

BEHAVIORAL HEALTH INTERAGENCY COOPERATIVE STATUS REPORT TO THE GOVERNOR DECEMBER 22, 2011

The Behavioral Health Interagency Cooperative (Cooperative) is pleased to present this report to the Governor Butch Otter, describing the status of its work since the execution of Executive Order 2011-01 on January 27, 2011. Since that time, the Cooperative has been working to:

Facilitate transformation efforts outlined in the October 2010 Behavioral Health Transformation Plan with consideration for fiscal restrictions in Idaho's budget, current needs of agencies, and recommendations of the Idaho Health Care Council. (EO-2011-01)

The Transformation Plan recommends the integration of the mental health and substance use disorder (SUD) systems. The Cooperative itself implemented that intent by assuming continued responsibility for the coordination of substance use disorder systems and services with the sunset of the Interagency Committee on Substance Abuse in June, 2011. The coordination effort took on new meaning as the 2011 State Legislature divided substance abuse funding by the four entities responsible for securing treatment services, including the Courts, Department of Correction (DOC), Department of Juvenile Corrections (IDJC), and the Department of Health and Welfare (DHW).

This report presents:

1. The status of agency coordination and application of that SUDS funding;
2. How that coordination effort and cross-agency quality assurance efforts are intended to evolve into the integrated behavioral health system,
3. The status of the Cooperative's progress in developing a regionally focused behavioral health system; and
4. Recommendations on which to *act* to start making the behavioral health system a reality.

1. Status: SUDS Funding

The Joint Finance Appropriations Committee (JFAC) appropriated substance use disorders treatment funding to the Courts, DOC, IDJC, and DHW in the 2011 Legislative session. In the past, all SUD funding was appropriated to DHW.

Within this new structure, DHW continues to administer the contract with the management services contractor, Business Psychology Associates (BPA). The Courts, DOC, and DJC were appropriated treatment dollars for certain populations. DHW was appropriated the funding for its intended populations and the administration of the SUD system. DHW is currently working on a BPA contract amendment which will move to a Master Contract to cover general contract provisions and separate Service Level Agreements (SLA) for the Courts, DOC, IDJC, and DHW. Currently DHW pays BPA for all services and then DHW is reimbursed by the Courts, DOC and IDJC. The new contract will allow BPA to directly bill each entity for the funded populations.

Early indication is that the new appropriation structure is effective at managing the budget and meeting the needs of the target population. The Courts, DOC, IDJC, and DHW are committed to

remaining consistent in the measurement of outcomes and standards of care, however, each have approached the funding change differently and in a way that addresses the special circumstances of the populations for which they are responsible. Below is a brief description of how each has structured their delivery system.

Courts

The Courts are responsible for all problem-solving courts except Child Protection Drug Court, which is the responsibility of DHW due to grant requirements. In this initial year, the Drug Court and Mental Health Coordinating Committee (pursuant to I.C. 19-5601) approved a plan for the administration of \$4,827,700 appropriated to the Supreme Court for funding substance use disorder treatment in problem-solving courts, consistent with best practices as identified in the Drug Court Standards and Guidelines for Effectiveness and Evaluation. The plan included a treatment voucher for 545 days (consistent with the drug court model and best practices), providing problem solving court coordinators the ability to authorize and discontinue treatment, continuing to compile and distribute monthly reports to the problem-solving courts to better inform them of their expenditures by provider and by offender, a change in direct client services administered by Business Psychology Associates (BPA) from a fee per service model to a reduced flat rate, and the need to continue to work with BHIC towards the development of a quality assurance process and to report on shared data elements.

Department of Correction

In its appropriation, DOC was assigned the felon criminal justice populations, minus those involved in drug court. This population includes those referred into treatment under Idaho Code 19-2524, risk to revoke, rider/parole reentry, and Easter Seals Goodwill Project.

DOC has implemented regional intake and diagnostic teams in each District Probation and Parole Office to manage the assessment, treatment recommendation, reporting to the courts prior to sentencing as well as post sentencing treatment for rider and parole reentry offenders. Additionally, the DOC, in collaboration with DHW, have identified specific DHW clinical staff to be assigned to each district probation and parole office to better facilitate the evaluation needs of Idaho Code 19-2524 offenders in preparation for sentencing.

DOC has created a detailed voucher system for the delivery of substance use disorder services. Working in collaboration with managed service contractor BPA, the SUDS Administrative team direct and monitor all services with best practice and fiscal confines as the basis for service. The IDOC field service clinical teams provide diagnostic evaluations and direct service for rider and parole reentry offenders. The network of providers, managed by BPA, continue to provide the core direct and recovery support services the Idaho Code 1925-24, risk to revoke and Easter Seals Good will Project populations.

The public/private partnership will allow for more control over entry into treatment, level of care, and length of stay. The enhanced controls allow the department to better monitor utilization, cost, and public safety concerns.

Department of Juvenile Corrections

The SUD treatment appropriation made to IDJC was targeted to serve justice involved youth not currently served by a juvenile drug court. These youth are typically already on probation and therefore are already being served by county probation officers under the jurisdiction of the court.

Providing effective SUD treatment for this population in the community benefits the juvenile and family; helps to protect community safety and may also help to avoid the costs of commitment to IDJC custody. In the new system, counties by judicial districts have created regional teams that make all decisions regarding treatment of their juvenile probationers. IDJC works closely with the counties to manage the funds by carefully reviewing billing for services and by reporting monthly on utilization and costs for each county and region. Decisions about the allocation of these funds may then be made based upon solid data.

As the SUD treatment program for juvenile justice involved youth operates today, there is funding and flexibility to address current needs as identified by District SUDS Teams. IDJC works continually and successfully with BPA and IDHW to address client and process problems as they arise. The new system has addressed provider concerns directly and specifically as those have been identified. IDJC works with District Teams to refine tools used for SUDS case decision making and will be enacting plans to provide further flexibility to support needed services for those counties who may expect to exceed their individual allocation of funds. Feedback from the judiciary, from county probation and from many providers has been overwhelmingly positive.

The juvenile justice system has accomplished these objectives while maintaining strict adherence to IDHW promulgated rules for SUD providers and for the most part services have been provided by BPA network providers. County probation departments across the state have done remarkable work to engage juveniles and families who are ready to change. They have engaged providers in offering the most appropriate services for appropriate lengths of time and they work closely with IDJC in managing budget.

Department of Health and Welfare

DHW responsibilities include Access to Recovery (ATR) grant clients (supervised misdemeanants, juveniles returning to communities from a county detention or correctional facility, and military), non-criminal justice adults and juveniles, clients re-entering communities from state hospitals, Medicaid-Only, federal block grant clients (pregnant women and intravenous drug users), child protection SUD referrals, Child Protection Drug Court and general misdemeanor clients. The FY 2011 SUD treatment budget was over-spent by \$2.5 million and all of that liability was covered from the IDHW FY 2012 appropriation. This creates a challenge in providing services for all of these populations in FY2012.

Result

Each partner in this effort is now able to both focus more directly on client populations and better fiscally manage their treatment budget. The process to accommodate the appropriation change has been a complicated one, but one that is creating a more manageable SUD treatment system. The table below provides an accounting of the agencies' appropriation, treatment budget, year to date expenditures, and client counts.

Note that the Treatment Budget is the portion of the appropriation that is identified for services to clients. The difference between the appropriation and the treatment budget are funds spent for activities other than direct substance abuse treatment services. Specifically,

- The Supreme Court has allocated \$4,727,695 for treatment from the \$4,827,700 substance use disorder appropriation. This is based on a formula of \$3,945 per adult and juvenile drug court slot. The \$100,005 of unallocated funds is currently held in reserve for the hiring of two positions to assist in the administration of the appropriation.

- Of the DOC appropriation, \$1,083,400 is dedicated to the Bonneville Project and \$4,787,600 to direct services, leaving \$1,501,300 for sixteen (16) direct service and six (6) administrative personnel and overhead and expenses.
- For IDJC those funds designated as Treatment Services includes the portion of the appropriation that is identified only for direct services to juveniles. \$256,400 of the IDJC Juvenile Justice SUD appropriation includes the costs of case processing fees formerly paid to the management services contractor (MSC). Having state and county personnel handle many of these functions will reduce payments to the MSC and provide for the administrative costs necessary to exercise sound internal controls without dedicating additional treatment funds for this purpose.
- DHW covered the entire FY2011 overspend (\$2.45 million) within its allocation, and it has a Federal Substance Use Disorders block grant requirement for maintaining funds spent on prevention activities (\$1.6 million).

Entity	Appropriation	Treatment Budget	YTD Expenditures	Unduplicated Client Count
Courts	\$ 4,827,700	\$ 4,727,695	\$ 1,477,472	1,287
DOC	7,372,300	5,871,000	2,010,607	1902
IDJC	4,032,000	3,775,600	609,282	479
DHW	10,804,000	6,753,615	2,863,289	3,934

2. Cross-Agency Quality Assurance

With regard to system coordination and transformation plan implementation, the Cooperative adopted the following three coordinated operating guidelines.

1. Web Infrastructure for Treatment Services. WITS is an internet-based electronic health record used by state contracted substance use disorder treatment providers. The technology complies with HIPAA and meets state and federal reporting requirements. It allows providers to assess patients, manage treatment, bill, and collect outcomes measurements real time. In October, 2009 DHW integrated Adult Mental Health services into the system; in July 2011, Children's Mental Health. This operational guideline confirms the Cooperative's intent to partner and pursue the use of the system effective July, 2012. The initiative affords systems and providers the opportunity for real-time information, process and treatment efficiencies, and a continuum of service to consumers and families across the behavioral health spectrum.
2. Quality Assurance. This operational guideline reflects the initial agreement of all Cooperative entities to accept responsibility to measure the quality and performance of treatment providers, including the achievement of system and client outcomes in the behavioral health system. The guideline goes on to describe those shared expectations in more detail.
3. Service Standards and Provider Guidelines. This guideline formalizes the role of the State Behavioral Health Authority (Department of Health and Welfare) in developing statewide service standards and provider qualifications, as well as the Cooperative members' role in reviewing and confirming the service standards and provider qualifications as developed by the Authority. The Department's role as a Behavioral Health Authority was a key recommendation of the Transformation Plan of October 2010, as well as of the WICHE report of 2009.

Additionally, the Cooperative is generating a fourth operational guideline regarding Outcomes Reporting. In order to ensure the system is one that effectively reports results across systems and positions the Cooperative to make meaningful system-side decisions, the Cooperative identified an initial series of data for which they have shared definitions and will report collectively. The Cooperative also identified a list of data elements to be defined and developed over the next year for which they intend to report collectively in the future, and which features an outcomes-based approach. Cooperative entities will continue to report about the populations they serve in a manner that most appropriately reflects their unique roles in the system.

The Operational Guidelines address the immediate needs for SUDS system coordination and efficiency, with the intent to apply the shared guidelines and processes through the integrated behavioral health system as it becomes a reality. While these guidelines have direct applicability to the four entities with SUDS funding, they have been developed with the attention and input of all of the members of the Cooperative, knowing that they will become the baseline on which the coordination of the entire system is based, and they will influence proposed regional entities' future roles and requirements within the system.

3. Progress: Regionally Focused Behavioral Health System

The *Transformation Plan* proposes a structure featuring a regionally-focused behavioral health system, and presents a proposed structure. Seeking to implement this recommendation, the Cooperative asked two regions to propose what an effective and meaningfully regionally-based structure would look like from their perspective. The Cooperative sought to understand the regional preferences regarding a structure, and hoped to be able to pilot or in some fashion pursue the development of such a structure in order to test its effectiveness.

Proposed regional structures were presented at the November 2, 2011 meeting of the Cooperative. At that time, the Cooperative recognized that a "pilot" of either proposed structure - both of which require statutory change and establishment of fiscal entities - was probably not realistic. Instead, the Cooperative sought another discussion with the regions to explore how to move forward with a regional entity in a manner that meets the objective for regional leadership and coordination of community-based behavioral health services in a manner that addresses regional and Cooperative entity needs.

Subsequent to that third set of meetings, region 7 stakeholders revised their proposed structure to look more like Region 2's. Both regions feel strongly about moving forward with the generation of the regional entity, and seek the Cooperative's support in making that happen legislatively. Both regions intend to move forward on their own initiative to pull together the work of the Regional Advisory Council's and Regional Mental Health Boards to effect a coordination of mental health and substance use disorder interests, and to use their collective resources to try to pursue grant funding, potentially using their respective Public Health Districts as a fiscal agent.

The Cooperative discussed those proposals at its November 21, 2011 meeting. In response, the Cooperative formed a Behavioral Health Legislative Proposal Subcommittee to craft language for proposed legislation that describes a new system featuring regional entities to coordinate community-based services. Details of that effort and copies of that Cooperative product are forthcoming. Inputs to that product include a body of work on behavioral health conducted in recent years, including the Regions 2 and 7 proposed structures for the Cooperative (2011),

Transformation Plan (2010), WICHE Report (2008), and the work of the Legislative Council Interim Committee (2006).

4. From Recommendations to Reality: Call to Action

Idaho State Planning Council on Mental Health to Idaho's Behavioral Health Planning Council

The Cooperative proposes that the Governor pursue the modification of the Idaho State Planning Council on Mental Health (Idaho Code 39-3125) to become Idaho's Behavioral Health Planning Council. This integration of the advocacy and advisory role of the Council will help drive the integration of the behavioral health system on behalf of consumers and families. Language intended for revision to 39-3125 is included as Attachment A for review and use by the Governor's Office. It comes with the full support of the Cooperative members and the members of the existing Planning Council.

Regional Structure

The Cooperative continues its important work to develop proposals for regionalized community-based services for the behavioral health system. As the Cooperative develops these proposals, they will be delivered to the Governor for consideration.

ATTACHMENT A: State Behavioral Health Planning Council - Language for Statutory Changes

Description of the Transformation Workgroup proposal to develop the State Behavioral Health Planning Council

Introduction

The integration of the mental health and substance use disorder systems into a single behavioral health system necessitates a full capture of the mental health and substance use disorder perspective both at the state-level advocacy and advisory levels. Furthermore, the federal application and reporting processes for the Community Mental Health Services and the Substance Abuse Prevention and Treatment Block Grants have been combined to promote consistent planning across both systems. The purpose for changing to a State Behavioral Health Planning Council is to carry out these federal changes, but also to help drive the integration of the behavioral health system from an advocacy standpoint.

The existing State Mental Health Planning Council has served an important role in the current mental health system and will continue as transformation evolves. The transformation process includes many of the current functions and responsibilities of the Council as per Idaho Code 39-3125. The Council's work is key to securing the federal Block Grant for Community Mental Health Services which helps fund these services, as described in 42 U.S. Code § 300x et seq.

Role and Responsibilities

Responsibilities of the State Behavioral Health Planning Council are to:

- Provide comment on publically funded entities' plans that may impact behavioral health services and submit recommendations as appropriate. Provide guidance to the State Mental Health Authority in the development and implementation of the State Behavioral Health Systems Plan.
- Advocate for adults with severe mental illness (SMI) and children with identified behavioral and/or emotional disorders; adults and children with substance use disorders; and other individuals with mental illness or emotional problems to ensure that individuals have access to treatment, prevention, and rehabilitation services including those services that go beyond the traditional mental health system.
- Collaborate with stakeholders statewide to promote prevention, effective treatment, recovery, and resiliency.
- Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health and substance abuse services within the State.
- Provide a report to the Governor and Legislature each year by June 30th on the council's achievements and the impact on the quality of life that mental health and substance use services has on citizens of the state.

The State Planning Council consists of volunteers who advocate on behalf of individuals with mental illness and will expand to include substance abuse issues as outlined by transformation. The Council's advocacy efforts include monitoring the changes in statute and rule that effect individuals receiving or accessing behavioral health services. The Council will continue to promote recovery efforts, prioritize and address concerns, stay informed on changes in service provision and the impacts, and keep behavioral entities in the seven regions informed about current issues. The present and the increasing responsibilities of the Council as outlined by transformation needs to be addressed by providing staffing

for the Council's use in order to remain effective, efficient and professional in the Council's correspondence, reporting, and monitoring.

Membership and Appointments

Proposed membership is to be consistent with federal requirements and also inclusive of substance use disorders and suicide prevention. Regional representation is specifically required to integrate regional needs and advocacy into the Council's deliberations and processes. Not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services, not including ex officio members. The respective ratio of parents of children with a serious emotional disturbance will be considered to other members of the Council. The State Planning Council shall strive to be inclusive, balanced, and representative of a broad spectrum of entities with interest in behavioral health issues and concerns, while being mindful of the need to keep the Council as small and functional as possible.

The State Planning Council shall notify the Regional Behavioral Health Community Development Boards or other entities when a vacancy appears on the Planning Council. The nomination(s) will be sent to the Executive Committee for approval and submitted to the Governor for consideration. Individuals who are nominated must complete an application and submit it to the Special Assistant for Boards and Commissions in the Governor's office. The Governor's office will notify the State Planning Council once an appointment has been approved.

Proposed membership includes:

- Consumers and family representation, from throughout the state, amongst the seven Regional Boards, and through an advocacy organization to ensure the perspectives of adults with serious mental illness, children with emotional disturbance, and individuals with substance use disorders are well represented.

The membership shall also be inclusive of one representative of each of the principal state and governmental agencies, entities, or their subsidiaries as outlined in this document:

- the Division of Behavioral Health, Department of Health and Welfare
- the Division of Medicaid, Department of Health and Welfare
- the State Department of Education
- the Division of Vocational Rehabilitation
- the Department of Juvenile Corrections
- the Department of Correction
- from the Housing Authority
- the Judiciary branch of government
- first responders
- County Government and County Juvenile Justice

The membership will also include two ex officio members of the state legislature – one for each of the House and Senate Health and Welfare Committees