with whom he/she is serving and supporting, keeping in mind that this is but one experience and it does not mean that others will have the same experience or needs.
1.9.7. Frequency and Length of Service:
1.9.7.1. The frequency by which a CPS meets and works with the participant and the length of this service is determined by the peer, CPS and mental health clinician.
1.9.7.2. The frequency and length of service are periodically re-evaluated depending on the intensity of the CPS services needed. The higher the intensity and frequency of the services, the more often a reevaluation occurs.
1.9.8. CPS performs activities *with* an individual, and not *for* or *to* the individual so that the individual can regain control over their own life.
1.9.9. CPS is under the direct supervision of a designated CPS Supervisor.
1.9.10. CPS refers participant to the appropriate resources if they are unable to benefit from peer services.
1.9.11. CPS working within an agency adheres to the documentation requirements of the agency.

Special considerations: Services that a CPS does not provide: counseling/therapy, social work, drug testing, diagnosing of symptoms and disorders, prescribing, acting as a legal representative, participating in the determination of competence, and providing legal advice. CPS work to equalize the power differentials in the peer support relationship.

1.10. Organizational Readiness and Responsibility

Rationale: Optimal employment and use of a certified peer specialist requires awareness and understanding of peer recovery, resilience, trauma and hope as they relate to the Certified Peer Specialist providing services and to the participants who receive these services. Certified Peer Specialists are an equal member of the staff.

1.10.1. Organizational Readiness is preparing an organization or agency for the employment of a Certified Peer Specialist (CPS); ensuring that staff members understand the purpose of CPSs and how CPS duties enhance the organization's mission, including any unique issues to employing CPSs.
1.10.2. Agency establishes a readiness plan that includes criteria, by which the agency hires, supervises and works to maintain CPSs.
1.10.3. Agency that employs CPSs communicates clearly and respectfully with all employees, including CPSs, about practices that are most effective in promoting recovery and resilience of participants receiving services from the organization.

1.10.4. Agency engages in educational opportunities for all staff that prepare them to better understand the strengths and opportunities offered by the CPS
1.10.5. Agency adheres to Idaho's CPS standard and all other agency-related standards.
1.10.6. Agency ensures that all CPSs are supervised by a CPS Supervisor who has been designated as such by the certifying body, and that the services rendered by the CPS are under a comprehensive, individualized, participant-centered-and-driven plan.
1.10.7. CPS Supervisors are designated by each agency that employs CPSs and the Supervisor is approved by the certifying body. A list of approved CPS Supervisors is maintained by the certifying body.
1.10.8. Agency utilizes trauma-informed principles when employing CPSs.
1.10.9. The state's approved certifying agency tracks certifications and continuing education status of Idaho's Certified Peer Specialists.
1.10.10. Agency does not employ or utilize clients who are receiving services at their agency as a peer specialist for that agency.
1.10.11. Agency develops a written job description that specifies the duties and responsibilities of the CPS within that agency.

Special considerations: Dual relationships are important ethical considerations when staffing an agency. Hiring a former participant as a CPS could present difficulty for the CPS and staff. Several of the issues that arise from this practice include: privacy and access to records, access to treatment services for the CPS if needed, and residual power differential among staff.

1.11. Ethics

Rationale: A code of ethics in any profession guides the professional in areas of role-function, relationships, levels of responsibilities and liability.

1.11.1. Certified Peer Specialist adheres to the Idaho CPS Code of Ethics while performing duties of a CPS.
1.11.2. CPS completes at least annual ethics training, provided by either an employer or via other avenues approved by the certifying body.
1.11.3. Agencies that employ CPSs provide accessible opportunities for ethics training to all service- providing staff members, including CPSs, at least annually.
1.11.4. Provider organizations document completion of ethics training in each employee's file, including each CPS's file.
1.11.5. CPS keeps personal documentation of completed ethics training as required by the certifying body.

Special considerations: A clinician or professional person may hold certification as a CPS; however, a CPS working with a particular participant as a CPS provider cannot also be the clinician (i.e. other professional) who is providing any other services to that same participant. In other words, an individual cannot be the CPS provider and the other professional provider of a participant at the same time.

Additional Considerations: *Agencies that employ Certified Peer Specialists adhere to this standard and all of the Core Standards put forth by the State Behavioral Health Authority.*

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Questions:

What is the difference between a certified peer specialist and a peer specialist? Only the certified peer specialist has completed the required training and demonstrated competency in the Idaho Peer Specialist standards.

How can someone become a certified peer specialist if they have achieved a level of recovery that no longer requires professional support – since there is a 1 year documented experience requirement from a provider? Every situation is unique so contacting the certifying entity to discuss the specifics of your situation would be best. Different types of documentation from a professional may be accepted and it does not necessarily have to be from a currently treating provider.

Why does a certified peer specialist with a bachelor's degree in human services require fewer work experience hours than a peer without a degree? Knowledge of service delivery and theoretical approaches are core features of bachelor's degree programs. Given the graduate's experience in this area, fewer experience hours are needed.

Where did the requirement for 200 experience hours or 100 with bachelor's degree come from? The Department's behavioral health standards workgroup researched national and other states' standards for peer support, family support, and recovery coaching. Some standards require up to 1,000 hours of work experience. This requirement for Idaho's standards was decided on among the workgroup to ensure an adequate amount of knowledge and experience while maintaining a level of feasibility for prospective peer service providers in Idaho.

How long does a certified peer specialist have to report changes to the certifying body? This is determined by the certifying entity but should be done as soon as feasible.

2.0 Recovery Coaching

2.1. Recovery Coach Definition

Rationale: All individuals play an important role in promoting recovery from a substance use disorder. Personal recovery, lived experiences and wellness bring a unique and significant benefit to recovery coaching. A recovery coach is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovering community and serves as personal guide and mentor in the management of personal and family recovery. Written descriptions of a recovery coach help clarify the role and functions of the recovery coach in supporting an individual's recovery. All recovery coaches, including certified recovery coaches and peer specialist recovery coaches meet the following standards.

2.1.1. Recovery Coach completes the 30 hour Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy (RCA) training and have a Certificate of Completion signed by a Department-approved RCA trainer.

2.1.2. Recovery Coach completes the 12 hour Connecticut Community for Addiction Recovery (CCAR) Ethical Considerations for Recovery Coaches and have a Certificate of Completion signed by a Department-approved Ethics trainer.

2.1.3. Recovery Coach is non-clinical and does not diagnose or offer primary treatment for addiction or any mental health issues.

2.1.4. Recovery Coach works with individuals beyond recovery initiation through stabilization and into recovery maintenance.

2.1.5. To avoid role ambiguity and conflict, Recovery Coach does not fulfill other service roles (therapist, counselor, case manager, nurse, physician, clergy, etc.) to individuals that they are coaching.

2.1.6. Recovery Coach supports all pathways to recovery and is not associated with any particular method or approach.

2.1.7. Recovery Coach supports any positive change, helping persons in recovery to avoid relapse, build community support for recovery, or work on life goals not related to addiction such as relationships, work, education etc.

2.1.8. Recovery Coach links persons in recovery to recovery community and helps persons in recovery build community relationships.

2.1.9. Recovery Coach promotes recovery by serving as a guide and mentor for persons in recovery.

2.1.10. Recovery Coach abides by the Idaho Code of Ethics for Recovery Coaches.

2.1.11. Recovery Coach must be at least 18 years old.

Special considerations: The clinical therapeutic relationship is by nature, unequal. The boundaries of the relationship are strictly defined and preclude the counselor or therapist from sharing personal information and the counselor or therapist tends to have significantly more power in the relationship than the participant. The recovery coach relationship is a reciprocal relationship and the recovery coach not only shares personal information with the participant but is expected to act as a friend, mentor and companion to the individuals they are coaching.

2.2. Recovery Coach Trainers

Rationale: A Recovery Coach Training of Trainers (TOT) program is essential for capacity building and continued success and sustainability of Recovery Coaching in Idaho. The

Training of Trainers courses provide trainers with background knowledge and skills that will enable them to effectively mentor and train other persons to become recovery coaches.

2.2.1. Recovery Coach Trainer meets standards as stated in section 2.1.

2.2.2. Recovery Coach Trainer completes an *Application for Recovery Coach Training of Trainers (TOT)* that includes:

2.2.2.1. Motivation for applying for training;

2.2.2.2. Willingness to do recovery coach trainings;

2.2.2.3. Willingness to work with the Division of Behavioral Health in planning trainings;

2.2.2.4. Letter of support from current employer;

2.2.2.5. Willingness to train the curriculum as it was presented by Connecticut Community for Addiction Recovery (CCAR);

2.2.2.6. Willingness to present as a positive supporter of the recovery coach model; and

2.2.2.7. Experience as a trainer.

2.2.3. Recovery Coach Trainer completes the Connecticut Community for Addiction Recovery (CCAR) 30-hour Recovery Coach Academy training.

2.2.4. Recovery Coach Trainer completes the 12-hour Connecticut Community for Addiction Recovery (CCAR) Recovery Coach Academy Training-of-Trainers (TOT) course.

2.2.5. Recovery Coach Trainer completes the 12-hour Connecticut Community for Addiction Recovery (CCAR) Ethical Considerations for Recovery Coaches.

2.2.6. Recovery Coach Trainer completes the 12-hour Connecticut Community for Addiction Recovery (CCAR) Ethics Training-of-Trainers (TOT) course.

Special considerations: The TOT courses are designed to familiarize participants with the full Recovery Coach Academy and Ethical Considerations for Recovery Coaches curriculum and to learn optimal methods of delivering the training. It is not intended to train participants on how to train (training skills); therefore, those attending the TOT courses should be experienced trainers.

2.3. Certified Recovery Coach

Rationale: A certification process helps establish a valid, reliable and defensible methodology for the evaluation of recovery coach competency and promotes standards of training and competency that increases the professionalism of the recovery coaching field. Certification provides employers and participants with evidence and documentation that the certificate holder has demonstrated a certain level of job-related knowledge, skills, abilities, and practical experience. Certification also empowers the holder via the knowledge and skills obtained, as well as by the fact that he/she has successfully accomplished the completion of all requirements. A Certified Recovery Coach (CRC) is any individual that has completed the certification process through the certifying body and is actively certified as a Certified Recovery Coach.

2.3.1. Certified Recovery Coach meets standards as stated in section 2.1.

2.3.2. Certified Recovery Coach completes a total of 46 hours of training in the following performance domains:

2.3.2.1. Advocacy—10 hours;

2.3.2.2. Mentoring/Education—10 hours;

2.3.2.3. Recovery/Wellness Support—10 hours; and

2.3.2.4. Ethical Responsibility—16 hours.

2.3.3. Certified Recovery Coach has a high school diploma or jurisdictionally certified high school equivalency.
2.3.4. Certified Recovery Coach has 500 hours of volunteer or paid work experience specific to the domains of Advocacy, Mentoring/Education, Recovery/Wellness Support and Ethical Responsibility.
2.3.5. Certified Recovery Coach has 25 hours of supervision specific to the domains of Advocacy, Mentoring/Education, Recovery/Wellness Support and Ethical Responsibility. Supervision must be provided by an organization's documented and qualified supervisory staff per job description.
2.3.6. Certified Recovery Coach abides by the Idaho Code of Ethics for Recovery Coaches.
2.3.7. Certified Recovery Coach passes the Idaho Recovery Coach certification exam with a score that meets the standard set by the certifying body.
2.3.8. Certified Recovery Coach earns 10 hours of continuing education per year, including 3 hours in ethics.
2.3.9. The certifying body tracks certification and continuing education status of Idaho's Recovery Coaches.
2.3.10. The certifying body maintains sole discretion to suspend or revoke certification of Recovery Coaches certified under the auspices of the certifying body.
2.3.11. The certifying body oversees the Certified Recovery Coach certification process and approval of all certification materials including application forms, required documentation, continuing education, fees and testing tools.

2.4. Peer Specialist Recovery Coach (PSRC)

Rationale: People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery. The Peer Specialist Recovery Coach (PSRC) is a designation designed for Certified Recovery Coaches who are in recovery from a substance use disorder. A PSRC has specific knowledge and understanding through lived experience that makes him/her uniquely qualified to provide peer support for another person in recovery from a substance use disorder. It includes those who have received formal system services and those on pathways to recovery through other religious and spiritual approaches.

2.4.1. Peer Specialist Recovery Coach meets standards as stated in 2.1.
2.4.2. Peer Specialist Recovery Coach is certified by certifying body according to standards stated in section 2.3 prior to seeking designation.
2.4.3. Peer Specialist Recovery Coach has a substance use disorder and at least one (1) ongoing and continuous year of recovery.
2.4.4. Peer Specialist Recovery Coach is willing to self-identify as a peer, share his/her story and provide peer support to others who can benefit from the PSRC's lived experiences.
2.4.5. Peer Specialist Recovery Coach writes a *Statement of Personal Recovery* that demonstrates recovery status and personal commitment to recovery maintenance.
2.4.6. Peer Specialist Recovery Coach abides by the Idaho Code of Ethics for Recovery Coaches.
2.4.7. Designation as a PSRC is issued by the Department's contracted agency.

2.4.8. The PSRC designation is renewed annually by the Department's contracted agency. Peer Specialist Recovery Coach meets the following requirements for renewal:

2.4.8.1. Current certification through the certifying body as a Certified Recovery Coach and in good standing with the certifying agency;

2.4.8.2. 6 hours of continuing education related to the performance domains and tasks listed in the Training section 2.5 including 1 hour of ethics; and

2.4.8.3. 3 Letters of Recommendation/Support.

2.4.9. The Department contracted agency maintains sole discretion to inactivate or terminate a PSRC designation issued by the Department contracted agency. Reasons for inactivation or termination may include, but are not limited to:

2.4.9.1.1. Ethical violation substantiated by the Department's contracted agency;

2.4.9.1.2. Failure to comply with conditions of renewal;

2.4.9.1.3. Failure to document appropriate continuing education as required Department's contracted agency; and

2.4.9.1.4. Suspension or termination of recovery coach certification by the certifying agency.

2.4.10. The Department-contracted agency oversees the PSRC designation process and approval of all designation materials including application forms, required documentation, continuing education, fees and testing tools.

Special considerations: Continuing education required for Certified Recovery Coach recertification may meet continuing education requirements for PSRC annual designation.

2.5. Training

Rationale: The purpose of training is to introduce individuals to the key concepts, fundamental skills and core functions of recovery coaching. Training helps facilitate an individual's competence as a recovery coach and help ensure that individuals have the necessary knowledge and skills to provide quality services. Standardized training helps ensure that recovery coaches learn essential knowledge and skills needed to perform recovery coaching services.

2.5.1. Recovery Coach training includes, at a minimum, the following competency areas:

2.5.1.1. **Advocacy-**

2.5.1.1.1. Serve as participant's individual advocate;

2.5.1.1.2. Advocate within systems to promote participant-centered recovery support services;

2.5.1.1.3. Assure that the participant's choices define and drive their recovery planning process; and

2.5.1.1.4. Promote participant-driven recovery plans by serving on the participant's recovery-oriented team.

2.5.1.2. **Mentoring/Education-**

2.5.1.2.1. Serve as a role model of a person in recovery;

2.5.1.2.2. Establish and maintain a reciprocal relationship rather that a hierarchical relationship;

2.5.1.2.3. Promote social learning through shared experiences;

2.5.1.2.4. Teach participants life skills;

2.5.1.2.5. Encourage consumers to develop independent behavior that is based on choice rather than compliance;
2.5.1.2.6. Assure that participants know their rights and responsibilities; and
2.5.1.2.7. Teach participants how to self-advocate.

2.5.1.3. **Recovery/Wellness Support-**
2.5.1.3.1. Serve as an active member of the participant's recovery-oriented team;
2.5.1.3.2. Assure that all recovery-oriented tasks and activities build on participant's strengths and resiliencies;
2.5.1.3.3. Help the participant identify his/her options and participate in all decisions related to establishing and achieving recovery goals;
2.5.1.3.4. Help the consumer develop problem-solving skills so s/he can respond to challenges to their recovery; and
2.5.1.3.5. Help the consumer access the services and supports that will help him/her attain his/her individual recovery goals.

2.5.1.4. **Ethical Responsibility-**
2.5.1.4.1. Respond appropriately to risk indicators to assure the participant's welfare and physical safety;
2.5.1.4.2. Immediately report suspicions that the participant is being abused or neglected;
2.5.1.4.3. Maintain confidentiality;
2.5.1.4.4. Communicate person issues that impact ability to perform job duties;
2.5.1.4.5. Assure that interpersonal relationships, services, and supports reflect the participant's individual differences and cultural diversity;
2.5.1.4.6. Document service provision as required by employer; and
2.5.1.4.7. Gather information regarding participant's personal satisfaction with progress toward his/her recovery goals.

2.5.2. Training is 46 hours of face-to-face instruction with 10 hours in each of the domains of Advocacy, Mentoring/Education, and Recovery/Wellness and 16 hours in the domain of Ethical Responsibility.

Special considerations: Training conducted through interactive video telecommunications may be considered face-to-face. Any exceptions to the training as outlined here are reviewed by the certifying body.

2.6. Ethics

Rationale: Aspiring to be ethical involves sustained vigilance in preventing harm and injury to each person served. It is important that all recovery coaches are familiar with and follow ethical guidelines and expectations of service delivery for those served.

2.6.1. Recovery Coach adheres to the Idaho Code of Ethics for Recovery Coaches.
2.6.2. Recovery Coach completes ethics training at least annually.
2.6.3. Agencies employing or utilizing volunteer recovery coaches establish procedures for ethical decision making including methods for dealing with allegations of violations of ethical code.
2.6.4. Recovery Coach makes every effort to protect the confidentiality of the participant and adhere to limits of confidentiality as determined by applicable laws.

Special considerations: Recovery Coaching relationships are less hierarchical than the clinical counselor-client relationship. As such, the ethical guidelines that govern the clinical counselor are not applicable in the Recovery Coaching capacity.

2.7. Recovery Coaching Services

Rationale: Recovery Coaching is a set of non-clinical, participant-centered activities that engage, educate and support an individual to successfully make life changes necessary to recover from disabling substance use disorder conditions. Depending on the scope of work of the organization in which the recovery coach is providing services, the tasks carried out by the recovery coach can vary. Generally speaking, the services that a Recovery Coach provides should be participant-centered, participant-driven, culturally sensitive, recovery-based and community-based with the participant's rights protected. These services broaden the continuum of care provided in the typical treatment setting; they are part of an array of services. Recovery coaching services are partners to more traditional services, but should not be used as a substitute for clinical services when the need for clinical services is indicated. The purpose for these services is to help the participant feel less isolated and more empowered within their recovery and engaged in their community.

2.7.1. Recovery Coach utilizes a participant-centered recovery wellness plan to help participants develop effective recovery and general life goals.

2.7.2. The Recovery Wellness Plan is the participant's plan and is written, maintained and kept by the participant. Copies of the plan may be but are not required to be kept in the participant treatment file.

2.7.3. Recovery coaching services are delivered primarily face-to-face, secondarily by telephone, or via social media.

2.7.4. Recovery coaching services are delivered individually and in group sessions

2.7.5. Recovery coaching services are non-clinical activities designed to help initiate and sustain the individual in his/her recovery. The scope and types of recovery coaching services may include:

2.7.5.1. Mentoring or Coaching—assists participants with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery;

2.7.5.2. Recovery Resource Connecting—connects participants with professional and non-professional services and resources available in the community that can help meet the individual's needs for recovery;

2.7.5.3. Facilitating and Leading Recovery Support Groups—facilitates or leads recovery-oriented group activities. Some of these activities are structured as support groups, while others have educational purposes. Many have components of both; and

2.7.5.4. Building Community—helps participants make new friends and begin to build alternative social networks.

2.7.6. Recovery Coach refers participants to the appropriate resources if they are unable to benefit from coaching.

2.7.7. Recovery coaching services are delivered in both clinical setting and the community including:

2.7.7.1. Free standing peer recovery support or consumer run organization locations;

2.7.7.2. Facilities where other outpatient substance use disorder services are provided;
2.7.7.3. Natural community settings;
2.7.7.4. Facilities where inpatient services are provided;
2.7.7.5. Prisons, jails, forensic facilities;
2.7.7.6. Other community based settings; and
2.7.7.7. Supportive housing locations (e.g. Staffed Safe and Sober Housing facilities).

2.7.8. Specific caseload sizes are determined by the complexity of issues presented by the treatment population and the availability of ancillary services in the area.

2.7.9. Frequency of service depends on where the person is in their stage of recovery but no less than monthly.

2.7.10. Recovery Coach working within an agency adhere to the documentation requirements of the agency.

Special Considerations: A clinician or professional person may hold certification as a Recovery Coach; however, a Recovery Coach working with a particular individual as a Recovery Coaching provider cannot also be the clinician (i.e. other professional) who is providing any other services to that same individual. In other words, an individual cannot be the Recovery Coaching provider and other professional provider of a participant at the same time.

Services that a recovery coach does not perform include: counseling/therapy, drug testing, diagnosing of symptoms and disorders, recommending medications or monitoring their use, acting as a legal representative, participating in the determination of competence, and providing legal advice.

Although a recovery coach could work with a larger caseload, it is important to consider the amount of time required by each individual receiving the service. As is the case across the behavioral health field – as caseloads increase, recovery coaches lose their capacity to effectively teach behavioral skills.

Billable recovery coaching services vary across funding sources. Agencies need to ensure that recovery coach services are approved for direct billing and meet criteria for reimbursement and have guidelines on how to bill for these services to foster financial sustainability.

The use of social media creates potential risks of unintentional improper disclosure of a participant's personal and private information. Recovery coaches should be aware of the limitations of privacy online and ensure that they maintain confidentiality when using social media for recovery coaching services.

2.8. Reciprocity

Rationale: The time and effort a person expends obtaining a certification is valued. In circumstances where an individual has received certification from another state, it is important to have a process for reviewing whether reciprocity to provide similar services in Idaho is appropriate.

2.8.1. Individuals requesting reciprocity for Certified Recovery Coach submit an Idaho Certified Recovery Coach application along with a copy of his/her certification to Idaho's certifying body.

2.8.2. If Idaho's certifying body finds the application deficient in any of Idaho's requirements, a letter explaining needed documentation will be sent to the applicant. The applicant has 30 calendar days to respond with an explanation as to how the requirements will be completed and 60 days to complete said requirements.

2.8.3. Individuals requesting reciprocity for Peer Specialist Recovery Coach designation must have Idaho certification as a Certified Recovery Coach and may apply to the Department-contracted agency to qualify as a Peer Specialist Recovery Coach in Idaho.

Special Considerations: Certification titles and role of recovery coaches vary from state to state. An individual may qualify as a peer under the certification in another state but designation as Peer Specialist Recovery Coach is needed to qualify as a peer in Idaho.

2.9. Organizational Readiness and Responsibility

Rationale: Optimal employment and use of recovery coaches requires awareness and understanding of peer recovery, resilience, trauma, and hope as they relate to the recovery coach providing services and to the participants who receive those services. Recovery coaches can provide a unique perspective to the rest of the team and work to foster positive, effective relationships with the persons served. Organizational readiness is essential to ensure that recovery coaches have a place of employment that understands their purpose and is aware of the strengths and limitations in the recovery coaching scope of practice.

2.9.1. Recovery Coaches are treated as equal to any other staff of the agency, are provided equivalent opportunities for training and pay, and benefits competitive and comparable to other staff based on experience and skill level.

2.9.2. Agency engages in educational opportunities that prepare them to better understand the strengths and opportunities offered by the Recovery Coach.

2.9.3. Agency provides ongoing supervision to Recovery Coach that is non-clinical and trauma-informed, facilitated by a qualified supervisor that is trained on the unique issues of a recovery coach.

2.9.4. Agency ensures that performance evaluations reflect the Recovery Coach role and are completed in a way that promotes recovery.

2.9.5. Agency does not employ or utilize clients who are receiving services at their agency as a Recovery Coach for the agency.

2.9.6. Agency develops a written job description that specifies the duties and responsibilities of the Recovery Coach within that agency.

2.9.7. Recovery Coach assists in developing the plan for care, treatment, or services, when indicated by the participant served.

2.9.8. The plan for care, treatment, or services reflects the inclusion of recovery coaching as determined by the participant served.

Special Considerations: Implementing recovery coaching services likely requires modifications to existing treatment policies and guidelines and possibly the culture within existing treatment organizations. Traditional addiction treatment programs have been structured around a professionally-driven, short-term (e.g., four to six weeks), and residential- or outpatient-based model of treatment. Policies and guidelines have evolved to support these traditional treatment programs and, as a result, require some changes to support the application of a more client-centered, longer-term (e.g., 12 to 24 months), and community-based program. In addition, the culture and philosophical or ideological orientation of the treatment program also need to be

modified to incorporate a community-based, client-centered model of care. Both the collective organization and the staff members within all levels of the agency will be impacted by introduction of the RC program. The implementation of the RC program requires the involvement of staff from all levels of the organization and modifications to how the agency engages and provides services to its treatment population.

Supervisors need clear guidance about the role of recovery coaches within the organization and how to support them. Supervisors should receive training in how to supervise recovery coaches, including how to support recovery coaches in maintaining their own recovery, how to deal with relapse and how to help recovery coaches manage workforce challenges.

Safety is an important concern; therefore background checks may be required by law and rule. It is the responsibility of the agency or place of employment to ensure that the Recovery Coach meets applicable background check requirements.

Additional Considerations: *Agencies that employ Recovery Coaches adhere to this standard and all of the Core Standards put forth by the State Behavioral Health Authority.*

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3.0 Certified Family Support Partner (CFSP) Standards

3.1. Definitions

Rationale: A Certified Family Support Partner (CFSP) is a parent or adult caregiver who, through lived experience and specialized training, has acquired an understanding of another parent's situation via the shared emotional and psychological challenges of raising a child living with a behavioral health diagnosis. The relationship between the CFSP and the family being served is mutual, built on a connection and trust not obtainable through other service relationships (e.g. counselor, psychologist, minister) or someone without the shared experience. The CFSP partners with other agencies which serve the child and his/her family to improve the quality of life and opportunities of recovery for the child in the home, school and community.

3.1.1. CFSP has at least one year of lived experience as a parent or an adult caregiver who is raising a child or has raised a child who lives with a behavioral health disorder diagnosis (mental illness or co-occurring mental illness and substance use disorder) and has successfully navigated the various systems of care.

3.1.2. CFSP has gained appropriate knowledge, experience and skill via Idaho's approved certification process.

3.1.3. CFSP understands and lives by a prescribed code of ethics.

3.1.4. CFSP engages, educates, guides and supports family members to help them make successful life changes necessary for recovery. These changes are determined by the family being served.

3.1.5. Lived experience comes from raising a child before his/her 18th birthday and the lessons learned from raising this child.

Special considerations: Raising a child who has lived with a substance use disorder only (without presence of mental illness) does not qualify the parent or caregiver as a CFSP.

3.2. Qualifications

Rationale: Because raising a child who is living with a behavioral health diagnosis is a unique parenting experience shared by those who have parented a child who lives with emotional or behavioral concerns, certain qualifications are needed to understand and know how to navigate the systems involved in raising the child. It is only ethical that the CFSP meets certain criteria when working with children and their families.

3.2.1. CFSP candidate has experience raising a child who lives with mental illness, behavioral or emotional disorders.

3.2.2. CFSP candidate writes a personal Lived Experience Essay which includes challenges, triumphs, problem-solving methods, personal support system, and strategies for living with stressors.

3.2.3. CFSP candidate has completed 40 contact hours of training specifically designated for Idaho CFSPs and approved by the State Behavioral Health Authority.

3.2.4. CFSP candidate passes a post-training assessment established by the training entity and approved by the State Behavioral Health Authority.

3.2.5. A Letter of Completion is mailed to the CFSP candidate. The letter states either approval for the individual to take the certification exam or it provides individualized recommendations for the candidate to complete before moving forward with the certification exam.

3.2.6. Work Experience and Education:

3.2.6.1. If the CFSP candidate holds a bachelor's degree in human services (e.g. social work, psychology, education, sociology, social sciences), he/she documents 100 hours of work experience in the human services field within a year of completing the training. If the 100 hours of work experience are not completed within a year, a review is required by the certifying body.

3.2.6.2. If the CFSP candidate does not hold a bachelor's degree in human services (e.g.. social work, psychology, education, sociology, social sciences), he/she must have a high school diploma or GED and documents 200 hours of work experience in the human services field within a year of completing the training. If the 200 hours of work experience are not completed within a year, a review is required by the certifying body.

3.2.7. CFSP candidate completes 20 supervision hours with a designated Idaho CFSP Supervisor within a year of completing the training.

3.2.8. CFSP candidate passes the Idaho Certified Family Support Partner Exam with a score that meets the standard set by the certifying body authorized by the State Behavioral Health Authority.

3.2.9. Accommodations for the exam are provided as deemed necessary by the individual taking the exam. Examples of accommodations include, but are not limited to, extra time, a separate room, and use of a computer.

3.2.10. CFSP Supervisor is a degreed professional in the field of human services who has supervisory capacity within the agency and is designated as a CFSP Supervisor by the certifying body.

3.2.11. The CFSP Supervisor obtains such designation by applying to the approved certifying body and following the approved process for said designation. The certifying body maintains a current list of approved Supervisors.

3.2.12. CFSP maintains a working knowledge of current trends and developments in the fields of children's mental health, substance use disorders, child and adolescent brain development, education/special education, child welfare regulations, juvenile justice regulations, wellness and recovery, ethical practices and peer support services by reading current journals, books, etc., attending webinars, workshops and conferences as they relate to these fields, and sharing with other CFSPs.

3.2.13. CFSP must be at least 18 years old.

3.2.14. To avoid role ambiguity and conflict, CFSP does not fulfill other service roles (therapist, counselor, case manager, nurse, physician, clergy, etc.) to participants they are providing peer services to.

Special considerations: A clinician or professional person may hold certification as a CFSP; however, a CFSP working with a particular family or child as a CFSP provider cannot also be the clinician or professional person who is providing any other services to that same child or family. In other words, an individual cannot be the CFSP provider and the clinical/professional provider of the same child or family.

Safety is an important concern, therefore background checks may be required by law and rule, but are the responsibility of the agency or place of employment, and are not part of the certification process.

3.3. Training

Rationale: Although lived experience equips the CFSP with knowledge and understanding of family issues and concerns, there are areas in which the CFSP needs to be trained to verify certain skill sets. This training adds to the families' confidence and trust in the CFSP's abilities with whom they are working.

3.3.1. CFSP training includes, at a minimum, the following competency areas:

- 3.3.1.1. mental illness and substance use disorders and their effects on the brain;
- 3.3.1.2. advocacy skills used in multiple systems (children's behavioral health system, education and special education systems, child welfare system and juvenile court system);
- 3.3.1.3. ethics (boundaries, confidentiality, HIPAA, etc.);
- 3.3.1.4. the awareness of risk factors in participants' behaviors and the ability to access appropriate services;
- 3.3.1.5. communication skills (interpersonal and professional);
- 3.3.1.6. effecting change;
- 3.3.1.7. empowerment;
- 3.3.1.8. parenting special needs children and family dynamics;
- 3.3.1.9. the recovery process;
- 3.3.1.10. the effects of trauma;
- 3.3.1.11. wellness and natural supports;
- 3.3.1.12. family-centered planning;
- 3.3.1.13. maintaining one's wellness;
- 3.3.1.14. cultural sensitivity;
- 3.3.1.15. recovery plans; and
- 3.3.1.16. local, state and national resources.

3.3.2. Training is 40 hours of face-to-face instruction that is conducted by an IDHW DBH approved training entity. The training entity is separate from the certifying body. The certifying body is responsible for verifying competencies.

3.3.3. Curriculum includes all types of learning methods, including role-playing scenarios as a key element of building skills.

Special considerations: Any exceptions to the training as outlined here are reviewed by the certifying body.

3.4. Certification and Renewal

Rationale: Professional certifications are widely found in a variety of professional fields in the United States today. In the field of behavioral health, employers have a general obligation to perform due diligence in ensuring competency to the best of one's ability of the personnel providing services to other human beings. Certification provides employers and participants with evidence and documentation that the certificate holder has demonstrated a certain level of job-related knowledge, skills, abilities, and practical experience. Certification also empowers the holder via the knowledge and skills obtained, as well as by the fact that he/she has successfully accomplished the completion of all requirements.

3.4.1. CFSP meets the qualifications as stated in section 3.2.

3.4.2. Professionals claiming to hold certification status as a CFSP maintain documentation of said certification.

3.4.3. CFSP certification is valid for one year.

3.4.4. CFSP professional renews his/her certification annually by:

3.4.4.1. completing at least 10 hours of approved continuing education (e.g. trainings, workshops, webinars) per year and documenting said education. Continuing education topics can be from any of the competencies listed in the training competencies section in 3.3; AND

3.4.4.2. completing a renewal application; AND

3.4.4.3. maintaining a no-violations record regarding the CFSP Code of Ethics

3.4.5. CFSP follows the Certification Renewal Procedure put forth by the certifying body for Idaho's CFSPs.

3.4.6. CFSP is responsible for ensuring that the certifying body has all current documentation necessary for satisfying the certification criteria.

3.4.7. Employers of CFSPs are responsible to check with the centralized certification agency to ensure that the CFSP which they wish to hire has current certification status as a certified CFSP in Idaho.

3.4.8. The state's approved certifying agency tracks certifications and continuing education status of Idaho's CFSPs.

3.5. Termination, Inactive Status & Reactivation

Rationale: Certification reveals to others that a person has reached a particular level of competency. If these levels are not maintained, a person's certification may be terminated or revoked. Termination can be due to deficient documentation or a Code of Ethics violation.

3.5.1. Deficient documentation is the failure to submit on time requested documentation and application for certification and renewal, or any other requested materials from the certifying entity

3.5.2. A Code of Ethics Violation is the failure to abide by the CFSP Code of Ethics and/or providing false information on documents

3.5.3. Inactive Status is when a CFSP in good-standing requests such status because he/she is unable to meet the requirements for recertification due to a decline in physical or mental health or an extenuating circumstance; such as, a death of a close relative, divorce or marriage, long-term illness of family member, loss of employment, birth of a child, military deployment, or other circumstance that is approved by the certifying body.

3.5.4. Reactivation is accomplished by submitting all required documentation, including a new application packet and verification of CEUs earned within one year of resubmission.

3.5.4.1. It is the applicant's responsibility to ensure that all documentation is completed and submitted.

3.5.4.2. If application is incomplete, a deficiency letter is sent to the applicant and applicant has 30 calendar days to mail all required documents. If 30 days go by and documents are not received by the certifying body, the applicant's certification expires and applicant will need to re-apply, submitting all certification documentation and a new application.

3.5.5. Applicants who have violated the Code of Ethics will, in addition to the documentation in 3.5.4, submit a report that details the nature of the violation,

admission of the violation, corrective actions taken and insurance that the violation will not recur. The CFSP Peer Review Board, which is defined by the certifying entity, will determine re-instatement based on the seriousness of the violation, applicant's report and the corrective actions taken.

Special considerations: Inactive status is not granted for the failure to comply with continuing education requirements or a reported Code of Ethics violation.

3.6. Reciprocity

Rationale: The time and effort that a person expends obtaining a CFSP certification is valued. Idaho also values its certification process and therefore, reciprocity from another state's certifying board is permitted as long as certain conditions are met.

3.6.1. Applicant submits a CFSP application along with a copy of his/her certification and either a copy of the certifying state's requirements or a website where these can be found.

3.6.2. If applicant is deficient in any of Idaho's requirements, a letter explaining needed documentation will be sent to the applicant. The applicant has 30 calendar days to respond with an explanation as to how the requirements will be completed and 60 days to complete said requirements.

3.7. Reporting Changes

Rationale: Idaho values its CFSPs and wants to maintain communication with each one. The best way to do this is to know how to reach each CFSP to report CFSP news, events and any changes to the certification requirements. It also aids in networking with all CFSPs in the state. In addition, this allows IDHW to know how many CFSPs are available in different parts of the state and who they are.

3.7.1. Certified Family Support Partner (CFSP) reports changes in name, address, telephone number and email address.

3.7.2. CFSP reports a change in supervisor's name.

3.7.3. CFSP reports a change in employment status.

3.7.4. CFSP reports a violation in Code of Ethics

Special considerations:

Failure to report changes may result in termination of certification or other disciplinary measure as determined by the certifying body.

3.8. Grievance Procedures

Rationale: There are times when applicants will not agree with decisions made the certifying board. To be properly and fairly heard, a procedure has been identified for the applicant to voice his/her grievance.

3.8.1. Applicant may file a grievance when there is a valid factual reason to do so, such as: being denied certification, questioning the outcome of the review board, or applicant is subject to an action by the certifying board that he/she deems unjustified.

3.8.2. Applicant must file said grievance within 30 days of notice or action deemed unjustified.

3.8.3. Peer Review Board reviews the grievance, but the certifying body has authority to make the final decision regarding any remedy to be made.

3.9. Provision of Family Support Services

Rationale: Depending on the scope of work of the agency in which the CFSP is employed, the tasks carried out by the CFSP can vary. Generally speaking, the services that a CFSP provides should be child-centered, family-driven, youth-guided, community-based with the child's rights protected and culturally sensitive. These services broaden the continuum of care provided in the typical treatment setting. They are not in lieu of other treatment practices; rather they enhance other practices. The purpose for these services is to help the family feel less isolated and more empowered within the recovery process and engaged in the community.

3.9.1. CFSP services may be provided to all participants who are in need of such services.

3.9.2. Participant and/or family member outcomes expected during and after a CFSP works with the family include, but are not limited to:

3.9.2.1. ability to identify and use wellness tools;
3.9.2.2. increased social skills;
3.9.2.3. demonstrated ability to live more independently;
3.9.2.4. re-engaging with support systems that may have been lost;
3.9.2.5. improvement in child's educational goals;
3.9.2.6. improved quality of life;
3.9.2.7. less stress;
3.9.2.8. sense of purpose;
3.9.2.9. increased empowerment;
3.9.2.10. belief that recovery is possible;
3.9.2.11. increased self-esteem;
3.9.2.12. demonstrated ability to self-advocate; and
3.9.2.13. increased participation in community, school and positive recreational activities.

3.9.3. Services provided by the CFSP include, but are not limited to:

3.9.3.1. advocating for the needs of the family;
3.9.3.2. teaching family members and participant how to develop self-advocacy and problem-solving skills;
3.9.3.3. mentoring the participant and family members to instill a sense of hope;
3.9.3.4. role modeling behaviors, attitudes and thinking skills needed for resiliency and coping;
3.9.3.5. helping family members identify and utilize their strengths;
3.9.3.6. role modeling the facilitation of collaborative relationships;
3.9.3.7. teaching participant and family about causes of disorders and importance to adhering to treatment; utilizing evidence-based interventions that assist in meeting goals;
3.9.3.8. assist family members in identifying and connecting to services and community resources;
3.9.3.9. assist family members in articulating their needs and goals in preparing for meetings as well as service plans;
3.9.3.10. provide family-based programs such as classes on parenting special needs children;

3.9.3.11. teach caregivers how to document all activities that pertain to the child's appointments, meetings, needs, goals, and strengths; and

3.9.3.12. assist in preparing for the child's transition to adulthood.

3.9.4. These services shall be delivered primarily face-to-face, and secondarily by telephone or social media.

3.9.5. CFSP shares his/her personal story when appropriate for the benefit of the family with whom he/she is working, keeping in mind that this is but one experience and it does not mean that other families will have the same experience or needs.

3.9.6. CFSP, in collaboration with the family, and any other professionals for which the family gives consent (i.e. the child's behavioral health provider, the child's primary care physician, and any other agency professional that is involved with the child's care), assists in developing an individualized family-centered service plan that includes a description of the family's goals, timeframes for meeting these goals, and the interventions that will assist in meeting the goals.

3.9.7. Frequency and Length of Service:

3.9.7.1. The frequency by which a CFSP meets and works with the family and the length of this service is determined by the child's mental health team (i.e. clinician, parents/caregivers, child [if child is an adolescent], and CFSP) and evidence-based practices.

3.9.7.2. The frequency and length of service are periodically re-evaluated depending on the intensity of the CFSP services needed. The higher the intensity and frequency of the services, the more often a re-evaluation occurs.

3.9.8. CFSP performs activities *with* an individual, and not *for* or *to* the individual so that the child and the family can regain control over their own lives.

3.9.9. CFSP is under the direct supervision of a designated CFSP Supervisor.

Special considerations: CFSP services augment other professional treatment services. Services that a CFSP does not perform include: counseling/therapy, drug testing, diagnosing of symptoms and disorders, prescribing, acting as a legal representative, participating in the determination of competence, and providing legal advice.

3.10. Organizational Readiness & Responsibilities

Rationale: Organizational readiness is essential to ensure that CFSPs have a place of employment that understands their purpose and in order for families to receive the care and support they need.

3.10.1. Organizational Readiness is preparing an organization or agency for the employment of a CFSP, ensuring that staff members understand the purpose of CFSPs and how CFSP duties enhance the organization's mission.

3.10.2. Agency establishes a readiness plan that includes criteria by which the agency hires, supervises, and works to maintain CFSPs.

3.10.3. Agency adheres to Idaho's standard of Certified Family Support Partners and all other agency-related standards.

3.10.4. Agency trains staff members in the purpose and value added by CFSPs.

3.10.5. Agency ensures that all CFSPs are supervised by a licensed mental health provider and that the services rendered by the CFSP are under a comprehensive, individualized, child-centered and family-driven plan.

3.10.6. CFSP Supervisors are designated by each agency that employs CFSPs and the Supervisor is approved by the certifying body. A list of approved CFSP Supervisors is maintained by the certifying body.
3.10.7. Agency utilizes trauma-informed care principles when employing CFSPs.
3.10.8. The state's approved certifying agency tracks certifications and continuing education status of Idaho's Certified Peer Specialists.

3.11. Ethics

Rationale: A code of ethics in any profession guides the professional in areas of role-function, relationships, levels of responsibilities and liability.

3.11.1. Certified Family Support Partner (CFSP) adheres to the Idaho CFSP Code of Ethics while performing duties of a CFSP.
3.11.2. CFSP completes at least annual ethics training, provided by either an employer or via other avenues approved by the certifying body.
3.11.3. Agencies that employ CFSPs provide accessible opportunities for ethics training to all service- providing staff members, including CFSPs, at least annually.
3.11.4. Provider organizations document completion of ethics training in each employee's file, including each CFSP's file.
3.11.5. CFSP keeps personal documentation of completed ethics training as required by the certifying body.

Special considerations: A clinician or professional person may hold certification as a CFSP; however, a CFSP working with a particular family or child as a CFSP provider cannot also be the clinician or professional person who is providing any other services to that same child or family. In other words, an individual cannot be the CFSP provider and the clinical/professional provider of the same child or family.

Additional Considerations: *Agencies that employ Certified Family Support Partners adhere to this standard and all of the Core Standards put forth by the State Behavioral Health Authority.*

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Quality Assurance Program

Division of Behavioral Health

Submitted by Candace Falsetti- CO 3rd, 4-24-2015, #2

2015

Idaho Department of Health and Welfare

Quality Assurance Program

Quality Assurance Program

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Quality Assurance Program

Revisions:

Title	Date	Revision #	Notes
Quality Assurance Program	**March 16, 2015**		
“”	**March 27, 2015**	**1**	**Added definitions Clarified role of Qa Checked BPA QA description Checked IYTP description**
Same	**April 24th, 2015**	**2**	**Clarified role of QA compared to Contract Monitors**

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): 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: A program for 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

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.

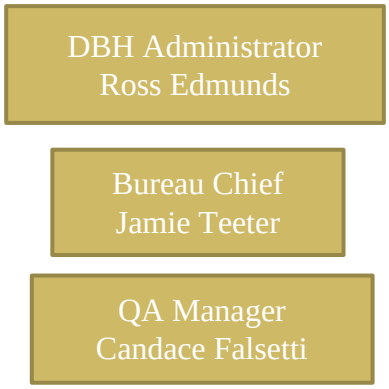
A set of key outcome/performance measures that will be used for evaluation are in development. The measures will be identified based on the following philosophy:

- 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.

A list of possible 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.

Once key indicators of performance and outcome measures have been identified the process for reporting of outcomes will be developed. Outcome measures will be utilized to evaluate the impact of the QAP.

DBH QA Management Structure



Quality Assurance Program

Quality Assurance Methodology

The Quality Assurance (QA) methodologies that will be employed will include review of State operated and contractor records, reports, policy and procedures, site visits, direct interviews, and surveys. QA findings will be assessed and addressed as quality improvement (QI) through various quality techniques such as Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis.

QAP Functional Areas

QAP identifies the areas of responsibility specifically assigned to the Quality Assurance Unit. These functional areas are listed below.

Idaho Behavioral Health Plan (IBHP)

Managed Services Contractor (SUDS)

19-2524

Preadmission Screening and Resident Review (PASRR)

Continuous Quality Improvement (CQI)

Facility Approval

Critical Incident

Jeff D – Quality Management Improvement Activity (QMIA) plan Development

Idaho Youth Treatment Plan (IYTP) Evaluator

Quality Improvement (QI) Work Plan

Performance Improvement Projects (PIPs)

A high level description of each functional area follows.

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

Quality Assurance Program

DBH QA monitors the IBHP progress toward the goals for transformation through:

i. Evaluating targeted IBHP responsibilities and processes to ensure they are within an acceptable range meet state and federal laws, requirements and standards.

   IBHP responsibilities that DBH QA will evaluate include, but are not limited to:

   a. Transformation
   b. Care Management:
      i. Authorization and Denials
      ii. Records of ICM, Discharge Coordination
      iii. Care Coordination with PCP
   c. Provider Network:
      i. Provider credentialing
      ii. Provider audit findings, action plans
      iii. Provider training plans
   d. Quality Assurance:
      i. Member Rights
      ii. Member Satisfaction

ii. Assessing the impact of IBHP processes based on the quality aims set by the Institutes of Medicine (IOM) for quality assurance: effectiveness, efficiency, equitable, safe, timely, client centered.

   The impact will be measured utilizing identified key outcome measures

Managed Services Contractor (SUDS)

In addition to, and in support of, contract monitoring central office 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.

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 ensure that consideration is given to the behavioral health needs as part of presentencing determination.

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. If the information is not adequate to develop a treatment recommendation the DBH clinician requests a full MHE. Information regarding treatment recommendations are communicated to the PSI and are notated in the final report.

In addition to the Utilization Management processes noted 19-2524 staff work with IDOC and 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 screening to develop recommendations, which may include a comprehensive MH evaluation. 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.

Quality Assurance Program

Facility Approval

In accordance with Idaho Statute and IDAPA all SUDs provider must have facility approval by the state authority. DBH QA staff designated lead completes all initial site certifications and monitors the work of the MSC.

DBH is in the process of developing IDAPA rule for Facility Approval for a Behavioral Health Agency.

Critical Incidents

Regional Programs report all Critical Incidents to central office administrators and QA. Critical incidents are also reported by the IBHP and 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

Jeff D Quality Management Improvement Activities (QMIA) Plan Development

DBH QA will work with the Jeff D implementation team to develop a Quality Management Improvement Activities (QMIA) plan that will define the QA processes to be implemented in regards to Jeff D Members.

Idaho Youth Treatment Program (IYTP) Project Evaluation

QA acts in the role of Project Evaluator for the grant for the Idaho Youth Treatment Program. The Project evaluator performs a variety of monitoring, evaluating and reporting functions as described in the IYTP Project Evaluation Plan.

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)

Systemic issues that are appropriate may be addressed through a PIP. A PIP 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.

Quality Assurance Program

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:

Quality Assurance Program

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

Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
Client/Family Centered (Engagement)	Parent/Family voice, choice, and preference are assured throughout the process	What proportion of cases involves caregivers and children in case planning and service delivery?	Number of cases in which client or family were involved in service planning Number of cases in which age-appropriate children were involved in case planning	Client satisfaction surveys Direct client survey (phone calls?)
		How do clients/family perceive the quality of the collaboration?	Client and family perception of collaborative service delivery	
	Collaborative Assessment of Environmental Factors	Are client and family strengths and needs integrated into treatment?		
	Services are maintained	Are clients 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 Clients have improved family mental health/substance abuse and relationship status	To what extent are family strengths and needs assessed and integrated into treatment?	Items from the *CANS*, CALOCUS, CAFAS , GAIN, LOCUS Measure for Social connectivity? Wellness Assessment (Optum's WA)	Results of outcomes tools
	High utilizers	Are clients and families receiving appropriate services?		Encounter data
Linkages	Evidence of Care coordination with other mental health providers	To what extent is the treatment plan coordinated with other agencies?	Treatment plan indicates coordination with other agencies as needed Client perceptions of service availability, access post-	

Quality Assurance Program

Domain	Measure	Question	Data Elements	Data Source(s)
			discharge	
	Evidence of Care Coordination with Primary Care	To what extent is treatment integrated?	Treatment plan indicates coordination with other primary care	
	Evidence that physical health issues are assessed	To what extent are physical health issues assessed?		
Safety	Risks are identified and clients 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		

17. Community Living and the Implementation of Olmstead

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 substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of 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 residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain 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:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
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?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

17. Community Living and Implementation of Olmstead

Page 68 of the application Guidance

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:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.

The State of Idaho does not currently have an actively managed Olmstead plan. Based on an Idaho Attorney General opinion, Idaho declared that the state was in full compliance with *Olmstead*, and that no plan was necessary. However, noting that there was widespread disagreement with this position, the Governor created a "Community Integration Committee" (CIC) to explore barriers to integrated services for people with disabilities, and to make non-binding recommendations to the state. The Committee consulted reports, evaluations, people with disabilities, and advocates. The Committee's last report was submitted in 2004. While the Community Integration Plan has not been monitored in several years, the emphasis on community integration and community living is still strongly implemented by individuals and systemically. The Division of Behavioral Health has for years utilized state funding to assist patients access appropriate community housing. This includes individual projects for brick and mortar, rental assistance programs, and contracts with providers of community living and supportive housing.

The Department is now in its second year of utilizing a managed care organization to administer its Medicaid outpatient services. The array of services include standard outpatient services, but introduced a new service to Idaho call community reintegration. This service pulls together case management, peer support, and medication management into a short term intervention to successfully reintroduce patients into their communities safely and effectively. Additionally, the Division of Behavioral Health maintains Assertive Community Treatment (ACT) teams in every region of the state to assist patients transitioning home from hospitalization.

Idaho is fairly new to implementation of peer support services and recovery coaching services. Idaho has a statewide certification program for peer specialists and recovery coaches. Currently, peer support is a Medicaid reimbursed service through the managed care model. The Division of Behavioral Health employs at least one peer specialist on each of the ACT teams. It is Idaho's goal to continue the strong momentum it currently has with regard to peer support and recovery coaching over the coming years.

The Division of BH maintains a contract with the Idaho Division of Vocational Rehabilitation to work with all ACT team patients on employment and vocational opportunities. This has been a very successful partnership and will continue. Idaho does not have a supportive employment program established under the Behavioral Health Authority.

The Idaho Home Choice Program was implemented in October 2100 and is designed to rebalance long-term care spending from institutionalized care to home and community-based care. As of Jul6y 2014, the Home Choice Program has helped 187 of 345 anticipated participants transition into the community. It is anticipated at the end of the five year grant period, Idaho will have diverted $1.9 million of Medicaid state fund spending from institutionalized care to home and community based care.

2. How are individuals transitioned from hospital to community settings?

The Division of Behavioral Health had developed a policy regarding state hospital discharges. The policy identifies 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.

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 PSR and counseling 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 region shall 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.

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?

Efforts currently underway to address ADA community integration mandate required by the Olmstead Decision are largely focused on individual patients. Idaho does not have a current statewide plan. Having said that, Idaho's system is largely voluntary and directs incredible resources to assisting patients in discharging from institutions. Idaho has an average length of stay at its state institutions far below the national average. Additionally, Idaho boasts a 30 and 180 day readmission rate below the national average. Again, the efforts for community integration focus on the patient care and support. As systemic barriers to community living and reintegration are identified, they are addressed to assure the rights of Idahoans are upheld.

4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Idaho has not been involved in litigation or a settlement agreement with the DOJ regarding community integration.

5. Is the state involved in a partnership with other state agencies to address community integration?

As reported above the Division works in partnership with the Division of Medicaid, Optum Idaho, the Idaho Department of Vocation Rehabilitation, and the Department of Corrections and Juvenile Justice in coordinating and delivering needed behavioral health services.

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. 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 mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health 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.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

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.[93] 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 liaison 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 more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

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 substance use disorders and co-occurring disorders 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's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] 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.

[92] 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.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

Idaho Substance Use Disorders Response:

Currently, Idaho has three distinct systems for the delivery of substance use disorders services to children and adolescents. Children qualifying for Medicaid are served under the Department of Health and Welfare, Division of Medicaid contract with OPTUM. This is a managed care contract that makes OPTUM responsible for the delivery of all aspects of substance use disorders, co-occurring and mental health services for children and adolescents. The Idaho Legislature also provides funds to the Department of Juvenile Corrections for the delivery of substance use disorders services to children and adolescents involved in the county or state criminal justice systems. Both of these systems are established outside the scope and authority of the SSA.

The Department of Health and Welfare's Division of Behavioral Health (DBH) contracts with Business Psychology Associates (BPA) to manage the delivery of care for children and adolescents diagnosed with a substance use disorder, who are not served under either of the systems outlined above. With a statewide network of private providers, BPA has developed a substance use disorders treatment system that is accessible, acceptable and effective. Four major components within this system ensure that children and adolescents receive all the services and supports they need to build a sustainable recovery.

The first component is the qualifying clinical and financial screening. Per state-established procedures, all children, adolescents and adults seeking state-supported substance use disorders treatment services are screened clinical and financial need to determine eligibility for DBH-funded services. The requirement for financial need is waived if the child or adolescent needs treatment and the parents refuse to provide financial information or pay their co-pay. Once a child/adolescent is determined to be eligible, BPA makes available information the network treatment providers in their community who treat children and adolescents. Based on this information the child and their family/guardian select a provider.

The second component of the DBH-required system is a comprehensive assessment and client-driven treatment plan. All providers within the BPA network are required to employ the "Global Appraisal of Individual Needs" (GAIN) assessment to evaluate client need in the dimensions of the "Diagnostic and Statistical Manual." This enables the substance use disorders treatment provider to assess the "whole" child and identify the full scope of their needs. Based on the findings of the GAIN assessment, the treatment provider works with the child/adolescent, and if appropriate, the parent/guardian, to develop a treatment plan the is client driven.

The third component of the DBH-required system is delivery of treatment services partnered with ongoing review and updating of the treatment plan. Once again, in partnership with the child/adolescent, and their parent/guardian as appropriate, treatment and support services are delivered to address the client's needs and goals. Based on the assessment and the child/adolescent's decisions, treatment services may include the whole family. Case management services are also initiated in the delivery of treatment services. The case manager provides the essential element of the partnership, pulling together treatment services with community-based

resources to enable the child/adolescent to initiate the foundation for a sustained recovery. The case manager bears the primary responsibility for working with other agencies such as education, juvenile corrections and child protection.

The fourth component of the DBH-required system is discharge planning. Discharge planning is initiated with the child/adolescent, and if appropriate, the parent/guardian, as soon as the treatment plan is completed. Discharge planning not only focuses the treatment episode on recovery and resilience, it also builds a foundation for a successful, sustained recovery.

The Idaho Department of Juvenile Corrections, along with the Idaho Department of Corrections and the Idaho Judiciary, is a partner in the contract the Division of Behavioral Health holds with Business Psychology Associates. They access the treatment provider network and cover the cost of services via the contract. Per the first paragraph of this response, the Department of Juvenile Corrections has its own county-based system serving children and adolescents involved in the criminal justice system. The Department of Education, does not fund or manage the delivery of substance use disorders services. The Department of Education works with the Department of Juvenile Corrections and the Division of Behavioral Health to ensure children and adolescents within their systems are able to access education services, and, when appropriate have access to the resources and support.

The Department of Health and Welfare's Division of Family and Community Services is the state agency responsible for child welfare. The Division of Behavioral Health partners with the Division of Family and Community Services on the delivery of substance use disorders services for adults and children/adolescents involved in the child protection system. This partnership ensures parents and children get all services needed to facilitate re-unification and reduce recurrence of problem behaviors.

The Division of Behavioral Health employs three major methods for training substance use disorders professionals and recovery coaches. Given the sized and topography of Idaho, the most accessible methods of training are webinars and video conferences. The Division of Behavioral Health's contractor, Business Psychology Associates, is responsible for maintaining an education website where network provider staff can access information on available trainings. As information on new trainings becomes available, the material is added to the website or provided directly to the network via electronic mail.

The second method of training employed in Idaho is face to face sessions. These sessions focus on specific skill areas and are often offered in multiple locations to facilitate access. The Division of Behavioral Health also supports the annual Idaho Conference on Alcohol and Drug Dependency. The 15 conference included speakers on facilitating change within individuals, families and communities, Understanding Adolescents and Trauma, and Prevention, Care, and Collaboration: Marijuana and Adolescents. Finally, the Division of Behavioral Health provides funds to support the Idaho RADAR Center which provides a broad range of video and written professional and client treatment resource materials for children and adolescents.

The Division of Behavioral Health has adapted the Web Infrastructure for Treatment Services (WITS) data system to meet the needs of the partnering Idaho agencies responsible for the

delivery and management of substance use disorders treatment services. This system captures all client demographic, diagnostic, service utilization and outcome data on individuals served by the Division of Behavioral Health.

Because the Division of Behavioral Health is responsible for a statewide substance use disorders treatment system, responsibility for partnering with schools on is the responsibility of the community-based provider network. This method reduces bureaucracy and increases the capacity of treatment providers and case manager to use local resource to develop community-based solutions to address the needs of each child and adolescent.

Children and adolescent services are delivered to individuals under the age of 18. The Division of Behavioral Health does offer a grace period for a minor who entered an adolescent treatment program at age 17 and turned 18 before the treatment episode was completed. In this case, the individual may remain in the adolescent treatment program until it is clinically determined they may be discharged. Should the individual relapse after completion of the treatment episode, they would be referred to a facility treating adults.

Children involved in the child protection (CP) system, have an assigned CP case manager who continues to supervise their case while they are receiving treatment services. As a part of discharge planning, the treatment provider and CP case manager meet to identify the resources the child/adolescent will need to sustain recovery. This includes housing.

C. Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Page 70-71 of the application Guidance

Please consider the following items as a guide when preparing the description of the state's system:

How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

The most significant impact to the children's system is of care in Idaho is the settlement of the long standing Jeff D lawsuit in 2015. There have been several prior consent decrees, in 1983, 1990, and 1998 and several court orders aimed at resolving the lawsuit. The issue of separating children from adults in the state hospital has been resolved. There is a separate Adolescent Unit at State Hospital South that provides and ensures the separation of adults and children. The main focus since 1990 has been the provision of community-based mental health services. The 1998 consent decree required the State to conduct a needs assessment of children with serious emotional disturbances and implement the recommendations of that needs assessment. There were fifty recommendations as a result of the needs assessment. The Federal District Court ordered the parties to negotiate an implementation plan in 2000 on how to implement those recommendations. This led to a court approved implementation plan in 2001 with more than 250 action items. The District Court held compliance hearing in September 2006 to determine if the Defendants were in compliance with the consent decrees. The District Court found in February 2007 that the Defendants were in compliance with all but 21 of the action items. The District Court was willing to consider vacating the consent decrees if the Defendants were able to comply with the 21 action items. In June 2007 the Defendants presented the District Court with information concerning compliance with the 21 action items and filed a motion to vacate the consent decrees. The District Court vacated the consent decrees and dismissed the case on November 1, 2007.

Plaintiffs filed an appeal with the Ninth Circuit Court of Appeals. The Ninth Circuit reversed the order vacating the consent decrees and reinstated the case in May 2011. In June 2011, the District Court instructed the Parties to follow a meet-and-confer process to address concerns regarding Defendants' compliance with the consent decrees. 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. These confidential negotiations, which began in October 2013, were conducted using a mediator. This Agreement is the result of the negotiations.

The Agreement contains eleven sections and four appendices. The sections address various items such as the background of the case; goals to guide the development, implementation, and delivery of services; specific commitments the State will undertake; specific outcome measures regarding the State's commitments; and criteria to determine when the case can be dismissed as well as several other sections. The appendices address the way services will be delivered, principles of care, service descriptions, and a governance structure to assist in interagency coordination and implementation of the Agreement.

The Agreement is designed to establish a comprehensive and coordinated system of care for children with serious emotional disturbances and their families. It targets the delivery of individualized, coordinated, medically necessary services, preferably in the child's community, designed to meet their individual needs. The intent is to have standardized screening to identify children who may benefit from further mental health evaluation and connect them with services. A standardized assessment process will assist in identifying children's strengths and needs, thus tailoring services to build upon those strengths and develop services to address their needs. Effectiveness of services on the child's mental health and improvement in functioning will be measured in a systematic and standardized fashion. Care of children

with high needs will be coordinated through a family-driven team approach to service planning and delivery. This team approach will assist in reducing fragmented service delivery between agencies that may be serving the family such as schools, juvenile justice, mental health providers, and child welfare.

A stakeholder governance body, the Interagency Governance Team (IGT) will assist in identifying system barriers, assist in resolving those barriers, and provide oversight and accountability for the implementation of the Agreement. Members of the IGT include parents, youth, advocates, Departments of Health and Welfare and Juvenile Corrections, State Department of Education, and a private mental health provider.

An implementation plan will be developed within nine months of the Court's approval of the Agreement. The implementation plan will provide more details and specific activities that will be carried out by the Defendants to meet their obligations under the Agreement. The implementation plan will also specify time frames for the activities and measures to determine completion or compliance with those activities. The implementation plan will be developed collaboratively with the parties and include relevant stakeholders. It will also be submitted to the Court for approval.

The Agreement outlines an overall time frame of about eight years. The first nine months after Court approval of the Agreement is devoted to the development of the implementation plan. That is followed by four years to complete the implementation plan. Once the implementation plan is completed, there is a three year period of sustained performance. The Agreement outlines specific measures to determine if the Defendants are in compliance with the implementation plan and sustained performance period. The case will be dismissed after the sustained performance period once the Defendants have shown substantial compliance during that time. The Court is expected to issue a permanent injunction to continue the services and supports developed through the implementation plan upon dismissal of the case.

The state of Idaho remains committed to the establishing and monitoring a system of care approach to support the recovery and resilience of children and youth with mental health and substance use disorder diagnoses in several ways. The Division of Behavioral Health's Policy Unit is tasked with developing policy and clinical practice standards. The Division's Quality Assurance (QA) Unit provides quality assurance oversight on provider implementation of clinical practice standards. The QA unit is in the process of developing a comprehensive Idaho quality improvement plan that will include a description of the children's system and the consumer perspective. The contracted Idaho Behavioral Health Plan provider, Optum Idaho will become a key partner in the planning process, and with respect to collecting and evaluating system data to help guide system activities. The Federation of Families contracts with the Division to provide supportive services for children and families. The Federation is expected to provide input into the establishment of a system of care in Idaho. The Substance Use Disorder Treatment (SUD) Management Services contractor will oversee the delivery of treatment and recovery support services to youth addicted to alcohol or other drugs. The intake process, using the GAIN assessment, will provide the care manager with the information needed to make a diagnosis as well as identify other service needs. The SUD Treatment provider assigned to treat the youth will be responsible for delivery of treatment services. The SUD Treatment provider may also provide case management or the service may be provided by a different organization. In any case, the case manager is responsible to ensure youth receive all services they and their family need to support and sustain a full recovery.

What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental and substance use disorders?

The state has established "Principles of Care" under the Jeff D class action lawsuit Settlement Agreement. These Principles include individualized care planning. A workforce development plan will be developed

that includes a Practice Manual which includes the Principles of Care and training of providers to the Practice Manual.

The Division of Behavioral Health has policies that describe guidelines for individualized care planning for Regional Behavioral Health Centers (RBHC). The Division's Quality Assurance team provides RBHC reviews of regional cases to determine the impact of policy on individualized care planning in each region. Optum Idaho, the Medicaid contractor for the Idaho Behavioral Health Plan is responsible to ensure individualized care planning from Medicaid service providers of care to Medicaid funded children. All youth receiving services in state-approved substance use disorder treatment programs must have an individualized treatment plan that addresses the substance use, co-occurring mental health disorders, physical health as well as other problems affecting the youth's major life areas. The development of a treatment plan must be a collaborative process involving the youth, family members, and other support and service systems. All youth receiving Behavioral Health-funded substance use disorders treatment are assessed using the GAIN, which assesses all life areas, not only substance use thus ensuring the youth and their clinician have the information they need to develop a comprehensive care plan.

How has the state established collaboration with other child and youth serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)

The settlement aims to address the gaps in Idaho's mental health system, making it more effective and efficient in meeting the needs of children with serious emotional disturbances and their families. The settlement commits the state to taking a number of concrete steps to develop and implement a sustainable, coordinated, and comprehensive mental health system, including:

- Creating a statewide process, across all child-serving systems, to identify and screen youths for unmet mental health needs
- Providing a comprehensive array of community-based services and supports to children when medically necessary
- Delivering services using a consistent approach that engages families, youths, and their support systems
- Monitoring and reporting on service quality and outcomes for youths

The settlement is the result of more than a year of negotiations. Participants include key community stakeholders representing parents, advocates and private providers, along with representatives from DHW including Medicaid, and Family and Community Services, the Idaho Department of Juvenile Corrections (IDJC), and the Idaho State Department of Education (SDE).

The IGT provides the state level vehicle for collaborative efforts. At the individual child level, staff will use a child and family team approach as described in the Practice Manual to coordinate services which would include other child serving agencies. Additionally, children with intensive needs will be provided with a facilitated wrap around approach to treatment planning which will include collaboration with child serving agencies.

Idaho has established collaboration with other child and youth serving agencies to address behavioral health needs in several ways. The governor appointed Behavioral Health Integration Committee is developing a memorandum of understanding for collaboration between key child and youth serving agencies. The Juvenile Justice Children's Mental Health (JJCMH) workgroup includes representation from regional mental health programs, the Idaho Division of Juvenile Corrections, county probation and the Federation of Families. The JJCMH meets regularly to address system issues and to identify shared policy goals between agencies.

The Division of Behavioral Health-funded Substance Use Disorders Treatment providers are required to conduct a GAIN assessment on all youth referred for treatment services. This assessment evaluates a broad range of areas related to the youths' life areas. As a part of this process SUD Treatment providers must either directly provide case management services or partner with a care management agency to ensure all service needs identified in the assessment are addressed. Some services, such as transportation, life skills and family therapy are covered by the Division of Behavioral Health. Other services such as mentoring, parenting education, tutoring, behavioral management, and health care are provided by other agencies within the community. To meet clients' needs, the SUD Treatment providers have developed relationships with a broad range of community organizations including health care providers, public health districts, school districts, faith-based and recovery support groups, law enforcement agencies, battered women and crisis shelters, child protection agencies and youth organizations.

How will the state provide training in evidence based mental health and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

The contract provider of the Medicaid behavioral health plan, Optum, is required to provide evidence-based treatment which requires their providers to be trained in evidence based practices. Children's mental health program staff provide Parenting with Love and Limits (PLL), an evidence-based program. This requires training which is conducted by a PLL certified trainer. Wrap Around training is provided by department staff using a copyrighted Wrap Around training curriculum. The contractor for Functional Family Therapy is required to be certified in the program which requires staff providing the service to be trained.

The Division is responsible for only a segment of the Behavioral Health System, and therefore plans to collaborate with other partners to identify methods to provide training in evidence based mental health and recovery services. The substance abuse prevention services have been collaborative with a broad range of community providers, sharing CSAP and other organization developed evidence or research-based webinars, providing written materials and videos through the Idaho RADAR Center and participating in cross-training activities with Juvenile Corrections and Education. The SSA will continue to support two prevention tracks in the annual Idaho Conference on Alcohol and Drug Dependency. One track focuses on prevention professional development and has had speakers on adolescent development, identifying drug-endangered children, providing youth with emotional support, and risk and protective factors. The second track focuses on coalition development and includes current research on youth engagement, preventing underage drinking and community planning for healthy youth. In addition, the annual conference provides cutting edge research on topics of multi-disciplinary interest include ethics, culturally appropriate care, adolescent brain development, child trauma and healthy child development. A variety of training tools are used to disseminate current research and information on evidence-based programming for SUD Treatment and Recovery support services. Idaho's current training initiatives for SUD treatment professionals focus on GAIN Site Interviewer Training, recovery support service skill development, adolescent treatment via telehealth and trauma focused cognitive behavioral therapy for adolescents.

How will the state monitor and track service utilization, costs and outcomes for children and youth with mental health, substance use and co-occurring disorders?

The SMHA uses the Web Infrastructure for Treatment Services (WITS)which can track utilization, document costs, and outcomes. Utilization is recorded through encounter notes and vouchers. Costs are captured through processing of invoices from the vouchers. Outcomes are measured through the changes in CAFAS/PECFAS scores as well as changes in CALOCUS scores which are recorded in the electronic system. Optum, Idaho is responsible to ensure monitoring, tracking and data collection for children and youth receiving Medicaid reimbursable services. The WITS electronic health record system used by the

Division will provide data that will help with monitoring and tracking service utilization, costs and outcomes. The SUD Treatment system use of WITS across multiple governmental agencies (e.g., IDHW, IDOC, IDJC, ISC) will also be beneficial in this effort. With respect to assessment tools, children's state funded services are monitored in some areas with the CAFAS, and the ASAM can be used to measure level of care needs for youth with SUD diagnoses.

Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so what is that position (with contact information) and has it been communicated to the state's lead agency of education?

The IGT referenced in #1 provides the state level vehicle for collaborative efforts. The IGT includes the SMHA Commissioner and a state level educational representative. Individual clinicians working with a child and family coordinate with the schools at the individual child level.

What age is considered the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care?

Youth transition to adult services at age 18. Independent living and transition planning begins any time between age 14 and 16. Youth served in the state's behavioral health system begin actual transition to the adult system 6 months before their 18th birthday. These transition activities include planning/staffing for the provision of adult services, connecting to community resources, and introducing adult service providers to the youth

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

20. Pregnant Women and Women with Dependent Children

Idaho Response

The Idaho Department of Health & Welfare's Division of Behavioral Health is responsible for compliance with admission requirements for pregnant women. The Division contracts with an intermediary to manage the delivery of substance use disorder services in Idaho. All Substance Abuse Prevention and Treatment block grant requirements specific to the delivery of substance use disorders treatment services are included in Attachment 11. This includes the requirement to make treatment services available to pregnant women within 48 hours of request for treatment.

All individuals seeking substance use disorders treatment services in Idaho must call the state intermediary for screening and admission to treatment. The intermediary providers a 1-800 number to facilitate access to these services. The call includes an initial clinical screening and a financial qualification. All pregnant women who meet both clinical and financial need are immediately admitted to treatment and referred to a network provider. They are encouraged to a specialized pregnant women and women with dependent children provider, but may select any network provider. If the woman is in crisis or indicates a discomfort or reluctance to call the treatment provider, the screening staff call the provider wit the woman on the line to facilitate follow-through.

All Idaho substance use disorders clients are admitted to treatment upon conclusion of the initial screening and financial qualification. The intermediary manages a large network of treatment providers, which enables to place clients needing immediate services in a treatment program within 48 hours. Compliance with this requirement is evaluated during weekly meetings with the provider as well as contract monitoring visits.

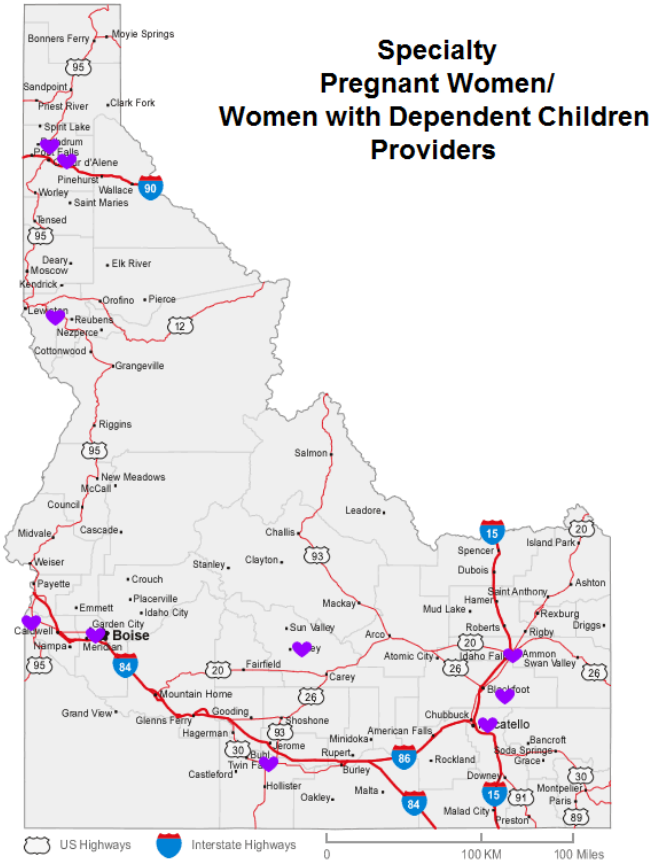
In Idaho, all clients are admitted into treatment at the conclusion of the initial assessment and financial qualification. Those not meeting clinical or financial criteria are referred to other resources. The immediate admission to treatment is supported by a statewide network of providers which is able to initiate treatment services immediately upon receipt of the client's authorization for care. Should demand ever exceed the current provider network's capacity, the Division will implement a triage system, ensuring pregnant women and IVDU-using individuals are given first priority to access services. The Division also has an established process for implementation of interim services which includes provision of educational materials and weekly contact until each pregnant woman begins receiving treatment services.

Compliance monitoring for pregnant women access to treatment and comprehensive services for pregnant women and women with dependent children is conducted by the Division of Behavioral Health's Operations Program Manager and by clinical staff within the Operations unit. Compliance is evaluated informally during weekly meetings with the intermediary contractor. At these meetings they review the current status of pregnant women admissions and initiation of treatment services. These meetings facilitate real-time evaluation of the pregnant women's access to care. Formal evaluation of compliance is conducted quarterly during contract monitoring site visits. During this time records of all client's admission to treatment are

reviewed to determine need to shift funds in order to ensure compliance with pregnant women admission requirements.

Direct-service providers who deliver treatment and recovery services to pregnant women and women with dependent children are monitored on an ongoing basis by the intermediary. The evaluation includes access to treatment and compliance with service delivery requirements. Findings of these site visits are submitted to the Division for review and, if necessary, corrective action. The Division also conducts provider audits to evaluate the accuracy of the intermediary's provider monitoring and compliance with all federal requirements. The Division has not required a corrective action plan in the past ten years.

All providers within the intermediary's network serve pregnant women. Currently there are ten providers who deliver specialized pregnant women and women with dependent children services. All specialty providers deliver outpatient or intensive outpatient treatment and recovery support services. Women who need a higher level of care are referred to a higher level of care and upon completion of that level are given the opportunity to transfer to a specialty provider. Below is a map depicting the specialty provider network.



At this time, the Division is researching the use of medication assisted treatment (MAT), and established minimum standards fore the implementation of this service. The Division has not allocated state-funding for this service. The cost of maintenance medications are a challenge for a small state. The substance use disorders treatment budget is fully expended on current priority

populations and approved services. Without a significant increase in funding, the state will have to decide which of the current populations and services will be discontinued in order to support MAT.

Twenty-two of Idaho's forty-four counties are designated as frontier and an additional fourteen are identified as rural. Because Idaho is a large, mountainous, sparsely populated state, it is a challenge to make services available statewide. Maintaining gender-specific services requires a minimum treatment population to support treatment and education groups. Currently, most of Idaho's specialty providers are located in larger communities. Idaho is evaluating the use of telehealth to address these challenges. Un- or under-served areas include counties with low populations and mountainous topography with too few clients to sustain a specialized program.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

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

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

IDAHO SUICIDE PREVENTION PLAN:

AN ACTION GUIDE

2011

"Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it's the only thing that ever has."

—Margaret Mead

Support staff that helped with creation of this plan:

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Susan Soule – Workgroup Facilitator
Kathy Tidwell – Researcher/Writer

Cover Photo © Henry E. Stamm IV

Suggested Reference

Suicide Prevention (2011). Idaho Suicide Prevention Plan: An Action Guide. Boise, ID.

Electronic Copies

Electronic copies of the State Suicide Prevention Plan are available at several websites:
SPAN Idaho: www.spanidaho.org/ispplan.pdf
Department of Health and Welfare: http://healthandwelfare.idaho.gov (click on 's' and look for 'suicide prevention')
Idaho State University Institute of Rural Health: www.isu.edu/irh/publications

Dear Idahoans,

The Idaho Council on Suicide Prevention would like to thank you for the opportunity to address the critical issue of death by suicide in Idaho. Suicide is a major public health issue and has a devastating effect on Idaho's families, schools, faith-based organizations, businesses and communities.

This Idaho Suicide Prevention Plan is intended to empower communities in providing suicide prevention, intervention and response to suicide attempts and completions. Ultimately, our goal is to reduce the number of deaths by suicide throughout our state. Idaho consistently has a higher suicide rate than the United States as a whole. A total of 1,286 people died by suicide in Idaho in just five years from 2006 through 2010 (Bureau of Vital Records and Health Statistics, 2010, 2011).

The first Idaho Suicide Prevention Plan was presented in 2003. Since that time much positive work has been accomplished. In 2006, a Governor's Executive Order created the Idaho Council on Suicide Prevention to provide a coordinating body to lead suicide prevention efforts in Idaho. Strong collaborations have been established with the State Planning Council on Mental Health, the Division of Behavioral Health, the Division of Public Health, the Department of Education, Suicide Prevention Action Network of Idaho (SPAN Idaho), Idaho State University's Institute of Rural Health and other partners. However, there is much work yet to be done.

Today our state faces new challenges and new opportunities. The Governor's Executive Order has given the Idaho Council on Suicide Prevention the responsibility to ensure the continued relevance of the Idaho Suicide Prevention Plan. In order to meet that responsibility the Idaho Council on Suicide Prevention recognized it was time for a comprehensive review and revision of the Idaho Suicide Prevention Plan to meet today's realities. In 2010, the Idaho Council on Suicide Prevention began the development of this new Idaho Suicide Prevention Plan.

This Idaho Suicide Prevention Plan was created by gathering input from stakeholders from all across Idaho. The Idaho Council on Suicide Prevention has made a special effort to include the voices of all segments of the state: governmental leaders, individual citizens, faith-based groups, business community, military, Hispanics, Native Americans, community action organizations, health care providers, advocates for lesbian, gay, bisexual and transgendered (LGBT) persons, education professionals, survivors and others. Suicide prevention has a role for everyone. It is the hope of the Idaho Council on Suicide Prevention that you will be able to recognize a role for yourself and your community within the pages of this document.

It is with deep appreciation the Idaho Council on Suicide Prevention now recognizes the many collaborators and stakeholders who have contributed to creating this revised Idaho Suicide Prevention Plan. We look to the future because of the tremendous strength of our collective will to stop unnecessary death by suicide.

Sincerely,

Kathie Garrett

Chair – Idaho Council on Suicide Prevention

"There is a role for everyone in this action plan. You can make a difference."

Acknowledgement of Partners

This document would not have been possible without the dedicated efforts of many people throughout the state. Individuals have given of their time to attend meetings, work on committees, review data and to thoughtfully discuss the issue of suicide in Idaho. Idaho State University's Institute of Rural Health facilitated and funded the process through a grant from the U.S. Substance Abuse and Mental Health Services Administration.

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Idaho Suicide Prevention Plan Review Work Group

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Pam Catt-Oliason – Idaho Commission on Aging
Ginger Floerchinger – Franks – Idaho Trauma Registry
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Rick Huber – Consumer Advocate
Deedra Hunt – Idaho Commission on Aging
Crystal Ikebe – Jason Foundation
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Kurt Lyles – Idaho Department of Health and Welfare
Chris Lymberopoulos - Parent / Advocate
Kirby Orme – Physician / Survivor
Kate Pape – Ada County Sheriff's Department
Catherine Perusse – Suicide Prevention Action Network of Idaho (SPAN Idaho)
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Elke Shaw-Tulloch, Idaho Department of Health and Welfare

This Idaho Suicide Prevention Plan is presented to the state by the Idaho Council on Suicide Prevention.

Members of the Council are:

Legislators:
- Hon. Rep. Sharon Block & Hon. Sen. John Goedde

Idaho Department of Health and Welfare:
- Elke Shaw-Tulloch & Kurt Lyles

Department of Education:
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Adult Corrections:
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Suicide Prevention Action Network of Idaho (SPAN Idaho):
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National Alliance on Mental Illness (NAMI):
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Idaho State University - Institute of Rural Health:
- Ann Kirkwood

Boise State University:
- Peter Wollheim

Mental Health Professional:
- John Landers

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- Mary Pierce

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IDAHO SUICIDE PREVENTION GOALS

Goal 1: Public Awareness
Idahoans understand that suicide is preventable and accept responsibility for their role in suicide prevention.

Goal 2: Anti-Stigma
Idahoans understand and accept that seeking help for mental health issues is to be encouraged and supported.

Goal 3: Gatekeeper Education
The education of professionals and others working with people at risk for suicide includes effective suicide prevention curricula and ongoing gatekeeper and other suicide prevention training.

Goal 4: Behavioral Health Professional Readiness
Mental health and substance abuse treatment professionals are trained to use current, appropriate, and recommended practices for assessing and treating individuals who show signs of suicide risk.

Goal 5: Community Involvement
Community leaders and stakeholders develop and implement suicide prevention activities that are current, recommended and culturally appropriate that are specific to their regions and communities.

Goal 6: Access to Care
Crisis intervention and behavioral health services, including mental health and substance abuse treatment, are widely available, culturally appropriate, accessible, and valued by communities.

Goal 7: Survivor Support
Information and services are in place in all regions of Idaho to support survivors and others affected by suicide in a sensitive and culturally appropriate manner.

Goal 8: Suicide Prevention Hotline
An Idaho statewide suicide prevention hotline is established and funded.

Goal 9: Leadership
The Idaho Council on Suicide Prevention oversees suicide prevention activities at all levels, as guided by the Idaho Suicide Prevention Plan, and works in collaboration with a lead Idaho state government agency that is responsible for Idaho's suicide prevention and intervention efforts.

Goal 10: Data
Data are available on which to make decisions regarding suicide prevention services.

INTRODUCTION

Suicide is a preventable tragedy. It takes lives, harms families and exacts a human and financial toll on our communities. Over five years from 2006 through 2010, more than 1,200 Idahoans died by suicide (1,286 deaths). Idaho consistently is listed in the top 10 states in the country for its rate of suicide, with rates ranging from a low of 12.8 per 100,000 people in 2000 to 19.9 in 2009 (Bureau of Vital Records and Health Statistics, 2011). Approximately 30,000-35,000 people die by suicide in the United States each year for a national rate of about 12 per 100,000 people.

Two hundred ninety Idahoans completed suicide in 2010. This followed 307 in 2009, the most in any given year on record (SPAN Idaho, 2010). The high number of suicide deaths is just part of the problem. Many people attempt suicide who do not die. While it is difficult to gather accurate information about the number of people who attempt suicide, or the number of people who are so troubled they often consider taking their own lives (called "suicidal ideation"), it has been estimated that for every completed suicide there are as many as 25 more people who attempt suicide but do not die (American Association of Suicidology, 2008). By this estimate, it is likely that as many as 7,250 people in Idaho attempted suicide in 2010, and approximately 825,000 attempt suicide in the United States each year.

"Suicide rate" is the number of suicide deaths per a population of 100,000 people in a specific time and place. By converting the numbers to a rate, comparisons of the frequencies of suicide in different places with different population sizes are possible.

Estimates of the number of people affected by a suicide death vary. This group called "suicide survivors" is made up of families, friends and others seriously affected by the suicide death of someone they care about.

"A suicide attempt is a non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior. A suicide attempt may or may not result in injury." (CDC)

Some estimates project that 5-6 people are affected by each suicide death. Others place the figure far higher at 14 (Jordan and McIntosh, 2011). This would mean as many as 18,004 people in Idaho became "suicide survivors" from 2006 through 2009. About 420,000-490,000 people in the United States each year become suicide survivors. Family members and friends also can be very concerned and worried about those who survive but are feeling so hopeless that they also attempt to take their own lives. While many factors influence whether or not a person will become suicidal, the loss of a family member or friend to death by suicide puts survivors at especially high risk for suicide themselves.

It is our hope that the Idaho Suicide Prevention Plan will empower communities to take action to make a difference. Together we can change the statistics and help all Idahoans embrace the most precious of all gifts - life. The Idaho Suicide Prevention Plan is an action guide to help individuals, organizations and communities plan suicide prevention activities that fit their specific needs. We believe there is a role for everyone in suicide prevention. The type of activities in which you choose to get involved will depend on many factors such as where you live (whether in a small rural community or a city), groups to which you belong (professional, cultural, or social) and your own personal values. Communities are more than geographic areas. They can be groups of like-minded people who agree to work together on an issue – in this case, suicide prevention.

History of Idaho Suicide Prevention Plan. Idaho's first Suicide Prevention Plan was written in 2003. The plan addressed awareness, infrastructure, and methodology for implementation. The full text of the original plan can be found at: http://healthandwelfare.idaho.gov/Portals/0/Children/DocumentsSrtView.pdf

Many of the first plan's objectives have been achieved. In 2006, the Idaho Council on Suicide Prevention was created by Executive Order of Governor Dirk Kempthorne. That Executive Order was renewed by both Governor Jim Risch and Governor C. L. "Butch" Otter. The Idaho Council on Suicide Prevention is made up of community leaders from all across Idaho who have a special interest in suicide prevention. There are representatives from government, education, health care, consumer advocacy groups, veteran's affairs, the state mental health authority, survivors, universities and others. One of the responsibilities given to the Idaho Council on Suicide Prevention is to oversee the suicide prevention activities being carried out throughout Idaho and to ensure the continued relevance of the Idaho Suicide Prevention Plan. In 2010, the Idaho Council on Suicide Prevention determined that it was time to review and update the Idaho Suicide Prevention Plan in light of successful completion of many of the original plan's initiatives and the new challenges which have emerged since 2003.

The 2011 Idaho Suicide Prevention Plan was created from input gathered from diverse stakeholders from all regions of the state under the direction of the Executive Committee of the Idaho Council on Suicide Prevention. In particular, the Suicide Prevention Plan Development Group, a gathering of more than 20 stakeholders from across the state, met in two working sessions in July and August 2010. At these meetings, facilitated and funded by the Idaho State University Institute of Rural Health, representatives discussed issues that affect our state and how we can work together to make a difference for suicide prevention. From those discussions, a set of Values and Guiding Principles were established which were approved and adopted by the Idaho Council on Suicide Prevention in October 2010.

Values & Guiding Principles

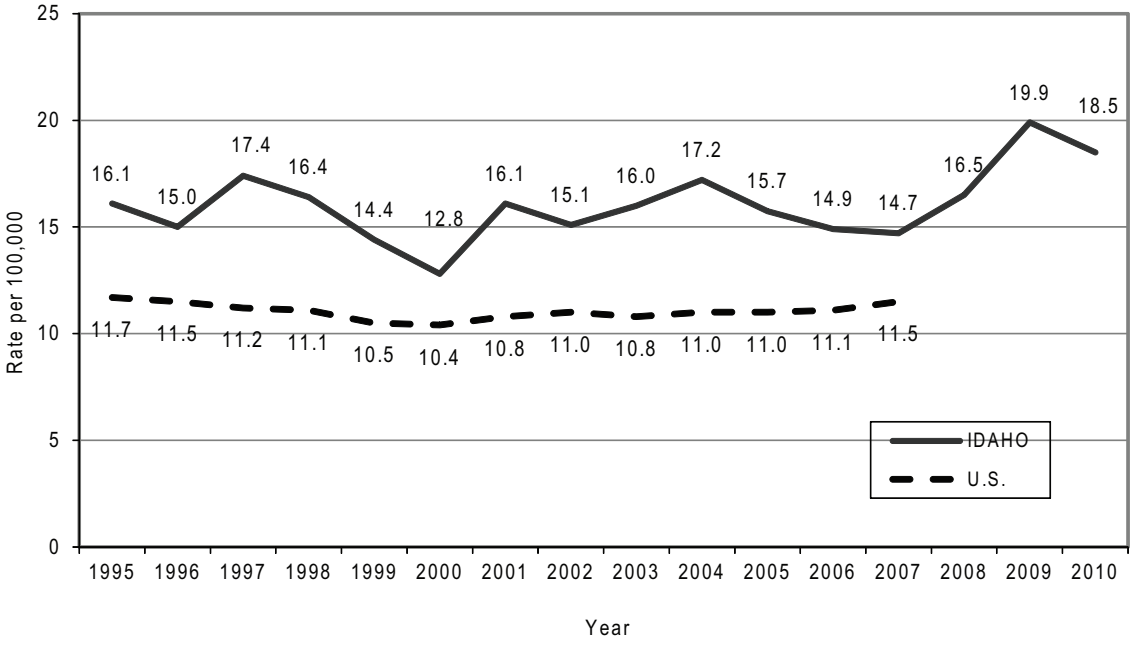
- **Suicide is a serious preventable public health problem that negatively affects communities and individual community members.**
- **Suicide arises from the interaction of individual, family, social and community factors. Suicide touches people of all ages and from all walks of life.**
- **Individuals who seek help for mental health concerns, including suicide, are to be accepted and supported, not stigmatized.**
- **Suicide prevention is the responsibility of the entire community and requires vision, will, and a commitment from the state, communities and individuals of Idaho.**
- **It is important for people to feel empowered to intervene with persons at risk for suicide.**
- **Adequate and accessible services for mental health diagnosis and treatment are essential for children and adults.**
- **Suicide prevention should be a part of an adequately funded and supported public and behavioral health system that addresses education, awareness, treatment and community engagement. It should include programs for communities and families with special attention paid to protect those known to be at high risk.**
- **Suicide prevention programs and program materials need to be culturally informed and respectful of the groups for which they are designed.**
- **Suicide prevention efforts should draw on appropriate best practice and evidence-based guidelines.**

ABOUT SUICIDE

Suicide is a major public health issue that affects tens of thousands of Americans every year. Although suicide is a problem for the whole country and throughout the world, it is important to know that suicide rates in Idaho are much higher than the United States as a whole. While there has been a slight drop in the Idaho suicide rate in 2010, we still have much work to do.

Figure 1 below shows Idaho suicide death rates as compared to the national rates over 16 years from 1995-2010.

Figure 1: Idaho and U.S. Resident Suicide Death Rates 1995 - 2010

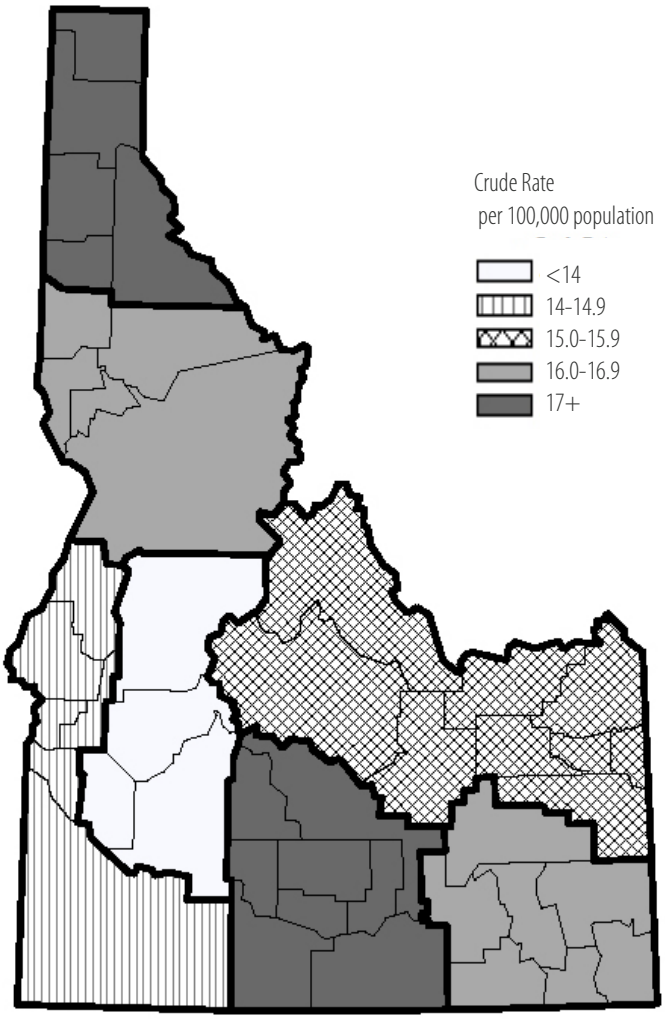


Rate: number of deaths per 100,000 population.
U.S. source: Centers for Disease Control and Prevention, CDC Wonder Mortality Query System.
Idaho source: Bureau of Vital Records and Health Statistics; Idaho Department of Health and Welfare (9/2011).

Idaho is among several states in the Intermountain West with rates much higher than the rest of the country. While the ranking of state suicide rates varies from year to year, Idaho typically ranks in the top 10. Just as suicide is not evenly distributed throughout the United States, it is not evenly distributed in Idaho. Some areas of our state have higher suicide rates than others. While the specific numbers for each region will vary from year to year, by looking at five year averages of rates we can get a better idea about patterns. The following chart shows how suicide rates vary in different parts of Idaho. It shows the highest rates are in the regions around Twin Falls and Coeur d'Alene, but all regions of Idaho are higher than the national rate of 12 suicides per 100,000 people.

People who kill themselves or attempt suicide have unique circumstances but there also are some overriding patterns we can study to help us target our suicide prevention efforts. Some of these patterns are:

Figure 2: Idaho Resident Suicide Death Rate by Region of Residence 2005-2009

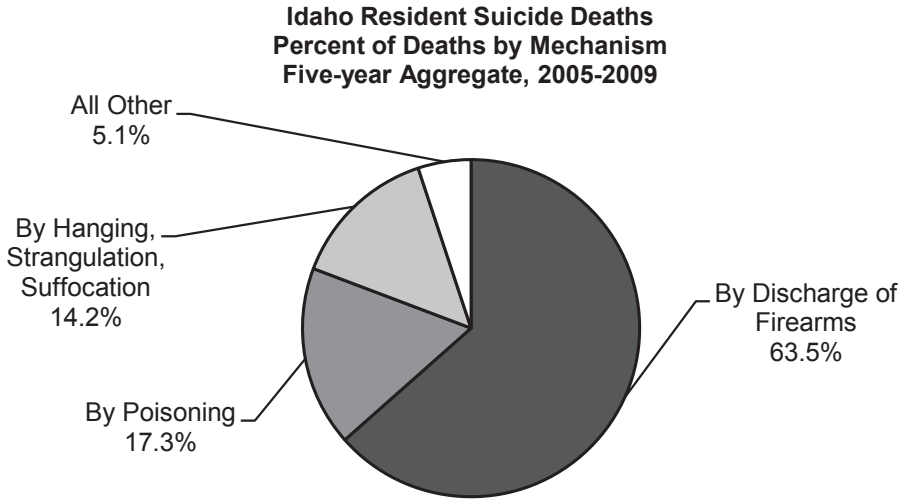


Source: Idaho Department of Health and Welfare Bureau of Vital Records and Health Statistics (4/2011)

- Men are much more likely to die by suicide than women. However, women attempt suicide about three times more often than men.
- The higher rate of attempted suicide in women is attributed to higher rates of mood disorders among females, such as major depression (American Foundation for Suicide Prevention, 2011).
- Men are more likely to use more immediate lethal means when they are suicidal, such as firearms. Most people who shoot themselves will die. Women often attempt suicide in other ways such as poisoning or drug overdose. While these suicide attempts are very serious and indicate a need for intervention, it is more likely that a person may be discovered and saved if they attempt through less lethal means.
- In Idaho, firearms are the primary means used for suicide deaths. Figure 3 illustrates that guns are used in 63.5 percent of all suicide deaths in Idaho while poisoning (which includes drug overdose) is the method used in 17.3 percent.
- These data emphasize the need for appropriate gun safety education and the availability of effective gun locks. If an individual is known to be at high risk for suicide it is recommended that all guns be removed from the home and stored in a safe place.

Figure 3 illustrates the methods used in completed suicide in Idaho from 1999 through 2003.

Figure 3: Suicide Methods in Idaho (1999-2003)



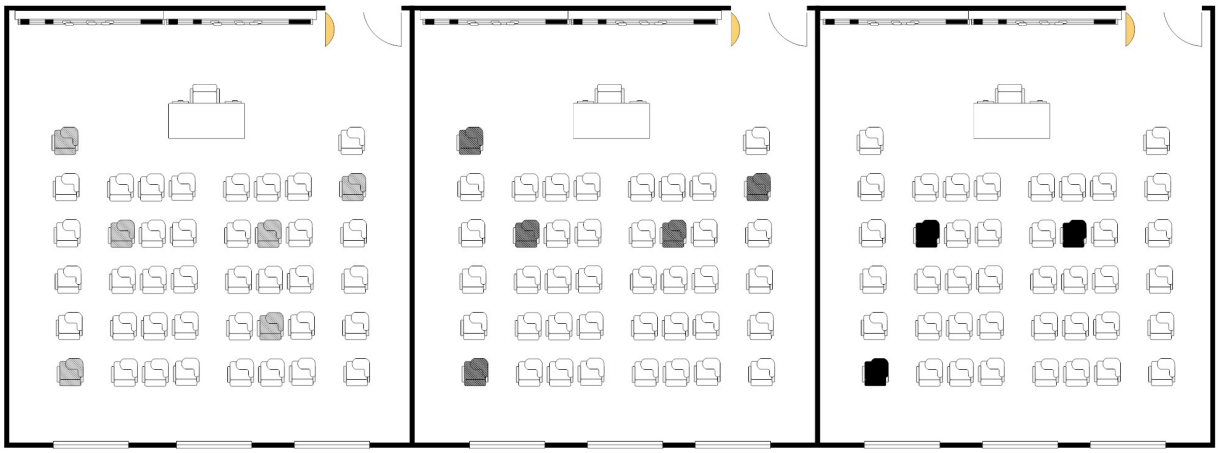
Source: Bureau of Vital Records and Health Statistics; Idaho Department of Health and Welfare (4/2011)

- Age is a factor in suicide risk. The age groups with the highest rates of suicide are those aged 65 and older, with those over 85 being at highest risk. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates (when categorized by gender and race) were white men age 85 and older.

- Of additional concern is the fact that "suicide rates for adolescents have doubled since 1970 and tripled since 1960, even as rates for other age groups have declined" (Mathur & Freeman, 2002).

Figure 4 shows the results of the Youth Risk Behavior Survey (YRBS), a survey that is given to students at public high schools in Idaho. It shows that in 2009 one in seven students who responded to this survey seriously considered suicide in the past year, one in eight students made a specific plan for suicide, and one in fourteen students actually made a suicide attempt.

Figure 4: Idaho High School Students Self-Reported Rates of Suicidal Ideation, Plan for Suicide and Attempted Suicide



One in 7 Idaho high school students has seriously considered suicide.

One in 8 Idaho high school students has a plan to complete suicide.

One in 14 Idaho high school students has attempted suicide.

Source: Idaho Youth Risk Behavior Survey (YRBS) 2009

Not everyone who attempts or completes suicide has a mental illness, and not all people with mental illnesses become suicidal. However, mental illnesses - especially depression – are a major risk factor for suicide. "While 95 percent of individuals with a mental illness and/or substance use disorder will never complete suicide, several decades of evidence consistently suggests that as many as 90 percent of individuals who do complete suicide experience a mental or substance use disorder, or both" (Center for Substance Abuse Treatment, 2008).

Research has shown that many people who die by suicide were drinking alcohol in the hours before they died (Kelly, 2009). Alcohol makes sad people feel worse. Alcohol clouds the ability to make good decisions and prompts impulsive acts. A person who is drinking and talking about suicide is at great risk for suicide.

Youths who bully and youths who are victims of bullying (including cyber-bullying) have also been identified as being at high risk for suicide (SPRC, 2011).

Warning Signs for Suicide

- **Threatening to, or talking about wanting to hurt or kill oneself**
- **Seeking access to methods of killing oneself**
- **Talking or writing about death, dying or suicide**
- **Abrupt personality changes**
- **Dramatic mood changes**
- **Feeling hopeless**
- **Feeling trapped**
- **Acting reckless or engaging in risky activities seemingly without thinking**
- **Hostile behavior**
- **Withdrawing from friends, family, and/or society**
- **Increasing alcohol or drug use**
- **Giving away possessions**
- **Previous suicide attempt**
- **Significant weight change**
- **Sleeping all the time or inability to sleep especially when accompanied by agitation**

Source: Idaho Suicide Prevention Action Network of Idaho (n.d.)

The Suicidal Process. Suicides often start as occasional thoughts about death and proceed to suicidal ideation. Suicide ideation is when severe, intrusive thoughts cause a person to dwell on the idea of suicide over a prolonged period of time.

Most people who think about suicide or develop a plan to kill themselves don't really want to die. They want the pain they are feeling to stop and are unable to see any other alternative.

The suicidal process happens over time beginning with the first thoughts about suicide. If the process does not stop, it may end in a completed suicide. The fact that the process takes time for most people means there is time to intervene successfully. There is time to reach out. There is time to get help.

Many different things may cause people to feel like killing themselves. Experts say the cause of suicide is "multidimensional," meaning that no single factor prompts a person to attempt suicide. Factors are present in clusters. For example, a person may not have the skills to solve problems. A mental illness may further complicate problem solving. Some other factors such as the sudden end of an important relationship or the loss of a job may contribute to the development of suicidal feelings. Factors such as these combine to create a great deal of emotional pain. Most of the time people manage to keep going until things improve. However, for some people, there are times when the pain seems too great. They feel they are unable to fix their lives or to feel better. They feel hopeless. They don't know where to turn to get help. They feel alone. They don't see any value to their lives. They feel useless or that they are a burden to others. Helpless, hopeless, alone, useless - these are the feelings behind thoughts of suicide. People with depression or other mood disorders have added vulnerability for suicide.

The Role of Economic Factors. A 2010 study on the impact of economic factors on U.S. suicide rates was conducted by the U.S. Centers for Disease Control and Prevention (CDC) and published online in the American Journal of Public Health. This research found that particularly among those in prime working ages (25-64), suicide rates were likely to increase during a recession. "Economic problems can impact how people feel about themselves and their futures as well as their relationships with family and friends. Economic downturns can also disrupt entire communities," said Feijun Luo, Ph.D., an economist in CDC's Division of Violence Prevention and the study's lead author

(CDC, 2011). In 2011, the Idaho Department of Labor reported that our state has lost over 58,000 jobs in recent years and that the current recession has cut more deeply into Idaho than any other since World War II. Additionally, Idaho ranks in the top ten states for home foreclosures. "The number of distressed properties, or properties in short sale, in foreclosure, or bank-owned reached 45 percent in December of 2010" (Idaho Business Review, 2011). One report says there has been a foreclosure filing for one in every 34 homes in the state as of summer 2011 (Estrella, 2011).

There are a number of ideas about why suicide rates are so high in Idaho and throughout the Intermountain West. Important factors may include remoteness, distance to care, a shortage of mental health care providers, economic stressors and access to lethal means, such as firearms. However, another key factor to consider is stigma.

The Stigma Connection. The word "stigma" literally means "a mark of shame or disgrace". A group of stigmatized people are seen as "less than" the rest of the population and may be subject to prejudice and discrimination. Stigma can erode an individual's sense of belonging and lead to hopelessness and isolation. Stigma contributes to suicide by making people with mental health concerns less willing to seek treatment. It also makes healing more difficult for family members and other survivors who feel judged if someone they cared about died by suicide.

An example of stigma related to suicide was seen in a study comparing the extent to which families lie about the cause of death for members who die in accidents or families of suicide victims. The study showed that family members of accident victims reported not lying about their relative's cause of death. However, 44 percent of the families of suicide victims reported lying at some time about their family member's cause of death (Joiner, 2005, pg. 6-7).

"Suicidal ideation" is a person's thought of harming or killing him/herself. The severity of suicidal ideation can be determined by assessing the frequency, intensity, and duration of these thoughts" (CDC, n.d.).

The report of the U.S. Surgeon General states that stigma regarding mental illness has been a barrier to treatment for decades (1999). Stigma appears to be worse in rural areas than in larger cities (Rost et al, 2011). In rural areas it is common to have a high degree of stigma and resistance to seeking help. As mentioned above, mental illness is a major factor for suicide. Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment. Stigma surrounding the receipt of mental health care is among the many barriers that discourage people from seeking treatment (U.S. Public Health Service, n.d.).

Knowing More Through Research. Although more research is needed to improve our response to suicide, we do know that communities that are informed in suicide prevention awareness can reduce the number of deaths. Information about suicidal thoughts, feelings, and attempts as well as knowledge of warning signs, and understanding risk and protective factors can have a positive impact.

One compelling, research-based theory by Dr. Thomas Joiner suggests that people who feel a sense of burdensomeness and a failed sense of belongingness, and who learn to overcome physical pain, are more likely to complete suicide (Joiner, 2005, pg. 97-112). Though there are still things we do not fully understand about suicide, focusing efforts on belongingness and helping people feel effective and useful can save lives. Families, organizations, and communities can engage in activities that help people to feel included and needed and that address risky behaviors.

There are a variety of data sources to help individuals and organizations better understand the problem of suicide in Idaho and to plan suicide prevention activities. A list of these is provided in the section titled How to Find Additional Data Sources On Suicide page 34. It is also important to identify the data we would like to know that is not currently available. Only by knowing what information we know and what is needed can an individual or group determine the next steps to take.

The key factor to recognize in gathering data or in designing new suicide prevention activities is that you are not alone. There are a number of individuals, organizations and resources available to help you get started. By working in collaboration with others, people in Idaho can strengthen one another's efforts and help each other find solutions to barriers.

HOW TO USE THIS PLAN

The best ways to address the serious problem of suicide in your community will depend on a number of different factors, including community-specific resources and challenges. A community can mean many different things, such as a town, a neighborhood, a county, a region, even an entire state. "Community" also can refer to any group of people who come together with a common interest, such as a consumer group, religious denomination, political party or student association. You might relate to different communities for different goals. Your community may be a geographic area, a professional organization or an agency. Regardless of how you define "community" the efforts of a group of people to reduce suicide is extraordinarily valuable for suicide prevention.

TAKING ACTION IS IMPORTANT

We can prevent suicide because:

- Many people who complete suicide tell someone about their suicidal thoughts or show behaviors that indicate their plans before they take their lives.
- Many people who complete suicide see their doctor or mental health professional within one month before their death.
- Many people who attempt suicide are glad to have survived.
- Most people who are suicidal do not want to die – they want the pain to stop.

YOU CAN MAKE A DIFFERENCE

What ideas occur to you as you read about suicide, stigma, research and action? Can you think of some ways you might decrease stigma? Is there something you can do to strengthen your community? What efforts might help someone who might be struggling? **No matter what your ideas are for taking action, they are important.**

The next section contains ten goals adopted by the Idaho Council on Suicide Prevention you can use to guide your efforts. They are not listed in priority order; all goals are important. Following each goal are subcategories to help you identify specific activities as well as measures to determine the success of your activities.

"How We Will Do It"— Under each goal are actions or strategies to guide how the goal can be implemented. Additional actions or strategies that support or help to accomplish the goal may be utilized.

"Ideas for Things We Can Do" —This section appears alongside each goal. It is a list of activities that communities can consider. There may be other activities that communities can select to carry out the goal. These are offered as suggestions to spark other ideas.

"Ideas for How We Measure Our Success" —This section offers some ways we can measure our progress in meeting the goal, measure our strategies and measure our activities. It answers the question: "Did our efforts make a difference?"

Whatever you do to implement and measure the goals outlined in this Idaho Suicide Prevention Plan, **we can make Idaho a stronger, healthier place to live by working together.**

"Community" can mean different things. It can refer to people who live in a specific area. It also can mean people in different locations who have common interests. A community of action is any social group working together to create change.

Measuring your success can be easy

An important part of suicide prevention efforts is to measure whether your activities are effective. There are many ways to measure success. You can keep track of processes or outcomes. For example, if you hold a meeting, you can record how many people attended, their affiliations and other pertinent information. If you are distributing materials, you can keep track of how many are distributed and to whom. Measuring outcomes is somewhat harder but can be simplified. For example, you can survey people who attend a training to find out what they've learned and how they plan to use the new information in practical terms. You could then survey these people sometime after training to find out if they did use the information.

Idaho Voices

Wade Virgin, Survivor

The date of May 5, 2004 has now taken its place with the other significant dates such as birthdays and holidays that we remember each year in our family. For us, May 5th now has its own meaning. Of course, it is Cinco De Mayo, celebrated by many in our area. However, it has even a deeper meaning to me. This is the day that we lost our brilliant son Russell, a victim of suicide. Russ was a high honor student at the University of Idaho, just a few weeks from graduating as an architect. He had just received a scholarship to assist in completing an advanced degree. He was what I call the "All American Boy", loved by everyone who knew him. How could something like this happen to him? There is not even a close second to the pain you feel from losing a child to suicide. The pain radiates from your chest area and I felt that I had literally broken my heart. It took weeks before the feeling finally subsided. The second major issue I dealt with was the overwhelming feeling of guilt that I had. What was wrong with me? Why couldn't I see that my son was in crisis?

The Suicide Prevention Action Network (SPAN) has helped me the following ways:

1. It gave me someone to talk to who would just listen as I talked out my problems.

2. It taught me that guilt feelings and pain are normal for someone who has lost a family member to suicide.

3. I have learned that there are physical and emotional differences for those who attempt and complete suicide.

Finally, I have learned that life goes on and things do get better as time passes. It really helps knowing that others care. I thank God in heaven and the many friends and people that have assisted me through this process. It is extremely important that we be there to assist suicide survivors.

GOAL 1: PUBLIC AWARENESS

Idahoans understand that suicide is preventable and accept responsibility for their role in suicide prevention.

How We Will Do It

1. Increase awareness that mental health issues, including depression and substance use disorders, play a role in suicide and are treatable.

2. Ensure current, appropriate, recommended mental health and suicide prevention information is available in a variety of settings.

3. Create and implement a comprehensive social marketing campaign specific to mental health and suicide prevention.

4. Educate the media on their role in preventing suicide and encourage their use of current, appropriate, recommended media guidelines for safe and responsible messaging related to suicide.

5. Educate policy makers and public figures that suicide is preventable and the importance of their role in suicide prevention. Enlist community members to participate in suicide prevention.

"Social marketing is the application of marketing technologies developed in the commercial sector to the solution of social problems where the bottom line is (voluntary) behavior change." (Andreasen, 2005).

Ideas For Things We Can Do

- ✓ Identify a variety of community settings and distribute suicide prevention information.

- ✓ Conduct a wide variety of community awareness and education events related to suicide prevention.

- ✓ Meet with local media representatives and distribute current guidelines for responsible reporting regarding suicide and suicide prevention.

- ✓ The Idaho Council on Suicide Prevention will work with key state-level stakeholders to craft and make available consistent messages for suicide prevention education and social marketing efforts.

Ideas For How We Measure Our Success

- Efforts have been initiated to engage key stakeholders, including policy makers, health and mental health and substance use treatment professionals, in appropriate suicide prevention activities.

- A plan has been developed and implemented to get current information about suicide prevention to a wide array of community settings where it is needed.

- A plan has been written and funds have been identified for a social marketing campaign specific to suicide prevention.

- Participation of community members in suicide prevention is tracked.

- Media guidelines have been disseminated and contacts documented.

Idaho Voices

Julie, Suicide Attempt Survivor

I was twenty years old and it was near Christmas. I had not wanted to go to college right out of high school, but that was unacceptable to my family, so I went to U of I and had about eleven majors my freshman year because I had no idea what I wanted to do with my life. I started my sophomore year living at home with my mother and attending Boise State, trying out yet another major. I rarely attended classes. One weekend day, I decided I had to express how much pain I was in. I went into my mother's medicine cabinet, and took several different pills from her many prescriptions. My mother was at home, and I must have told her what I had done, because she got me in the car and drove me to the hospital. They put a tube down my throat and were administering charcoal to neutralize the drugs. I woke up and pulled the tube out of my throat, and charcoal went everywhere. My mother slept on a cot in my hospital room that night. The next morning my physician came in and talked to me briefly and basically said that I shouldn't do that again. I was released to go home that day. My father sent me a Christmas card that said, "I'm glad you are okay." I told him, "That's just the point. I'm NOT okay." He berated me for trying to manipulate his emotions. I saw a counselor a few times. Then we moved to California. Much later, I was living away from home in a gross little apartment while going to beauty school. My boyfriend had dumped me without even a good-bye. One evening, I called the Suicide Hotline, and the woman told me I needed to call a friend, and I told her I didn't want to bother anyone. I was living with a friend after not working for about a year due to chronic migraines. I was extremely depressed and was not on any anti-depressants. I was making plans to kill myself. I ended up calling my friend and telling her what I was planning. She gave me some hotline numbers to call, which I did. I also told my mother how I had been feeling and she told me that she had been so afraid that I was going to complete suicide. I ended up moving back to Boise and moving in with my mother so she could support me and get me the care that I needed. Fortunately, I did get the care I needed with a combination of the right drug combination and talk therapy. It did take a while to get the drugs to the right combination and dosage, but it was worth sticking it out. I haven't had any suicidal thoughts since I started meeting with my Psychiatric Nurse Practitioner and my therapist. If I start feeling low I have both of them to turn to, and I feel safe asking for help and being honest about how I am feeling. You don't have to feel bad. There are many, many people who want to help you not only feel better in the short term, but also to deal with what is causing your pain in the long term. DON'T GIVE UP!!!!!

GOAL 2: ANTI–STIGMA

Idahoans understand and accept that seeking help for mental health issues is to be encouraged and supported.

How We Will Do It

1. Identify barriers and opportunities related to seeking help for mental health issues.

2. Ensure current, appropriate, recommended mental health information is available in a variety of settings.

3. Create and implement a comprehensive social marketing campaign specific to mental health and stigma.

"Stigma is when someone judges you based on a personal trait. Unfortunately, this is a common experience for people who have a mental health condition." (Mayo Clinic, 2009)

Ideas For Things We Can Do

- ✓ Encourage community members, including health care providers, to engage in open dialogue about mental illness.

- ✓ Community leaders identify barriers to seeking treatment for mental health concerns.

- ✓ Educate community members about stigma and its negative consequences for individuals and their families.

- ✓ The Idaho Council on Suicide Prevention will work with key state-level stakeholders to provide information about the value of seeking mental health care.

Ideas For How We Measure Our Success

- Barriers and opportunities related to seeking help for mental health issues have been identified and documented.

- Information about barriers and opportunities related to seeking help for mental health issues has been disseminated statewide.

- Information is available to professionals regarding the need for self-care when working with people who are suicidal.

- A social marketing campaign specific to mental health and stigma has been initiated.

Idaho Voices

Jeni Griffin, Survivor
Community Advocate & Trainer

Sugar- Salem High School invited me to come and help with an assembly about suicide prevention. They wanted their focus to be on the warning signs, the code of silence that youth take with friends, and how there are people they can turn to for help. The first speakers that day was a father whose son died by suicide about a year ago.

Then I spoke. My son died seven years ago by suicide. The father's story was mostly about how much he was going to miss out on things with his son. He expressed feelings to the students about how they need to watch out for each other and never think, "oh, he won't hurt himself". My talk was about the warning signs and what students should watch for in their friends' behaviors. Also, if they had thought of suicide themselves, that there was hope and help available. I talked about the code of silence, and how it proved deadly for my son, because there were several friends who knew he was at risk and had attempted several nights before. We had counselors available that day for the students after the assembly in case there was need for an intervention or if somebody just needed to talk.

One student came up to me afterwards and said that he had been thinking about suicide and that he even had a plan and the means to complete the act soon. But my story was able to touch him deeply. He said that he had never thought about who might find him, especially his mom, because that would hurt her too much. He was able to talk to a counselor at that time and get some help for his feelings. Another young girl came up afterwards and said that she was really worried about her friend and could we help. The counselors were able to talk to the girl's friend and alert her parents to the possible suicide risk of their daughter. An intervention took place for at least two students because of this assembly and untold other conversations that took place between friends wanting to look out for each other.

GOAL 3: GATEKEEPER EDUCATION

The education of professionals and others working with people at risk for suicide includes effective suicide prevention curricula and ongoing gatekeeper and other suicide prevention training.

How We Will Do It

1. Secure funding and opportunities to provide training for relevant entities involved in professional education and development, including higher education and others.

2. Collaborate to assist, train and support relevant entities involved in professional licensure, education and development.

3. Ensure that ongoing gatekeeper training opportunities are available to people who work with individuals at risk for suicide.

A "gatekeeper" can mean different things, depending on the setting. For example, a healthcare provider may make referrals to specialists and otherwise manage a patient's care. A "community gatekeeper" is a trusted person who knows the warning signs for suicide and assists an at-risk person get the help they need.

Ideas For Things We Can Do

- ✓ Communities identify local gatekeepers.

- ✓ Communities identify and provide opportunities for current, appropriate, and recommended gatekeeper trainings involving suicide prevention, intervention, postvention and self-care.

- ✓ The Idaho Council on Suicide Prevention will collaborate with professionals, gatekeepers and others responsible for training and curriculum requirements, to determine whether suicide prevention content is included.

Ideas For How We Measure Our Success

- The field training and curriculum requirements for professionals, gatekeepers and others have been reviewed for suicide prevention content.

- Recommendations for strengthening suicide prevention content in curricula have been made.

- Resources for gatekeeper training have been provided.

Idaho Voices

John Landers, PhD
Clinical Psychologist

I work as a clinical psychologist in an inpatient psychiatric hospital. Most people come to this facility as a result of extreme distress, which often includes experiencing suicidal ideation or even acting on those thoughts. My primary role at the hospital is to provide psychological assessments of patients when there are uncertainties regarding the diagnosis or proper treatment of the patient. Risk to self is one factor that I assess with every patient with whom I work. My risk assessments often include looking at prior behaviors as well as current symptoms. Recently, I have begun to measure thwarted belongingness, perceived burdensomeness, and acquired capability for suicide (i.e., learned fearlessness) with all patients who have been hospitalized. These factors are based on Dr. Thomas Joiner's groundbreaking and innovative research on suicide risk and potential and are quite new to the field of suicide risk assessment. I have found that including these new measures not only greatly enhances my ability to assess risk, but also gives me the ability to speak the language of my patients.

Just last week, when providing feedback to an adolescent female who has attempted suicide at least 10 times in the past two years, she said, "I've never had anyone be able to state so clearly why I become suicidal. When I feel alone and like I'm bringing others down, that is when I attempt." This new tool for assessing risk has also informed treatment planning, as now therapists can work to increase belongingness and decrease burdensomeness in those where these factors are leading to suicidal ideation and behaviors. Keeping up to date on the newest and empirically supported practices has significantly enhanced my work and been a great benefit to my patients.

GOAL 4: BEHAVIORAL HEALTH PROFESSIONAL READINESS

Mental health and substance abuse treatment professionals are trained to use current, appropriate, and recommended practices for assessing and treating individuals who show signs of suicide risk.

How We Will Do It

1. Engage mental health and substance abuse treatment professionals and other providers in developing university curricula, continuing education courses, and other professional suicide prevention training.

2. Ensure current, appropriate, and recommended suicide prevention, assessment, intervention and postvention training is available to mental health professionals and other health care providers.

3. Identify and disseminate information and training to mental health professionals and other health care providers on current, appropriate, and recommended practices to assess and treat people at risk for suicide, including self-care.

"Behavioral Healthcare: The provision of mental health and chemical dependency (or substance abuse) services." (Blue Cross/Blue Shield, 2011)

Ideas For Things We Can Do

- ✓ Identify local mental health professionals and other health care providers and encourage them to follow current, appropriate, and recommended practices for suicide risk assessment, intervention and follow up.

- ✓ Disseminate current, appropriate, and recommended practices to all mental health and other providers working with people at risk for suicide.

- ✓ The Idaho Council on Suicide Prevention and State of Idaho lead agency will collaborate with mental health professionals and other health care providers in developing university curricula, continuing education courses, and other professional training.

Ideas For How We Measure Our Success

- The key decision makers among mental health professionals have been identified and actively participate in curriculum development and education.

- Current, appropriate, and recommended sources for training have been identified.

- Materials for training have been identified and are available to all mental health professionals and other audiences.

Postvention activities occur after a suicide and involve interventions to support bereaved family, friends, professionals and peers—who are at risk of suicide themselves.

Idaho Voices

Mary Pierce, LCSW
Veteran's Affairs Suicide Prevention Coordinator

As part of my duties for the Boise Veteran's Affairs Medical Center, I monitor and support the care of veterans after they have survived a suicide attempt or are evaluated to be a high risk for suicide. Research shows that the greatest time of risk for suicide is the first 30 days after psychiatric hospitalization. The Veteran's Affairs (VA) Suicide Prevention Initiative includes identifying veterans at high risk for suicide, providing enhanced care, e.g., therapy, regular psychiatric evaluation, safety planning (including listing the National Suicide Hotline phone number, persons and services to call when feeling suicidal, and coping strategies to decrease suicidal ideation), regular suicide risk assessment, and case monitoring by the Suicide Prevention Coordinator. During one call to check in with a veteran on the High Risk for Suicide List, the veteran informed me that it was his birthday and that he was not doing well. He felt misunderstood and ignored by his family and planned to kill himself. After some conversation the veteran agreed to come to the Boise VAMC and be admitted to the psychiatric unit. His plan of care was modified to include more intensive individual and family therapy. This veteran is currently doing well and been removed from the High Risk for Suicide List. The veteran calls occasionally to update me on his progress and thank me for saving his life.

GOAL 5: COMMUNITY INVOLVEMENT

Community leaders and stakeholders develop and implement suicide prevention activities that are current, recommended and culturally appropriate that are specific to their regions and communities.

How We Will Do It

1. Ensure community leaders and stakeholders are aware of the Idaho Suicide Prevention Plan and the resources are available to help them develop and implement suicide prevention efforts specific to their communities.

2. Assist, train and support community leaders and stakeholders about current, recommended, and culturally appropriate suicide prevention activities.

3. Assist community leaders and stakeholders to identify their community's suicide issues or people at risk for suicide.

4. Assist community leaders and stakeholders to identify and understand the unique cultural characteristics of their region that may relate to suicide.

5. Support the development of community groups that promote access to and use of mental health services.

6. Ensure current, culturally appropriate, recommended suicide prevention information is widely available in a variety of community settings.

7. Provide opportunities for communities to network and share information about suicide prevention.

Ideas For Things We Can Do

- ✓ Community members gather public input to determine the status of and needs for suicide prevention efforts in their communities.

- ✓ Community leaders implement the Idaho Suicide Prevention Plan in their local area.

- ✓ Community leaders identify and support culturally diverse groups in their region on suicide prevention efforts.

- ✓ The Idaho Council on Suicide Prevention will work with key state-level stakeholders to develop and implement a plan to get current, culturally appropriate, recommended suicide prevention information to those settings where it is needed.

Ideas For How We Measure Our Success

- Community leaders and stakeholders promote suicide prevention.

- Stakeholders and others have received the Idaho Suicide Prevention Plan and have identified ways to implement it in their regions.

- Community specific and culturally tailored training has been conducted and documented.

- Current suicide prevention information is available in settings where it is needed.

- Communities have provided opportunities for networking and information sharing about suicide prevention.

Idaho Voices

Paula Campbell
National Alliance on Mental Illness (NAMI)-Boise
Vice President and Program Director

Our family has dealt with the maze of mental health treatment for the past six years in order to meet the needs of our son who was hospitalized in 2004. NAMI-Boise provided valuable resource information and free education classes and support.

It is critical that we utilize the funds we have available from both federal and state to create a better continuum of care for those in crisis.

It is even more important that we educate the public on the power of prevention, recognizing symptoms and utilizing community services before hospitalization is needed.

Stigma needs to be reduced once and for all.

GOAL 6: ACCESS TO CARE

Crisis intervention and behavioral health services , including mental health and substance abuse treatment, are widely available, culturally appropriate, accessible and valued by communities.

How We Will Do It

1. Encourage communities to value crisis intervention and behavioral health services.
2. Support the integration of and equitable funding for mental health and physical health services.
3. Support widely available, diverse and accessible behavioral health services in all regions of Idaho.
4. Identify and engage community champions to address suicide prevention.
5. Provide training about culturally appropriate crisis intervention and behavioral health services to communities.
6. Empower communities to reach out to policy makers in support of widely available, culturally appropriate and accessible crisis intervention and behavioral health services.

"Culturally appropriate" refers to many things. It can address ethnic and racial issues but can be expanded to include rural, economic, religious, job type, and even differences between regional characteristics.

Ideas For Things We Can Do

- ✓ Community members collaborate with local media to educate the community on the value of crisis intervention and behavioral health services.
- ✓ Community members support those providing crisis intervention services to use current, appropriate, recommended, culturally relevant practices.
- ✓ The Idaho Council on Suicide Prevention will collaborate with policy makers to support widely available, culturally appropriate and accessible crisis intervention and behavioral health services throughout the state.

Ideas For How We Measure Our Success

- Champions or group leaders support widely available crisis intervention and behavioral health services.
- Efforts to promote equitable, adequate funding and integration of physical and mental health services have been monitored.
- Community-specific and culturally tailored events and training have been conducted and documented.
- Interaction between community leaders and decision makers to promote suicide prevention has been documented.

"Unfortunately, despite ongoing efforts to educate the public, the same social stigma that surrounds suicide also continues to stand between many people with mental and substance use disorders and the care they need — care that could help thwart potential suicide." (Center for Substance Abuse Treatment, 2008)

Idaho Voices

Rich and Trudy Jackson
Suicide Survivor Support Group Facilitators

Rich and Trudy Jackson are the survivors of the suicide death of their son Jason. They facilitated a suicide survivor support group in Boise for 20 years and are pioneers in suicide prevention in Idaho.

Survivor support groups play a vital role in helping survivors cope with grief and make the choice to find new meaning and direction in their lives. Many survivors have found their support to be a major factor in finding a new way of living in a world forever change by their loved one's decision.

GOAL 7: SURVIVOR SUPPORT

Information and services are in place in all regions of Idaho to support survivors and others affected by suicide in a sensitive and culturally appropriate manner.

How We Will Do It

1. Provide information and services to survivors and others affected by suicide that will help them deal with their grief and unique circumstances.

2. Support stakeholders to appropriately address the consequences of a community suicide crisis.

3. Support the development and continuation of community suicide survivors support groups.

Ideas For Things We Can Do

- ✓ Community members create and maintain suicide survivor support groups.
- ✓ Communities provide resources and information to assist survivors in healing and moving forward.
- ✓ Community leaders support stakeholders in local suicide response.
- ✓ The Idaho Council on Suicide Prevention works with state-level stakeholders to educate people about the particular difficulties associated with losing someone to suicide.

Ideas For How We Measure Our Success

- Appropriate information to help survivors deal with their grief has been identified and distributed.
- Community plans have been developed and implemented to support survivors.
- Survivors of suicide report feeling a reduced sense of stigma.

"Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description." (Kay Redfield Jamison in US DHHS, 2001)

"A suicide survivor is someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (Jordan and McIntosh, 2011).

Idaho Voices

Ann Kirkwood, MA

Idaho State University - Institute of Rural Health
Director, Youth Suicide Prevention & Hotline Research
Director, Better Todays. Better Tomorrows.

Suicide prevention hotlines work. They provide needed access to care in some areas where mental health services are not widely available. Their services are available 24/7, 365 days a year. Responding to callers who are in a suicide crisis does save lives. A suicide prevention hotline in Idaho closed in late 2006 and the national Suicide Prevention Lifeline took on Idaho's calls as a professional courtesy. The locally funded hotline in Portland, Oregon, has temporarily answered Idaho calls in recent years at no cost to Idaho.

According to information from Lifeline, call volume from Idaho being answered in other states has more than doubled since 2007 (increasing from 1,534 in 2007 to 3,633 calls in 2009). However, operators in other states taking Idaho calls reported difficulties in making referrals for follow up care, an essential component to prevent additional suicide attempts and completions. The formation of a suicide prevention hotline in Idaho represents an opportunity to effectively address the issue of Idaho's high suicide rate.

In 2009, the State entered into a contract with the Institute of Rural Health at Idaho State University to study how a 24-hour statewide hotline could be established and maintained in Idaho. Data were collected from about 20 individual sources and 13 research projects were initiated. A full report and implementation guide from that effort is available on the IRH website at www.isu.edu/irh/publications/Hotline_Report_2010_web_pwp.pdf

Maintaining funding for the Idaho hotline is an important step in establishing its presence in Idaho.

GOAL 8: SUICIDE PREVENTION HOTLINE

An Idaho statewide suicide prevention hotline is established and funded.

How We Will Do It

1. Identify an entity in Idaho to provide statewide suicide prevention hotline services.
2. Identify adequate and sustainable funding to support a statewide suicide prevention hotline.
3. Secure certification and accreditation for a statewide suicide prevention hotline.
4. Promote the Idaho suicide prevention hotline number statewide.
5. Evaluate usage patterns of the statewide suicide prevention hotline.
6. Evaluate community awareness of and attitudes toward a statewide suicide prevention hotline.

Ideas For Things We Can Do

- ✓ Distribute hotline cards.
- ✓ Promote the hotline at community events.
- ✓ Distribute hotline cards to specific groups that interact with people at risk for suicide.
- ✓ The Idaho Council on Suicide Prevention will provide leadership to identify an entity in Idaho to operate a statewide suicide prevention hotline.

Ideas For How We Measure Our Success

- An organization has been identified that will operate an Idaho suicide prevention hotline.
- Options for short- and long-term funding to support a certified and accredited hotline have been identified.
- An accreditation application for the Idaho suicide prevention hotline has been submitted.
- Calls to the Idaho suicide prevention hotline are tracked and reported.

An Idaho hotline began as the Nampa Suicide Prevention Hotline in 1989. In 1994, it became Idaho Suicide Prevention Services operating statewide from Boise State University. The hotline was staffed almost entirely by volunteers. It closed in December 2006.

Idaho Voices

Kathie Garrett

Chair, Idaho Council on Suicide Prevention

The Idaho Council on Suicide Prevention is proud to be a part of Idaho's efforts to address the critical issue of suicide. The Council was established by Governor Kempthorne in 2006 and most recently appointed by Governor C. L. "Butch" Otter.

The Council has been given the following charge:

- To oversee the implementation of the Idaho Suicide Prevention Plan.
- To ensure the continued relevance of the Plan.
- To report to the Governor and Legislature annually.

By working in collaboration with partner groups, positive work has been accomplished. Ultimately, our goal is to reduce the number of deaths by suicide in Idaho. There is much work yet to be done. Everyone's efforts are needed to achieve our goals.

GOAL 9: LEADERSHIP

The Idaho Council on Suicide Prevention oversees suicide prevention activities at all levels, as guided by the Idaho Suicide Prevention Plan, and works in collaboration with a lead Idaho state government agency that is responsible for Idaho's suicide prevention and intervention efforts.

How We Will Do It

1. Ensure the continuation of the Idaho Council on Suicide Prevention.
2. Support efforts to secure adequate funding and administrative support for the Idaho Council on Suicide Prevention.
3. Obtain support and recognition for the Idaho Council on Suicide Prevention from decision makers at all levels.
4. Ensure the Idaho Council on Suicide Prevention continually evaluates membership representation to include appropriate diverse groups.
5. Ensure the relevancy and progress of the Idaho Suicide Prevention Plan.
6. Seek endorsement of the Idaho Suicide Prevention Plan by key decision makers.
7. Widely disseminate the Idaho Suicide Prevention Plan.
8. Evaluate implementation of the Idaho Suicide Prevention Plan.
9. Identify a lead state government agency responsible for Idaho's suicide prevention and intervention activities.
10. Support efforts to secure adequate funding for suicide prevention within the lead Idaho state government agency responsible for Idaho suicide prevention and intervention activities.

Ideas For Things We Can Do

- ✓ The Idaho Council on Suicide Prevention will establish bylaws that reflect its mission and duties assigned by the governor's executive order.
- ✓ The Idaho Council on Suicide Prevention membership and progress of the Idaho Suicide Prevention Plan will be evaluated by the Council annually.
- ✓ The Idaho Council on Suicide Prevention will report annually to the Legislature and Governor on the progress of the Idaho Suicide Prevention Plan and Council activities.
- ✓ The Idaho Council on Suicide Prevention will develop and implement a dissemination strategy for the Idaho Suicide Prevention Plan.
- ✓ Stakeholders throughout Idaho will promote the naming of a lead state government agency responsible for Idaho Suicide prevention activities.

Ideas For How We Measure Our Success

- The Executive Order creating the Idaho Council on Suicide Prevention is renewed on a regular basis to ensure continuation.
- A budget to support the Idaho Council on Suicide Prevention has been developed.
- Key decision makers have been provided information about the Idaho Council on Suicide Prevention.
- The Governor and Legislature are provided with an annual report on suicide and suicide prevention activities in the state of Idaho.
- A literature review and information on best practices, comparing the activities of Idaho to national evidence-informed practices, have been compiled in support of the Idaho Suicide Prevention Plan.
- A lead Idaho state government agency has been named.

Idaho Voices

Elke Shaw-Tulloch, MHS

Chief, Bureau of Community & Environmental Health
Division of Public Health
Idaho Department of Health & Welfare

It is important to collect, analyze and interpret health data. This helps us to do several things:

- Prove or disprove what is perceived to be true in regard to a particular issue, topic or project,
- Dispel myth and rumor, and
- Make informed decisions.

For example, a hospital may review data about postpartum depression onset to determine that conducting a depression screening upon discharge is not as effective as a two week follow up telephone call to new moms to detect symptoms of depression. Public health tobacco prevention programs may obtain data to determine which segment of the population is the most impacted by tobacco use so they can target tailor-made interventions to that population. We use data in our daily lives also to help us make health-related decisions, such as reviewing the nutrition label on a food item to determine whether the amount of calories and sodium meets your health goals, determining the most economical health care clinic to get flu shots to protect your family, or tracking the number of your child's sleepless nights to initiate a discussion about anxiety with your child's health care professional.

This same informed decision-making approach must also be applied to suicide prevention, intervention and postvention activities to ensure that activities are purposefully targeted to have impact and make change.

GOAL 10: DATA

Data are available on which to make decisions regarding suicide prevention services.

How We Will Do It

1. Determine data needed for effective suicide prevention services including surveillance and outcome data.
2. Continue to collect and improve existing suicide-related data at state and community levels.
3. Promote the availability of and increase the access to suicide-related data.
4. Assist stakeholders in understanding how data can be used to plan and implement suicide prevention services.
5. Create and implement a method to share suicide-related data statewide, with a special emphasis on region-specific surveillance and outcome data.

Surveillance (data) helps to define the problem for a community. It documents the extent to which suicide is a burden to a community and how suicide rates vary by time… geographic regions, age groups, or special populations.(NSSP pg 31)

Ideas For Things We Can Do

- ✓ Statewide suicide prevention leaders educate local stakeholders on how data can be used appropriately to plan and implement suicide prevention programs.
- ✓ Communities identify and collect relevant, reputable data and use it appropriately to plan suicide prevention activities.
- ✓ Local stakeholders identify community members who need suicide data.
- ✓ Create and implement a method to share suicide-related data statewide, with a special emphasis on region-specific surveillance and outcome data.

Ideas For How We Measure Our Success

- A group has been established to determine suicide data needs.
- Suicide data have been collected, recorded, tracked and trends over time have been identified.
- Data to support planning and evaluation efforts have been identified.
- Stakeholders have been trained to work with data.
- Data have been made widely available, as appropriate, to protect confidentiality of individuals.

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HOW TO FIND ADDITIONAL DATA SOURCES ON SUICIDE

There are a variety of data sources that could be useful for planning and measuring suicide prevention activities. This section lists some suggested sources for Idaho data. Please note that some recommendations are for types of data and others for sources of data. In most cases the types of data information also includes potential sources.

- ***Youth Risk Behavior Survey (YRBS)*** is part of a national survey of CDC, administered by the Idaho State Department of Education to students in grades 9-12 and is a self-report survey. It contains suicide related questions in addition to tracking behaviors among youth related to the leading causes of mortality and morbidity in six categories. Currently, data are collected every other year in Idaho. www.sde.idaho.gov

- ***Behavior Risk Factor Surveillance System (BRFSS)*** is the YRBS for adults and contains similar suicide related questions. The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, ongoing telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. www.cdc.gov/brfss

- ***Idaho Office of Vital Statistics*** The Idaho Bureau of Vital Records and Health Statistics maintains birth and death records filed from July 1911 to the present, and marriage and divorce records filed from May 1947 to the present. Some counties may have older birth, death, marriage, or divorce records in their files, but county files contain only records of vital events that occurred in that county. http://healthandwelfare.idaho.gov/?TabId=82

- ***Idaho State University Institute of Rural Health Awareness to Action Youth Suicide Prevention Project*** AAYSP conducts research and programs. Reports and data are produced, such as the Hotline Options Report. The purpose of the Idaho Awareness to Action Youth Suicide Prevention Project is to reduce suicide attempts and completions, regardless of ethnic/racial heritage, among Idaho youth ages 10-24. The overall goal of the project is to translate information into active suicide prevention by increasing adults' knowledge of youth suicide protective and risk factors and helping them to put that knowledge into active suicide prevention efforts. www.isu.edu/irh/projects/ysp/goals.shtml

- ***Idaho State University-Institute of Rural Health*** The IRH has offices in Pocatello and in Meridian. The mission of the IRH is to improve the health of communities through research, education, and service. The IRH conducts research and program activities. Specific projects or data requests are possible. Reports are available at www.isu.edu/irh.

- ***Idaho Suicide Data & Research Project*** presents Idaho-specific data for four special at-risk populations in Idaho. The website presents actual Idaho suicide data on each population, such as incidence, race, place of injury, mechanism of death, etc., as well as risk and protective factor data for each special population. The four special populations are teen males, Native American males, working age males, and elderly males. The reports page presents research-based reports on each of the special populations, as well as extensive research bibliographies. The project has been managed by Benchmark Research and Safety, Inc. www.idahosuicide.info

- ***National Violent Death Reporting System*** CDC has funded 18 states and established the National Violent Death Reporting System (NVDRS) to gather, share, and link state-level data on violent deaths. NVDRS provides CDC and states with a more accurate understanding of violent deaths. This enables policy makers and community leaders to make informed decisions about violence prevention programs, including those that address child maltreatment. Idaho is not among the NVDRS reporting states, however, NVDRS provides data that can be used to help guide Idaho programs.
  www.cdc.gov/ViolencePrevention/NVDRS

- ***Suicide Prevention Action Network, Idaho*** SPAN Idaho's mission is to reduce suicide in Idaho through statewide advocacy, collaboration and education in best practices. SPAN conducts suicide prevention conferences, trainings, survivor support, public awareness activities, and information and referral. SPAN spearheads statewide suicide prevention initiatives and works with national, state and local stakeholders to create positive change.
  www.spanidaho.org

- ***Suicide Prevention Resource Center*** SPRC includes 490 web pages and 250 library resources on suicide prevention information. The site includes a range of information from suicide prevention and mental health news to strategic tools for developing suicide prevention programs. The site includes individual state suicide prevention pages, news and events, an online library, training, and links to other web sites.
  www.sprc.org

- ***The National Suicide Prevention Lifeline*** 1-800-273-TALK (8255) is a 24-hour, toll-free, confidential suicide prevention hotline available to anyone in suicidal crisis or emotional distress. The Lifeline's national network of local crisis centers, provide crisis counseling and mental health referrals day and night. Although Idaho does not have a suicide prevention hotline that is part of the Lifeline system, Lifeline may be able to provide some data about Idaho calls that roll over to them. Idaho's calls as of summer 2011 were answered at the Portland, OR, call center which is funded by local Oregon resources.

- ***The Substance Use, Safety and School Climate survey and the Youth Risk Behavior Survey (YRBS)*** are administered bi-annually in alternating years by the SDE. The Substance Use, Safety and School Climate survey captures student reported data on risk behaviors and school safety. There were 15,200 students surveyed statewide in the fall of 2008. The YRBS captures student reported data on intentional and unintentional injuries, sexual behaviors that can result in HIV infection, other sexually transmitted diseases and unintended pregnancies; dietary behaviors, physically activity and suicidal tendencies. The 2009 YRBS survey was completed by 2,154 students in 53 public high schools.
  www.cdc.gov/HealthyYouth/yrbs

- ***WISQARS*** Web-based Injury Statistics Query and Reporting System (WISQARS), pronounced "whiskers", is an interactive database that provides national injury-related morbidity and mortality data used for research and for making informed public health decisions.
  www.cdc.gov/injury/wisqars

- One way to address the problem of suicide is through social marketing campaigns. Social marketing "refers primarily to efforts focused on influencing behaviors that will improve health, prevent injuries, protect the environment, and contribute to communities." (Kotler & Lee, 2008. p 7).

Social Marketing Resources

Archived webinar

ISU – Institute of Rural Health sponsored a webinar titled "Social Marketing: Putting it into Practice", which focused specifically on using social marketing for suicide prevention in July 2011. In this recorded webinar participants learn the basic principles of social marketing. Emphasis is placed on identifying appropriate behaviors, measuring change, and real world examples. The course is designed for people who are engaged in suicide prevention planning at the community level, but may be helpful to any grassroots effort for prevention or behavior change (http://vimeo.com/26646412).

Books

Andreasen, A. R. (1995). *Marketing social change: Changing behavior to promote health, social development and the environment*. San Francisco: Sage Publications.

Andreasen, A. R. (2006). *Social marketing in the 21st century.* Thousand Oaks, CA: Sage Publications.

Kotler, P. & Lee, N. R. (2008). *Social marketing: Influencing behaviors for good*. Third Edition. Thousand Oaks, CA: Sage Publications.

SPAN IDAHO

SUICIDE PREVENTION ACTION NETWORK OF IDAHO

Suicide in Idaho: Fact Sheet
January 2015

- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14. (The leading cause of death is accidents.)
- Idaho is consistently among the states with the highest suicide rates. **In 2013 Idaho had the 7th highest suicide rate, 47% higher than the national average.**
- In 2013, 308 people completed suicide in Idaho; a slight increase from 2012.
- Between 2009 and 2013, 79% of Idaho suicides were by men.
- In 2013, 65% of Idaho suicides involved a firearm. The national average is 51%.
- 15.8% (1 in 7) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- Between 2009 and 2013, 85 Idaho school children (age 18 and under) died by suicide. Fifteen of these were age 14 and under.
- It is estimated that suicide attempts in Idaho result in $36 million in costs annually. Idaho's costs for suicide completions annually is over $850,000 in medical care alone, and $343 million in total lifetime productivity lost.
- In 2013, there were 41,149 deaths by suicide in the United States, an average of 1 person every 12.8 minutes.

Idaho Resident Suicides by Region – 2013

Region	Anchor City	Suicides	Rate (per 100,000)	Population	Tot. # suicides 2009-2013	5-yr Avg Rate
1	Coeur d'Alene	41	18.8-	217,551	234	21.8
2	Lewiston	18	16.9-	106,588	105	19.8
3	Nampa	56	21.3*	263,411	228	17.8
4	Boise	77	16.8-	459,035	353	15.9
5	Twin Falls	41	21.7*	188,860	195	21.0
6	Pocatello	44	26.1*	166,138	175	21.1
7	Idaho Falls	31	14.7-	210,553	198	19.1

***** increase from 2012, - decrease from 2012

Idaho Suicides by Age/Gender 2009-13
Over 5 year period

Age	Total	Male	Rate	Female	Rate
< 15	15	12	4.0	3	1.1
15-24	219	172	29.8	47	8.5
25-34	202	168	31.3	34	6.6
35-44	262	193	39.4	69	14.5
45-54	321	244	47.9	77	15.0
55-64	243	184	40.0	59	12.6
65-74	119	103	36.1	16	5.4
75-84	68	63	44.8	5	3.0
85+	39	34	72.3	5	6.0

Method 2009-13
(all ages)

Firearm	64.95%
Poisoning	17.5%
Suffocation	12.3%
Cut/Pierce	.7%
Fall	1.3 %
Other	3.2%

Idaho Suicide Rates 2001 – 2013

Year	Number	ID Rate	US Rate
2001	213	16.1	10.8
2002	203	15.1	11.0
2003	218	16.0	10.9
2004	239	17.2	11.1
2005	225	15.7	11.8
2006	218	14.9	11.2
2007	220	14.7	11.5
2008	251	16.7	11.9
2009	307	19.9	12.0
2010	209	18.5	12.4
2011	284	17.9	12.7
2012	299	18.7	12.9
2013	308	19.1	13.0

Idaho Youth Risk Behavior Survey 2013 – Regular Public and Charter High School Students

Grade	Sad or Hopeless	Suicidal	Plan	Attempt	Medical Care For Attempt
9th	28.4%	18.2%	12.8%	8.3%	2.8%
10th	27.8	14.4	12.7	7.6	3.0
11th	31.	15.3	11.9	6.8	2.0
12th	29.3	14.9	14.3	5.7	1.9
Idaho Overall	29.4	15.8	13.0	7.0	2.5

Idaho Suicide Rate by County

5-year total number and 5-year average annual rate 2009-2013

(resident suicides per 100,000 people)

County	Number	Rate	County	Number	Rate
Ada	305	15.2	Gem	16	19.2
Adams	4	20.8	Gooding	15	19.8
Bannock	101	24.3	Idaho	16	19.9
Bear Lake	7	23.6	Jefferson	24	18.3
Benewah	9	19.6	Jerome	31	27.8
Bingham	38	16.7	Kootenai	140	19.8
Blaine	23	21.4	Latah	23	12.2
Boise	12	34.2	Lemhi	14	35.6
Bonner	46	22.5	Lewis	5	26.1
Bonneville	105	20.0	Lincoln	6	23.4
Boundary	17	31.3	Madison	10	5.3
Butte	3	21.6	Minidoka	12	12.0
Camas	2	36.6	Nez Perce	51	25.8
Canyon	170	17.7	Oneida	4	18.9
Caribou	9	26.2	Owyhee	8	14.0
Cassia	18	15.7	Payette	19	16.7
Clark	4	86.6	Power	4	10.3
Clearwater	10	23.4	Shoshone	22	34.7
Custer	12	55.8	Teton	15	30.0
Elmore	28	20.8	Twin Falls	88	22.6
Franklin	12	18.8	Valley	8	16.9
Fremont	11	16.9	Washington	11	21.7
			Idaho (total)	1,488	18.8 (5-year average)

Note: Rates for many counties are based on fewer than 20 deaths. Caution is advised when interpreting rates based on small numbers.

Sources: Idaho Bureau of Vital Records and Health Statistics,
Idaho Department of Health and Welfare,
Center for Disease Control and Prevention
Ann Kirkwood, Idaho Suicide Prevention Hotline Report, Idaho State University, Institute of Rural Health, 2010
State Department of Education, YRBS Idaho, 2013

Compiled by Jeni Griffin, Executive Director, SPAN Idaho
Special Thanks to Pam Harder, Research Analyst Supervisor, Bureau of Vital Records and Health Statistics

C. Environmental Factors and Plan

20. Suicide Prevention

Page 72 of the application Guidance
Narrative Question: In the FY 2016/2017 Block Grant application, SAMHSA asked states to:

Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.

Include a new plan (as an attachment to the block grant application that delineates the progress of the state suicide plan since the FY2014-2015 plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.

Until SFY 2013, there was no nationally certified suicide prevention hotline in Idaho. The National Suicide Prevention Lifeline reported 3,700 calls from Idahoans in 2010. The Suicide Prevention Action Network of Idaho (SPAN Idaho) provided a suicide fact sheet in January 2015 based on data from the Idaho Bureau of Vital Records and Health Statistics, the Idaho Department of Health and Welfare, the Centers for Disease Control and Prevention and YRBS Idaho (see attached). According to these statistics, suicide is the 2nd leading cause of death for Idahoans 15-34 and for males 10-14 years of age. The fact sheet reports that in 2013, 308 people completed suicide, with 79% by men, and 65% involving a firearm. Also in 2013, "15.8% of Idaho youth attending regular public and charter schools reported seriously considering suicide in 2013," with 7.0% reporting at least one attempt. The State Planning Council on Mental Health identified suicide prevention as a top area if interest in June 2015.

The Department of Health and Welfare contracted with Idaho State University's Institute of Rural Health to assess the need and viability of establishing an Idaho Suicide Hotline. This report can be accessed at www.isu.edu/irh/publications/Hotline_Report_2010_web_pwp.pdf. While a suicide hotline was a recognized need, there were challenges in identifying funding sources to establish and maintain operations for this type of resource. The Idaho Suicide Prevention Hotline was created in 2012 as a result of collaborative efforts between multiple entities, including the Idaho Council on Suicide Prevention, the Suicide Prevention Action Network of Idaho (SPAN Idaho), Idaho State University Institute of Rural Health, the Department of Veterans Affairs (Boise), the Idaho National Guard, the Idaho Department of Health and Welfare and Mountain States Group, Inc. Funding contributors to this project included United Way (Kootenai County, Southeast Idaho, and Treasure Valley), the Idaho State Legislature, the Idaho Department of Health and Welfare, Wells Fargo Bank, the Saint Alphonsus Health System, the Jeret 'Speedy' Peterson Foundation, Citi Cards, the Ada County Paramedics Association, the Suicide Prevention Action Network of Idaho and the Idaho National Guard.

Jannus, Inc. (formerly Mountain States Group) was awarded the contract to implement a suicide hotline in Idaho in SFY 2013. The hotline uses trained volunteers, and was launched on November 26, 2012. The program tracks caller demographics and general call information. The Idaho Suicide Hotline has received over 6000 calls since being established. As of November 2014, the Hotline began operating twenty-four

(24) hours a day, seven (7) day a week and currently has 73 trained volunteers. There were a total of 2869 calls received in 2014.

Idaho's Suicide Prevention Council developed a suicide prevention plan in 2003 (go to website http://healthandwelfare.idaho.gov/Portals/0/Children/DocumentsSrtView.pdf). In an effort to update this plan, a Suicide Prevention Plan Development Group met in July and August 2010 to discuss new suicide prevention challenges and collaboration opportunities. Representation included former legislators, survivors, mental health consumers and their families, aging and adult care providers, youth and school services, public and private mental health providers and veteran's mental health services, Native Americans, Hispanics and advocates for lesbian, gay, bisexual, and transgender (LGBT) persons. The Idaho Suicide Prevention Plan: An Action Guide (2011) is accessible at http://www.spanidaho.org/uploads/ispplan.pdf .

In partnership with Idaho State Department of Education (SDE), SPAN Idaho received the Garrett Lee Smith Memorial Act (GLSMA) grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to target youth, ages 10-24 in suicide prevention in October of 2013. The Idaho Lives Project (ILP), which will reach more than 31,000 individuals over the three-years of the grant, with training for youth, school staff, community adults along with health and mental health providers in effective response to suicidal youth. All goals of the project align with the goals of the Idaho Suicide Prevention Plan (ISPP) and the National Strategy for Suicide Prevention (NSPP).

In response to SCR104, approved during the 2015 Legislative session, the Health Quality Planning Commission (HQPC) seeks to prepare an implementation plan for a comprehensive suicide prevention program in Idaho. In partnership with the Idaho Council on Suicide Prevention (ICSP), HQPC will convene a select committee of statewide stakeholders to develop a system of care for addressing the implementation of the Idaho Suicide Prevention Plan across the state. This select committee will examine the goals of the Idaho Suicide Prevention Plan as developed and prioritized by the ICSP and develop a plan for an implementation program.

Environmental Factors and Plan

21. Support of State Partners

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 mental and substance use disorders 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 actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, 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 emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

SHERRI YBARRA
SUPERINTENDENT OF
PUBLIC INSTRUCTION

650 W. STATE STREET
P.O. BOX 83720
BOISE, IDAHO 83720-0027

OFFICE: 208-332-6800
FAX: 208-334-2228
SPEECH/HEARING
IMPAIRED: 1-800-377-3529

July 27, 2015

Ross Edmunds
Idaho Department of Health and Welfare
Division of Behavioral Health
PO Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The intent of this letter is to express support for the FFY 2016-2017 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant. As you have described, the block grant goals of promoting improved services and implementing evidence-based practices for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are congruent with our department goals.

Successful collaborative efforts between the Department of Education and the Division of Behavioral Health (DBH) currently include examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe and supported in their social-emotional development. For those youth at-risk of emotional, behavioral and substance use disorders, we partner to ensure they have the services and supports needed to succeed academically, and socially as well. The Division's Children's Mental Health (CMH) program and the Department of Education collaborate with local school districts to implement intensive community and school-based programs for children and youth with serious emotional disorders (SED). The Department of Health and Welfare provides technical assistance and professional subject matter expertise on youth with serious emotional and/or social disorders.

The Department of Education hopes to continue these collaborative efforts with the Division of Behavioral Health, as well as future partnering opportunities toward achieving the block grant goals. This collaboration will facilitate efforts to help children, youth and families navigate the system of care continuum, reduce out of home placements, and improve educational outcomes.

Feel free to contact me for more clarification on the State Department of Education's support of this effort.

Respectfully,

Matt

Matt McCarter, Director
Student Engagement, Career & Technical Readiness Division
State Department of Education
(208)332-6961
mamccarter@sde.idaho.gov

IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG – DIRECTOR

GARY M. MOORE – Administrator
DIVISION OF FAMILY AND COMMUNITY SERVICES
450 West State Street, 5th Floor
P.O. Box 83720, Boise, ID 83720-0036
PHONE 208-334-5700
FAX 208-332-7330

July 22, 2015

Ross Edmunds, Administrator
Division of Behavioral Health
Idaho Department of Health and Welfare
450 W. State Street, 3rd Floor
PO Box 83720
Boise, ID 83720

Dear Mr. Edmunds:

The Idaho Department of Health and Welfare's Division of Family and Community Services supports Idaho's FFY 2016-2017 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The Block Grant goals are to improve services and improve Evidence-Based Practices for youth with emotional and behavioral disturbances, substance abuse issues, and/or co-occurring disorders are consistent with the Department's goals.

The Division of Family and Community Services (FACS) has a history of collaborating with the Division of Behavioral Health in an effort to provide best practice services to Idaho citizens. The mission of our organization is to *Promote and protect the health and safety of Idahoans*. The Division of FACS' programs address child welfare and protection, foster care, and adoption. The Division of Behavioral Health's Children's Mental Health programs work with the local Child Welfare programs to resolve family issues that may put children at risk for maltreatment, out-of-home placement, and involvement with the foster care system. Service Integration, another FACS' program, works with Idaho's Health Information and Referral Center to facilitate family efforts to navigate the range of Department programs and services. The Substance Use Disorders (SUD) Program has established the child protection drug courts in Idaho, and the Division of Behavioral Health has agreed to consult with FACS on the use of title IV-E funding for post-adoption services.

Family and Community Services plans to continue to collaborate and explore future opportunities to partner with the Division of Behavioral Health in support of the Block Grant goals to help youth and families navigate the Department's programs and services, prevent out-of-home placements, and facilitate smooth transitions back into Idaho's communities.

Sincerely,

GARY M. MOORE
Administrator
Division of Family & Community Services

GMM/ap

C.L. "Butch" Otter

Governor

Elisha Figueroa

Administrator

304 N 8th Street, Room 455

Boise, ID 83702

208-854-3042

208-854-3041

State of Idaho

Office of Drug Policy

Executive Office of the Governor

July 21, 2015

Idaho Department Health and Welfare
Division of Behavioral Health
P O Box 83720
Boise, ID 83720

Dear Mr. Edmunds,

The Idaho Office of Drug Policy supports Idaho's 2016-2017 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The Block Grant goals to focus on the prevention of underage drinking, prescription drug abuse and normalizing marijuana use are consistent with our organization's goals.

The Office of Drug Policy has a history of collaborating with the Division of Behavioral Health in an effort to support development of strong positive family values and implement needs-based services to Idaho citizens. The Idaho Office of Drug Policy's mission is to lead Idaho's substance abuse policy and prevention efforts by developing and implementing strategic action plans and collaborative partnerships to reduce drug use and related crime, thereby improving the health and safety of all Idahoans. The Division of Behavioral Health programs work with my staff to support community coalitions and cross agency planning to prevent alcohol and drug abuse. A designated Division program specialist serves as a liaison to my office to support comprehensive planning and ensure no duplication of efforts. Representatives from the Division participated in the State Strategic Prevention Planning Committee and assisted with the development of the state's prevention plan. The State Epidemiological Outcomes Workgroup, Evidence Based Programs Workgroup and Idaho's Prescription Drug Abuse Workgroup all include members from the Department of Health and Welfare and the Division of Behavioral Health.

The Office of Drug Policy expanded its collaborative efforts with the Division in 2014 by taking on management of the primary prevention set-aside within the Substance Abuse Prevention and Treatment Block Grant. This partnership has enabled Idaho to unite all prevention efforts under one unit within state government and ensure there is no duplication of effort. Based on the resources the Division and the Office of Drug Policy have established to date, Idaho is well placed to continue delivering effective prevention programming.

Sincerely,

Elisha Figueroa, Administrator
Office of Drug Policy

IDAHO DEPARTMENT OF CORRECTION

To promote a safer Idaho by reducing recidivism

C. L. "BUTCH" OTTER
Governor

KEVIN H. KEMPF
Director

August 3, 2015

Ross Edmunds
Division of Behavioral Health
Idaho Department of Health and Welfare
PO Box 83720
Boise, ID 83702

Dear Mr. Edmunds,

The Idaho Department of Correction (IDOC) supports Idaho's FFY 2016-2017 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The Block Grant goals to improve services and implement Evidence-Based Practices for **population agency services** are consistent with our organization's goals.

The Idaho Department of Correction (IDOC) has a history of collaborating with the Division of Behavioral Health (DBH) in an effort to provide best practice services to Idaho Citizens. The mission of our organization is to protect the public, staff and those under our custody and supervision. And our vision is focused on the care and development of staff, sound security practices, and a reentry system that enhances public safety. The Division of Behavior Health programs work with my staff to address issues of mutual concern. Successful collaborative efforts between the Department of Correction and the Division of Behavioral Health (DBH) already include service to individuals referred (frequently) through mental health and drug diversion courts. Assertive Community Treatment (ACT) teams work with court representatives to develop individualized treatment plans for court referred participants. Treatment plans are designed to help participants stabilize, learn life management skills and avoid additional criminal activities.

The Idaho Department of Correction (IDOC) plans to continue its collaborative efforts with the Division of Behavioral Health to help adults, youth and families navigate the challenges of life.

Sincerely,

KHK

Kevin Kempf, Director
Idaho Department of Correction

Idaho Department of Juvenile Corrections

954 W Jefferson Street P.O. Box 83720 Boise, ID 83720-0285 Phone: (208) 334-5100 Fax: (208) 334-5120

Telecommunications Relay Service (TRS) 1 800 377-3529

C.L. "BUTCH" OTTER
Governor

SHARON HARRIGFELD
Director

An active partnership with communities

Idaho Department of Juvenile Corrections

March 31st, 2015

Mr. Ross Edmunds
Idaho Department of Health and Welfare
Division of Behavioral Health
PO Box 83720
Boise, Idaho 83720-0036

Dear Mr. Edmunds,

The Idaho Department of Juvenile Corrections (IDJC) is fully supportive of the FFY 2016-2017 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant Application. The Block Grant goals of promoting improved services and implementing Evidenced-Based Practices for Idaho youth with emotional and behavioral disturbances, substance use disorders, and/or co-occurring disorders are consistent with IDJC's Mission.

Historically, IDJC has had a productive and collaborative partnership with the Division of Behavioral Health (DBH). One such collaboration was, and still is, the placement of a Mental Health Clinician in each of our county juvenile detention centers across Idaho. As we begin the ninth year of the program, the Clinician project's high success rate, documented through data collection, is confirmed by the number of youth being provided with mental health services within the facility, as well as in the community upon release.

The most recent collaboration with DBH, as well as Idaho Department of Correction and Idaho State Courts, is our Substance Use Disorder Services (SUDS). Through the Idaho Behavioral Health Cooperative, IDJC has realized a long needed treatment program for youth with substance use disorders. In its fourth year, IDJC SUDS Unit has developed into a highly effective and efficient SUD service delivery system; serving youth in juvenile justice at the local level. This program has offered youth immediate SUD services such as outpatient, inpatient, individual and family therapy, telehealth services, and availability of supplemental services. Our collaboration with DBH has been foundational to the success of treatment services for youth.

Idaho Department of Juvenile Corrections, specifically the Community Operations and Program Services Division, is hopeful that our continued collaboration with the Division of Behavioral Health will afford youth in our juvenile justice system the services and assistance essential to becoming successful and productive citizens in our communities.

Sincerely,

Marcy Chadwell

Marcy Chadwell, Division Administrator
IDJC Community Operations and Program Services

An active partnership with communities

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LISA HETTINGER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

August 14, 2015

Ross Edmunds, Administrator
Division of Behavioral Health
Idaho Department Health and Welfare
P O Box 83720
Boise, ID 83720-0036

Dear Mr. Edmunds,

The Division of Medicaid (Medicaid) supports Idaho's FFY 2016-2017 Combined Mental Health and Substance Abuse Prevention and Treatment Block Grant application. The goals of the Block Grant are to improve services and implement evidence-based practices for services which are consistent with our organization's goals.

Medicaid has a history of collaborating with the Division of Behavioral Health (DBH) in an effort to provide best practice services to Idaho citizens. The mission of our organization is to promote and protect the health and safety of Idahoans. DBH and Medicaid program staff work together on issues of mutual concern. Our programs have worked closely on the implementation and ongoing operations of the Idaho Behavioral Health Plan (IBHP). The DBH has been instrumental in the coordination of care for Idahoans that touch both Divisions. Together, our Divisions continue to research and implement evidence-based practices so we may provide appropriate care while still managing fiscal responsibilities.

The Division of Medicaid looks forward to continuing its collaborative efforts with the Division of Behavioral Health to help adults, youth and families navigate the challenges of life.

Sincerely,

Lisa Hettinger
Medicaid Director

LH/tm

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, 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.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. 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.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] 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.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C. Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Page 75 of the application Guidance

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, 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.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

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. ***Please consider the following items as a guide when preparing the description of the state's system:***

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

The Planning Council reviews and comments on the state plan. Recommendations from the Council are incorporated into the plan. The Council also has a standing Block Grant sub-committee which reviews the plan throughout the year. The plan is posted on the Council's website as well as the Department of Health and Welfare website for public review and comment. Comments are provided to the Council chair who then includes the comments and feedback into the Council's letter of support which is included as an attachment.

2. What mechanism does the state use to plan and implement substance abuse services?

Idaho uses separate systems for planning and implementing substance abuse prevention and treatment services. The Office of Drug Policy (Office) within the Idaho Governor's Office is responsible for management of the primary prevention portion of the Substance Abuse Prevention and Treatment Block Grant. The Office conducts a data –driven needs assessment to identify communities with the most significant risk factors. The Office consults with the Community Coalitions of Idaho, the State Behavioral Health Planning Council and the Regional Behavioral Health Boards to evaluate the needs assessment data and identify areas or communities with little or no prevention resources. These risk factors and communities are prioritized for prevention programming support.

The Division of Behavioral Health within the Single State Agency is responsible for the planning and implementation of substance use disorder treatment services. Because the Division's substance use disorder treatment services are primarily funded by federal grants, the priority populations are defined in the funding agreements. In Idaho substance use disorder treatment planning and

implementation activities focus on how clients will be served. This includes establishing standards of care, identifying areas with service gaps, seeking qualified agencies and professionals, developing mechanisms to serve clients these areas and evaluating client outcomes to improve services.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

As stated previously the Council has been reorganized into the State Behavioral Health Planning Council which includes substance abuse prevention and substance use disorders treatment service provider, consumer and advocate participants in their meetings. The Council is fully integrated and addresses both mental health and substance abuse prevention and treatment including co-occurring disorder issues. The Office of Drug Policy has provided an overview of the prevention system.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

The Mental Health Planning Council has one member of Hispanic origin. She has knowledge of the needs of the Hispanic population in Idaho as well as the Juvenile Justice system. As a part of the reorganization into the State Behavioral Health Planning Council, the Council now has representative from the Nez Perce Tribe. The Council has designated positions for transition aged youth, LGBTQ, youth, aging, veterans, family members of youth with SED and adults with SMI. The Council has strived to assure representation of membership from across the state. The Council membership is required to reflect the state's population and the majority of the members must be mental health and substance use disorder consumers and family members.

5. 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.

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

The duties of the Idaho Mental Health Planning Council are established in Idaho Code Title 39, Chapter 31 Regional Mental Health Services. The Council responsibilities include advocating for children and adults with behavioral health disorders, advising the State Behavioral Health Authority on issues of concern, policies and programs; providing guidance to the Mental Health Authority in the development and implementation of the state mental health systems plan; monitoring and evaluating the allocation and adequacy of mental health services within the state; ensuring 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 is also responsible to establish readiness and performance criteria for the regional boards to accept and maintain responsibility for family support and recovery support services. The planning council will 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 reports 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 recommends the regional behavioral health centers assume responsibility over the services until the board demonstrates it is prepared to regain the responsibility.

State Behavioral Health Planning Council

FY2015 Report to the Governor, State Legislature, and Judiciary

Supporting behavioral health systems that are coordinated, efficient, accountable, and focused on recovery.

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Introduction

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

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

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

Over the past year, the Behavioral Health Planning Council has embraced the transformation process by recruiting members in order to meet requirements of both state and federal law. A complete list of our membership may be found in Appendix 2.

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

Significant Events of Fiscal Year 2015

There were five significant events impacting behavioral health services in the state during FY 2015. Each of these events focuses on a different key area of behavioral health: crisis care, recovery support, children's mental health, access to care, and community support services.

Crisis Care: Additional Funding and Development of Crisis Centers

The Behavioral Health Crisis Center of East Idaho (initially funded by the legislature in 2014) began operation in December 2014. During the first quarter of 2015 the Crisis Center received over 250 visits and the average length of stay was about 9 ½ hours. Based on data collected by the Center, an estimated $200,000 has been saved in emergency room and law enforcement costs since the Center opened. Not only is money being saved, but also individuals in crisis are being treated, evaluated, and cared for in an appropriate setting.

During the 2015 Legislative Session, the legislature approved funding for an additional crisis center for northern Idaho. A Contract is in place with Kootenai Health in Coeur d'Alene for the North Idaho Behavioral Health Community Crisis Center.

Recovery Support: Funding for Recovery Centers

In the fall of 2014, the Idaho Association of Counties applied for $500,000 in Millennium Fund grant money to develop Recovery Community Centers (RCCs) in four counties of the state. The funding, approved during the 2015 legislative session, will help RCCs establish staffing, track data, and work toward their missions for one year in Ada, Canyon, Latah, and Gem counties.

These RCCs are community based, volunteer driven venues for individuals to work with peers toward sustained recovery from a mental health issue or substance use disorder. These centers provide support, meetings, classes, information, and more for people on any path to recovery, with programming that is influenced and customized by the input of each center's volunteers and visitors.

Children's Mental Health: Jeff D. Settlement Agreement

In December 2014, after a 15-month mediation process, the Jeff D Mediation Team successfully completed a Settlement Agreement which will achieve substantial compliance and fulfill the purposes of previous consent decrees. The Defense & Plaintiff Parties agreed that the best interests of the Jeff D Class Members would be advanced through a negotiated Settlement Agreement rather

than a continuation of adversarial litigation. With the assistance of a mediator to facilitate negotiations, the parties held seventeen (17) in-person mediation sessions and numerous sessions via conference call. The goals of the Agreement are “to develop, implement, and sustain a family-driven, coordinated, and comprehensive children's mental health service delivery system.”

The Jeff D. Lawsuit dates back to 1980 when the State was sued for violation of Class Members’ civil rights due to housing juveniles with adults at State Hospital South and not providing community-based mental health and specialized educational services to children with serious emotional disturbances (SED). Within a few years, a separate unit for adolescents was opened at State Hospital South.

Over the ensuing 34 years, there has been ongoing litigation to determine whether Idaho has substantially complied with the case's consent decrees to develop community based mental health treatment services. In October 2013, with approval of the District Court, the plaintiff and defendant parties agreed to move to a mediation process to resolve outstanding issues.

The mediation team was comprised of representatives from the State Attorney General’s Office, Idaho Department of Health & Welfare (DHW) to include Children's Mental Health, Child Welfare, and Medicaid; Idaho Department of Juvenile Corrections (IDJC); State Department of Education (SED) and Legal Counsel from all Departments. The Plaintiffs were represented by local attorney, Howard Belodoff, co-counsel from the Young Minds Advocacy Project in California, a parent of a child with SED, a family advocate, and a private provider.

As stated in Section I of the Settlement Agreement, “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 objectives of the Agreement are the development and successful implementation of a service array and practice model that are consistently and sustainably provided to Class Members statewide, in the manner prescribed (in the Agreement). 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 the needs.”

Upon approval by the District Court, the timeline for the Agreement will be activated. There are three phases lasting over a period of approximately eight (8) years for completion of the Agreement and eventual dismissal of the case. The development of an Implementation Plan will take approximately nine (9)

months. This will be followed by four years for the state to put the plan into action. The final three years are to ensure compliance and that a sustainable system is in place. Upon successful completion of the final stage, the case will be dismissed by the District Court. At the same time, a permanent injunction will be issued to ensure the services and supports developed in the Agreement will continue to be available to Class Members in future years.

The work that took place over fifteen (15) months was a collaborative effort of the entire mediation team. Due to the skills and experience of the out of state mediators and attorneys from the Young Minds Advocacy Project, members of the team were able to move past an adversarial environment and find common ground that promoted a shared vision and development of principles regarding care and services for Idaho's children. These unifying ideas became the foundation on which a comprehensive mental health system to meet the needs of children with SED was developed.

Access to Care: Idaho Telehealth Access Act

During the 2015 Legislative session, the Idaho Telehealth Access Act (HB189) was passed by the legislature. This act was a product of the Idaho Telehealth Council and provides structure and clarity to the practice standards surrounding telehealth. While there remains much work to be done in order to create a sustainable, easily accessible telehealth system for behavioral health services, this act is an important first step in providing a foundation for the future.

Community Support Services: Transformation of Regional Behavioral Health Boards

Transformation has been a topic of discussion in Idaho for the last several years and has now become a reality. The Behavioral Health Planning Council (Council) has worked diligently to provide information to the Regional Behavioral Health Boards (Regional Boards) that will help guide them to make the necessary changes that will encourage Transformation within the behavioral health system of care in Idaho.

The Council developed the readiness criteria for the Regional Boards to empower them to restructure and to develop partnerships and proposals to ultimately provide regional family support and recovery support services at the local level.

The Regional Boards have three options from which to choose: maintain the current system; partner with another entity; or become an independent entity.

These decisions remain with each Board to establish their own identity. A Gaps and Needs Analysis was designed to assist the Council in understanding the

service needs of the Regional Boards as they moved these projects forward and helped the regions to fulfill their obligations under Idaho Code § 39-3135.

The Council has also established an application process for the Regional Boards to follow and has a committee standing ready to review. Once the Region is determined to be able to provide the identified services, the Council will make a recommendation to the State Behavioral Health Authority.

We are in exciting times that have been a long time coming to Idaho. The opportunities that exist have the potential to improve not only the lives of our citizens, but our communities as a whole.

Other Events of Interest

Substance Abuse Prevention

Substance abuse prevention in Idaho has seen continued growth and successes during the past year. Eleven Idaho communities, through the Office of Drug Policy, were awarded Strategic Prevention Framework Grants to implement population level prevention strategies and an additional seven (7) awards are planned for next year. Additionally, forty-eight (48) prevention providers statewide were awarded funding from the Substance Abuse Prevention and Treatment block grant to deliver evidence-based prevention programs in their communities.

In the policy arena, prevention efforts have experienced success as well. Because of collaboration by interested stakeholders, legislation was passed that increases the accessibility of opioid antagonist medications that reverse an overdose caused by opiates. It is not often that we can point to a policy and say with certainty that it will save lives, but that is exactly what this new law will do. It is also noteworthy that, although surrounded by states with some form of legalized marijuana, Idaho was once again able to stave off legalization efforts.

Lifespan Respite Project

The Idaho Caregiver Alliance has taken a collaborative approach to solving the respite need for all Idaho caregivers. Recognizing that respite is a lifespan issue, they have conducted a needs and capacity assessment of the current system, convened stakeholders and caregivers at summits across the state, launched an emergency caregiver respite project, and supported the passage of the Caregiver Task Force Concurrent Resolution (HCR 24) during the 2015 legislative session.

Peer Specialists and Recovery Coaches

The DHW Division of Behavioral Health has been working through the Request For Proposal (RFP) process to secure contractors for both the mental health peer specialist program and the certified family support partner training. Additional contractors are being sought to develop specialty endorsement trainings in the areas of crisis center peer services, serving criminal justice populations, and peer support for individuals with co-existing disorders. The Division of Behavioral Health is also developing the certification process for both the Certified Peer Specialists and the Certified Family Support Partners. The development of these evidence-based practices provides significant opportunity for continued improvement within the behavioral health system.

The DHW continues to offer training and support for Recovery Coaches, who act as peer mentors and guides for individuals navigating recovery from substance use disorders. To date, more than 300 recovery coaches have been trained and they continue to work and volunteer in different capacities around the state. In addition to the initial 30-hour Recovery Coach Academy, an ethics training for recovery coaches was developed and delivered statewide. The DHW has worked closely with the Idaho Board of Alcohol/Drug Counselor's Certification (IBADCC) to develop a credential for recovery coaching which will provide the opportunity for coaches to potentially start a career track in the substance use disorder field.

Recovery Idaho

Established in March 2014, Recovery Idaho, Inc. has made significant steps as Idaho's Recovery Community Organization during the past year. Recovery Idaho obtained its 501(c)(3) nonprofit status in early 2015 after establishing its board, bylaws, and other legal documentation. Recovery Idaho's Board of Directors now includes thirteen (13) individuals from around the state of Idaho and the organization is in the process of recruiting an Executive Director. Recovery Idaho has also agreed to take responsibility for establishing and managing a RCC for Gem County and Emmett and is taking a coordinating role in the ongoing success of other RCCs around the state.

Justice Reinvestment

As a result of the Justice Reinvestment Initiative and legislative support in FY14, a supplemental enhancement of $2,469,714 was approved for Idaho Department of Correction (IDOC) SUD services (prorated in FY14 to $818,900). In FY15, with access to a full year of enhanced funding, IDOC will serve approximately 4,600 offenders. The supplemental enhancement of $2,469,714 allows IDOC to serve an estimated 1,100 additional probationers and parolees. Community-

based service delivery is through the private provider network, allowing IDOC to maintain public safety while avoiding the corresponding costs of service delivery during a period of state incarceration.

Integration of Physical and Behavioral Health

In December 2014, the DHW received a state innovation model grant from the Center for Medicare and Medicaid Innovation for $39,683,813. The grant will be used to fund a four (4) year model test to implement the Idaho State Healthcare Innovation Plan (SHIP). The primary goal of the grant is to demonstrate that the statewide healthcare system can be improved through coordinated care between primary care providers and other medical services including behavioral health specialists. This integration of physical and behavioral health recognizes the need to treat the “whole person” when addressing behavioral health challenges.

Suicide Prevention

The Idaho Suicide Hotline began operation in 2012 and has received over 6,000 calls since that time. Beginning in November 2014, the Hotline began operating twenty-four (24) hours a day, seven (7) days a week. Currently, they have seventy-three (73) volunteers trained and they have already answered 1,900 calls during the first few months of 2015. The impact this hotline has made on the lives of Idahoans is significant and funding should continue to support this critical link in our behavioral health system. In the coming months the hotline will begin training its volunteers in crisis text response, a program that has shown great success in other states, especially with young adults and adolescents.

Suicide Prevention Action Network of Idaho (SPAN Idaho) promotes activities statewide with its chapters. In the last year, they held memorial walks in five (5) regions of the state, distributed prevention and awareness materials at a variety of community events (often with the Idaho Suicide Prevention Hotline), provided dozens of gatekeeper trainings to schools, churches, and other community organizations (including the Idaho Tax Commission statewide), and other activities. To help with the grieving process, SPAN also supports survivors of loss to suicide with regional groups and information packets.

In partnership with the Idaho Department of Education, SPAN administers the Substance Abuse and Mental Health Administration’s Garrett Lee Smith grant as the Idaho Lives Project (ILP). With these funds, they bring Sources of Strength to middle and high schools and juvenile justice centers around Idaho. Sources of Strength is a resiliency, peer-based, best practice and research-based program shown to reduce suicide and other risky behaviors among adolescents and through early adulthood. In the last year and a half, the ILP invited Dr. David Rudd to train 1,200 mental health and health care professionals in suicide risk management and assessment for their clients.

Specialty Courts

Thanks to the Idaho Legislature's continued commitment to recidivism reduction and offender accountability, there are sixty-seven (67) problem-solving courts that provide a cost effective alternative to incarceration. These courts consist of a multidisciplinary team, led by a judge that integrates treatment and accountability to reduce recidivism and return offenders to their families. There are Drug and DUI Courts that primarily deal with participants' substance use disorder and recovery support needs, and Mental Health Courts that specialize in serving offenders with a severe and persistent mental illness with Assertive Community Treatment provided by the DHW and community providers. The Idaho Departments of Correction, Health and Welfare, and Juvenile Corrections work collaboratively with the Judicial Branch on a myriad of behavioral health and substance use disorder issues.

Medicaid/Optum

Optum hired Field Care Coordinators in each region to collaborate with community partners to reduce service gaps for individuals transitioning between different levels of care and to provide additional support and consultation for Optum members, their families, and the providers who serve them.

Substance Use Disorder (SUD) Treatment

The DHW was selected as one of five (5) recipients of the Access to Recovery 4 (ATR 4) grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of ATR 4 is to increase access to substance use disorder treatment services while focusing on a client-centered approach with client choice in treatment services and planning. The ATR 4 grant provides funding for both Treatment and Recovery Support Services to assist clients in long-term recovery.

The grant funding will serve the following populations over a three-year period:

- Veterans with a SUD who have committed a crime and are on supervised probation or parole.
- Child Welfare families, specifically parents with a SUD and involvement in Child Welfare Court.
- Individuals and families experiencing homelessness both unsheltered and sheltered.

Substance Use Disorder Treatment Providers are very excited to be able to offer services to voluntary populations such as the homeless rather than just criminal justice clients and anticipate this funding will help many underserved Idahoans.

Ongoing Behavioral Health Planning Council Activities

- The Council is committed to supporting and monitoring Regional Behavioral Health Boards through attendance at regional board meetings, participation in monthly regional board chair phone calls, and development of transformation support materials.

- The Council encouraged all regions to complete and submit gaps and needs reports to the Council. This information was reviewed by the Council and used to complete this report. An overview of the gaps and needs can be found in Appendix 3. Additionally, each region's gaps and needs analysis can be found under the "reports" heading of our website: http://healthandwelfare.idaho.gov/Medical/MentalHealth/MentalHealthPlanningCouncil/tabid/320/Default.aspx .

  A more detailed statewide gaps and needs analysis is found on our website: http://healthandwelfare.idaho.gov/Portals/0/Medical/Mental%20Health/BHPC/RBHBGapsNeeds2014statewide.pdf.

- The Council supports quarterly statewide children's subcommittee network phone calls in cooperation with Idaho Federation of Families for Children's Mental Health to encourage the sharing of ideas related to children's mental health issues.

- The Council is committed to modeling an integrated behavioral health system through our inclusive membership, discussions, and actions.

- The Council created, and will continue to update, a statewide directory of prevention programs and providers. The document can be accessed via our website using this link http://healthandwelfare.idaho.gov/Portals/0/Medical/Mental%20Health/BHPC/2015%20Idaho%20Prevention%20Programs%20Directory.pdf .

- The Council is encouraging and supporting the Regional Behavioral Health Boards to remain connected with legislators through regional legislative events and sharing of information related to specific behavioral health needs in their regions.

Challenges for Fiscal Year 2016

- There continue to be service gaps for people below 100% of poverty, especially those without children. The Council supports efforts that will allow all Idaho residents to have access to health care coverage.

- Services and support for both children and adults in a mental health crisis is a critical component of treatment. The Council supports all efforts to establish additional crisis centers across Idaho to allow individuals in crisis to receive services in a setting other than a hospital or emergency room. Additionally, the Council supports a crisis support model for children that will allow them to receive support in a mental health crisis without unnecessary involvement of law enforcement or emergency room personnel.

- Respite is a critical support service for families that is not a covered under Medicaid or most private insurance. The Council supports efforts to find ways to develop a respite framework that meets needs across the lifespan and supports caregivers.

- Continued financial support will be needed for the establishment of additional community recovery centers in counties across the state. The Council supports the continued establishment of these centers.

- The reality that an adult or juvenile must be criminally involved in order to access behavioral health treatment still exists in many situations. The Council supports efforts to reduce the stigma of behavioral health treatment and create a system where treatment is accessible prior to involvement with the justice system.

- Challenges remain when attempting to access appropriate services for children with the most complex behavioral health needs. While the Jeff D. settlement addresses these issues, the actual implementation of that agreement is necessary in order for these children to begin to get the treatment they need. The Council supports all efforts to create an efficient, effective, and sustainable system as designed in the Jeff D. settlement agreement.

- There remains a need for more psychiatrists in our state, especially in our rural and frontier areas. The Council supports efforts to encourage recruitment and retention of both traditional and telehealth psychiatrists.

Closing

In closing, the Council would like to express our gratitude for the supportive actions of the Governor and the Legislature with regards to the behavioral health system this past year. We appreciate the passage of legislation strengthening anti-bullying regulations in schools, funds for a second crisis center, funding support for establishing four (4) community recovery centers, and passage of the Telehealth Access Act. Additionally, we appreciate you showing support for caregivers through the development of the Idaho Caregiver Task Force, and support for the Jeff D. mediation process and subsequent

agreement as well as the expansion of a regional medical education program known as WWAMI (an acronym representing the states it serves) to help with recruitment and retention of psychiatrists. Actions such as these do not go unnoticed by advocates and we are grateful for your support in the continued improvement of Idaho's behavioral health system.

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

Appendix 1: Idaho Code § 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.

Appendix 2: State Behavioral Health Planning Council Membership

State Behavioral Health Planning Council - 2015			
Name	**Region** **Type of Membership**	**Agency or Organization Represented**	
Rosie Andueza 7/15/14 Appointment Expires 7/1/15 – reapplied	Agency/Provider of Service	Behavioral Health	
Evangeline (Van) Beechler 2/23/15 Appointment Expires 7/1/16	Advocacy/ Consumer/Family Region IV	LGBTQ Representative	
Abraham Broncheau 2/23/15 Appointment Expires 7/1/17	Advocacy/Consumer/Family Region II	Tribal Representative	
Bujarski, Jo Ann 12/30/14 Appointment Expires 7/1/16	Agency/Provider of Service	Department of Education	
Stan Calder 7/15/14 Appointment Expires 7/1/2015	Advocacy/Consumer/Family Region 1	Family Member of an Adult/ Aging Community Mental Health	
Elda Catalano 7/15/14 Appointment Expires 7/1/2015 – Reapplied	Advocacy/ Consumer/Family Region III	Hispanic Representative	
Carol A. Dixon 7/15/14 Appointment Expires 7/1/15	Advocacy/ Consumer Family Region IV	Certified Family Specialist	
Jane Donnellan 7/15/14 Appointment Expires 7/1/15	Agency/Provider of Service Region IV	Vocational Rehabilitation Representative	
Martha Ekhoff – Chair 7/15/14 Appointment Expires 7/1//2016	Advocacy/ Consumer/Family Region IV	Certified Peer Specialist	
Judy Gabert New Appointment	Advocacy/Consumer/Family	Advocacy Organization SPAN Idaho	

Name	Region and Type of Membership	Agency or Organization Represented	
Jennifer Griffis 7/15/14 Appointment Expires 7/1/2015 – Reapplied	Advocacy/ Consumer/Family Region II	Family Member of a child/adolescent/ Transitional Youth Mental Health	
Rick Huber 7/15/14 Appointment Expires 7/1/15 – Reapplied	Advocacy/Consumer/Family Region V	Consumer/Client/ Person in Recovery Mental Health	
Susan Kim, Jardine-Dickerson 7/15/14 Appointment Expires 7/1/15	Advocacy/Consumer/Family Region VII	Suicide Survivor self or family	
Marianne C. King 7/15/14 Appointment Expires 7/1/15- Reapplied	Agency/Provider of Service Region IV	Office of Drug Policy	
Leanna Landis 8/13/14 Appointment Expires 7/1/16	Advocacy/ Consumer/Family Region IV	Transitional Aged Youth (18-25)	
Gregory Lewis New appointment	Agency/Provider of Service Region IV	Adult Corrections	
Pat Martelle 2/20/15 Appointment Expires 7/1/16	Agency/Provider of Service Region IV	Medicaid	
Bobbi Matkin 11/17/14 Appointment Expires 7/1/16	Advocacy/ Consumer/Family Region VI	Peer Specialist	
Holly Molino 7/15/14 Appointment Expires 7/1/15 – Reapplied	Agency/Provider of Service Region VII	Mental Health Treatment	
Angela Palmer 8/13/14 Appointment Expires 7/1/16	Agency/Provider of Service Region I	Substance Use Disorder Treatment Provider	

Name	Region and Type of Membership	Agency or Organization Represented	
Tammy K. Rubino 7/15/14 Appointment Expires 7/1/16	Advocacy/ Consumer/Family Region I	Community Coalitions	
Jody E. Sciortino 7/15/14 Appointment Expires 7/1/16	Agency/Provider of Service Region V	Youth/Corrections	
Judge Jon Shinderling or Judge Ron Wilper 8/27/14 Appointment Expires 7/1/16	Agency/Provider of Service Region V	Judiciary	
Julie Williams 8/15/14 Appointment Expires 8/1/2015 - Reapplied	Agency/Provider of Service Region IV	Division of Housing	
Teresa Wolf 7/15/14 Appointment Expires 7/1/2016	Agency/Provider of Service Region II	Counties	
EX –OFFICIO Program staff: Ross Edmunds Jayne Tabb	Agency Agency	Behavioral Health Program	
Positions to be filled:			
	Agency/Provider of Service	Social Services	
	Agency/Provider of Service	Primary Care Provider	
	Advocacy/ Consumer/ Family	Youth under age 18	
	Advocacy/ Consumer/ Family	Veteran	
	Advocacy/ Consumer/Family	Consumer/SUD Person in Recovery	
Current - Advocacy/Consumer Family: Member Totals: 13	Current - Agency/Provider of Service: Members Totals: 12	Current - Total Membership: 25	

Appendix 3: Summary of Regional Gaps and Needs Analysis

Regional Gaps and Needs General Overview
April 2015

Population Specific Concerns

Mental Health Services*

- limited access in rural areas
- difficult to access without criminal justice involvement
- limited psych bed availability
- need for a back-up plan when psych beds unavailable
- more psychiatrists needed for treatment and medication management

Substance Use Disorder Services*

- limited access in rural areas
- lack of detox services
- gaps in funding, especially related to prevention and early intervention

Children's Behavioral Health Services*

- youth mental health court
- lack of services for non-criminally involved at-risk youth
- reduction in Community Based Rehabilitation Services(CBRS)
- need for day treatment and therapeutic foster care
- need for school-based MH/SUD services including prevention and intervention
- need for parent education and training
- need for post-adoption/reactive attachment disorder services and supports

System Concerns

- need better integration between MH and SUD services within the Medicaid/Optum system, as well as treatment and services for those with dual diagnosis (SUD and MH) *
- lack of payment to providers in order to create "process paperwork"
- lack of clarity around desired outcomes from behavioral health authority
- lack of preventative medical care for those with BH issues
- need for an integrated BH and physical health model
- specialty court client issues

Gaps in Support Services

- housing*
- transportation*
- interpreter and language services* (Spanish and deaf)
- employment opportunities for MH and SUD clients

Gaps in Clinical Services

- respite care (children and adult)
- crisis services (children and adult)*
- financial help for medication (children and adult)
- education (public outreach, awareness, media relations, early intervention and prevention, support groups, promotion of recovery, resiliency, and wellness)*

Other Needs

- CIT training
- trauma informed care
- drug endangered children's protocol

* These items were mentioned by at least five (5) of the six (6) regions that reported.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Martha Ekhoff	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		662 Gamay Lane Boise, ID 83702 PH: 208-914-2234	mekhoff125@gmail.com
Kim Jardine-Dickerson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		ISU School of Nursing, 921 S. 8th Ave, Stop 8010 Pocatello, ID 83201 PH: 208-282-1102	jardsvsa@ISU.edu
Tiffany Kinzler	State Employees	Medicaid	Medicaid, 3232 Elder St. Boise, ID 83705 PH: 208-346-1813	KinzlerT@dhw.idaho.gov
Julie Williams	Others (Not State employees or providers)	Idaho Housing & Finance	Idaho Housing and Finance, P.O. Box 7899 Boise, ID 83707-1899 PH: 208-331-4758	Juliew@ihfa.org
Teresa Wolf	Providers		Nez Perce County, P.O. Box 896 Lewiston, ID 83501 PH: 208-799-3095	teresawolf@co.nezperce.id.us
Stan Calder	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1785 Windsor Coeur d'Alene, ID 83813 PH: 208-333-1638	stanleysteamer51@yahoo.com
Jennifer Griffis	Parents of children with SED		155 Cheyenne Drive Grangeville, ID 83815 PH: 208-983-0513	jengriffis@gmail.com
Rick Huber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		309 Pashermakay Court #7 Rupert, ID 83350 PH: 208-436-1841	rick2727272000@yahoo.com
Elda Catalano	Others (Not State employees or providers)		Canyon County, 1115 Albany St. Caldwell, ID 83605 PH: 208-454-7300	ecatalano@canyonco.org
Carol A. Dixon	Others (Not State employees or providers)		704 N 7th St Boise, ID 83702 PH: 208-433-8845	cdixon@idahofederation.org
Jane Donnellan	State Employees		650 W State ST Boise, ID 83702 PH: 208-834-3390	jane.donnellan@vr.idaho.gov
Judy Gabert	Others (Not State employees or providers)		SPAN Idaho, 18314 Madison Nampa, ID 83687 PH: 208-866-1703	jgabert@spanidaho.org
Marrianne C. King	State Employees	Office of Drug Policy	Bosie, ID 83702 PH: 208-854-3043	marianne.king@odp.idaho.gov
Leanna Landis	Individuals in Recovery (to include adults with SMI who are receiving, or		4526 W Brennen St Boise, ID 83705	leannalandis@u.boisestate.edu

	have received, mental health services)		PH: 720-238-7228	
Gregory Lewis	State Employees	Idaho Department of Correction	2400 N 36th St Boise, ID 83703 PH: 208-658-2034	glewis@idoc.idaho.gov
Bobbi Matkin	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2511 East Hill Road Eagle, ID 83616 PH: 208-233-2595	bmatkin@jannus.org
Holly Molino	Providers		422 Napa Dr Idaho Falls, ID 83404 PH: 208-705-6758	holly@accesspointkids.com
Angela Palmer	Providers		1200 Ironwood Dr, Ste 101 Coeur d'Alene, ID 83814 PH: 208-667-2979	angela.palmer@sequelyouthservices.com
Tammy Rubino	Family Members of Individuals in Recovery (to include family members of adults with SMI)		10617 N Lakeview Dr Hayden, ID 83835 PH: 208-651-6335	communitycoalitionsofidaho@gmail.com
Jody Sciortino	State Employees	Idaho Department of Juvenile Corrections	2724 S Wise Way Boise, ID 83716 PH: 208-577-5439	jody.sciortino@idjc.idaho.gov
Judge Jon Schinderling	State Employees		PH: 208-589-2604	jshindurling@co.bonneville.id.us
Rosie Andueza	State Employees	Idaho Department of Health and Welfare	450 W State St Boise, ID 83702 PH: 208-334-5934	anduezar@dhw.idaho.gov
Evangeline Beecher	Others (Not State employees or providers)		3314 N 32nd St Boise, ID 83703 PH: 208-353-7896	ebeechler@gmail.com
Abraham Broncheau	Federally Recognized Tribe Representatives		803 Hill Street Kamiah, ID 83536 PH: 208-935-8028	abebwolfis@gmail.com
Jo Ann Bujarski	State Employees	Department of Education	522 Welch St Meridian , ID 83646 PH: 208-288-1324	jbujarski@sde.idaho.gov
James Meers	Others (Not State employees or providers)		4325 E Stonebridge Dr Meridian, ID 83642 PH: 208-602-3184	
Sandra McMichael	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 388 Plummer, ID 83851 PH: 208-686-1449	

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	30	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	1	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	6	
Total Individuals in Recovery, Family Members & Others	17	56.67%
State Employees	8	
Providers	3	
Federally Recognized Tribe Representatives	1	
Vacancies	1	
Total State Employees & Providers	13	43.33%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	2	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Mr. Richard Armstrong
Idaho Department of Health and
Welfare Division of Behavioral Health
450 West State Street
Boise, ID 83720-0036

Dear Mr. Armstrong:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Casey Moyer
Martha Ekhoff

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory