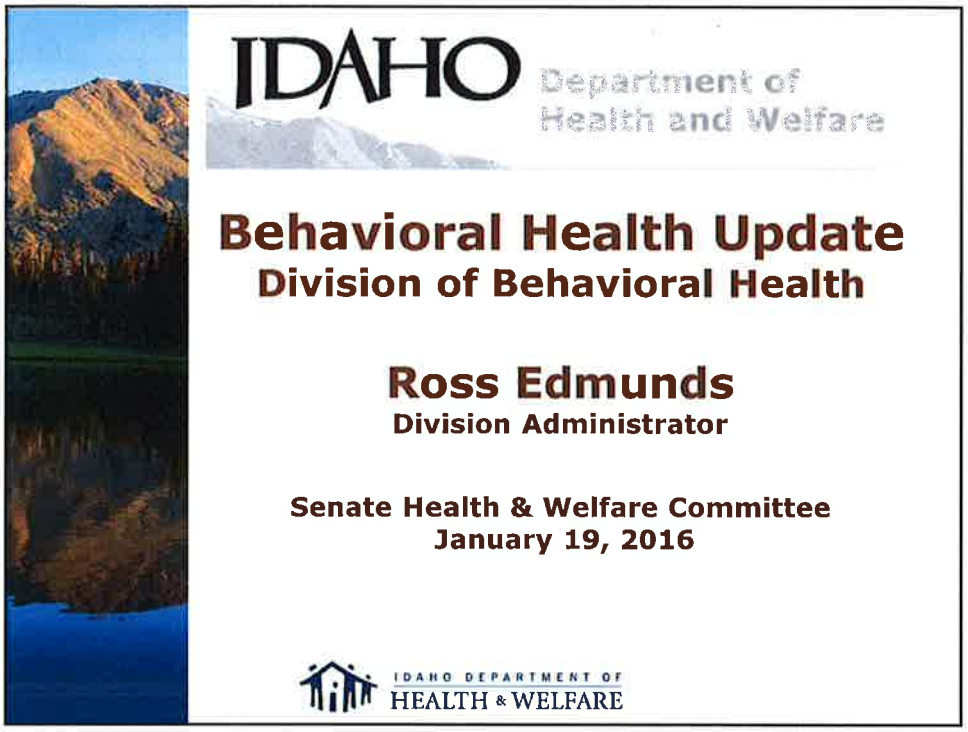
SENATE HEALTH & WELFARE COMMITTEE
Tuesday, February 9, 2016

ATTACHMENT 2


IDAHO
Department of
Health and Welfare
Behavioral Health Update
Division of Behavioral Health
Ross Edmunds
Division Administrator
Senate Health & Welfare Committee
January 19, 2016
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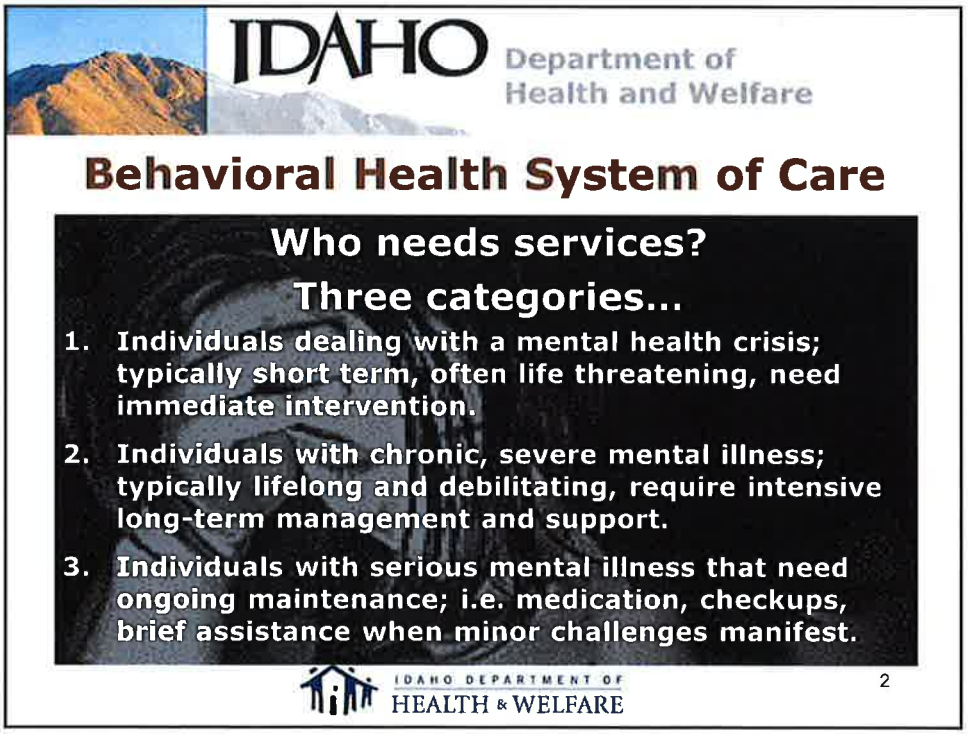
HEALTH & WELFARE


IDAHO
Department of
Health and Welfare
Behavioral Health System of Care
Who needs services?
Three categories...
1. Individuals dealing with a mental health crisis; typically short term, often life threatening, need immediate intervention.
2. Individuals with chronic, severe mental illness; typically lifelong and debilitating, require intensive long-term management and support.
3. Individuals with serious mental illness that need ongoing maintenance; i.e. medication, checkups, brief assistance when minor challenges manifest.
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Behavioral Health System of Care

What have we accomplished...

1. **Crisis centers** to more effectively and efficiently assist people experiencing a BH crisis.
2. **Crisis Intervention Teams (CIT)** statewide in partnership with law enforcement.
3. **Regional BH Boards** to provide leadership in communities and establish/manage recovery support services.
4. **A network of specialty BH providers** consistently managed by contractors, BPA Health and Optum.
5. **Recovery centers** to support people in recovery from BH disorders remain in recovery.

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Behavioral Health System of Care

What we are working on...

1. **Safe and stable housing** for adults with chronic mental illness who may never be able to live independently, Adult Residential Treatment Homes (ARTH).
2. Better access to ongoing **healthcare** for people with BH disorders, which is integrated with physical health into seamless delivery.
3. A more **effective BH system** to intervene with **children and families** as early as possible to reduce the impact of BH illnesses later in life.

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Behavioral Health System of Care

What we need to work on next...

1. We need **better access** to ongoing effective mental health and substance use disorders specialty treatment services.
2. Better access to effective treatment for offenders in the **criminal justice system**.
3. Opportunities to access services in **rural communities**, possibly through **technology**.
4. **More highly trained providers**; particularly psychiatrists, mid-level practitioners & psychologists.
5. Treatment for dealing with **trauma**.
6. Possibly most importantly, a **cultural shift** in the way we view BH illnesses and how we treat people with BH disorders.

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Behavioral Health System of Care

Who needs services?

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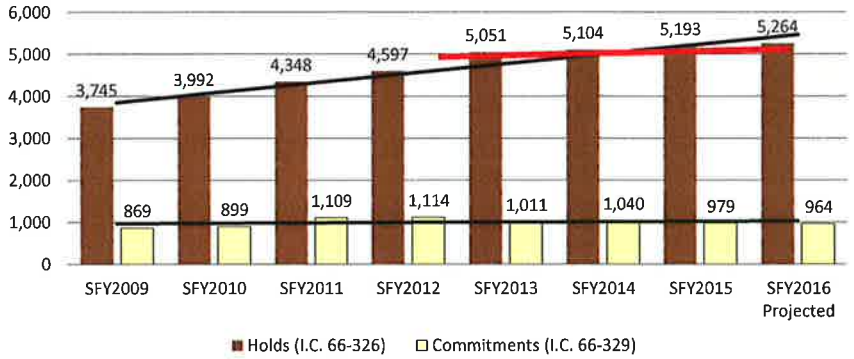
Increased Demand for Crisis Services

Protective Holds and Civil Commitments



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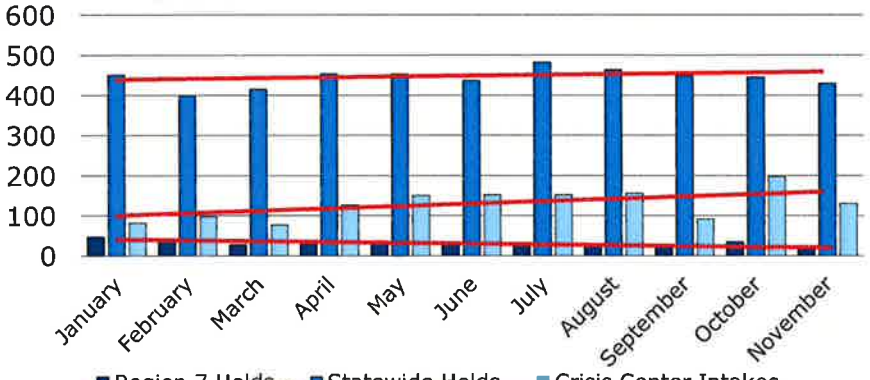
Community Crisis Centers Update

2015 Civil Holds (I.C. 66-326) and Behavioral Health Crisis Center of Eastern Idaho Intakes



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Community Crisis Centers Update

Eastern Idaho Crisis Center (opened 12/2014) :

- 2,349 Patients served
  - 1,536 admissions and 813 assessment and referral
- 259 Law enforcement referrals
  - Estimating nearly 1,200 hours of saved time
- 228 Hospital referrals/138 diversions from hospitalization
  - $280,000 estimated savings in Emergency Dept costs
  - $450,000 estimated savings in hospitalization
- 14 hours 39 minutes, average level of stay for admissions

Northern Idaho Crisis Center (opened 12/2015):

- 66 Patients served
- 8 Law enforcement referrals
- 4 Hospital referrals

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Jeff D. Update

Timeline to Dismissal

- Settlement agreement accepted by the Federal Court (June, 2015).
- Currently developing implementation plan (due end of March, 2016).
- Four years to implement the plan (2020).
- Two to three years of monitoring following implementation (2024).
- Joint motion of dismissal, provided successful implementation (2025 expected resolution).

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Jeff D. Update

Core Elements of the Settlement Agreement

- Medicaid will serve as the backbone for the system.
- Research suggests 5 to 7% of general population (approximately 9,000) of children <18 years have serious emotional disturbance, with less than half accessing services.
- Better cross-system coordination.
- Access to an effective continuum of services.
- Focus on better case/care management, particularly for the most severe.
- Families as full partners in their own care and in the system design, delivery, and evaluation.

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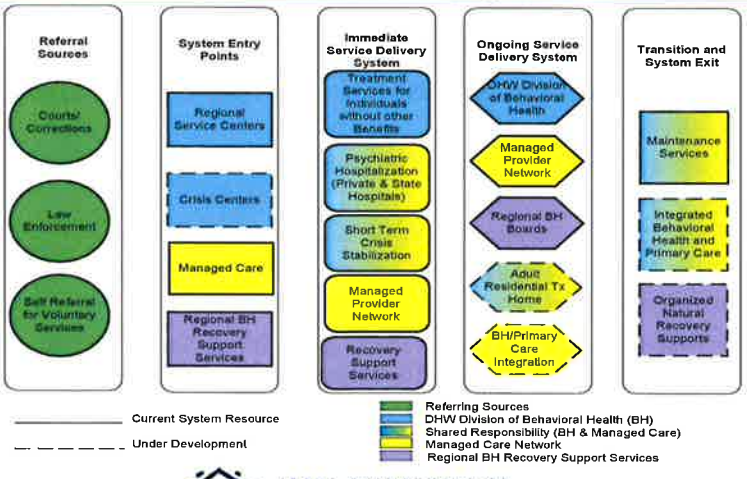
Public Behavioral Health System Redesign



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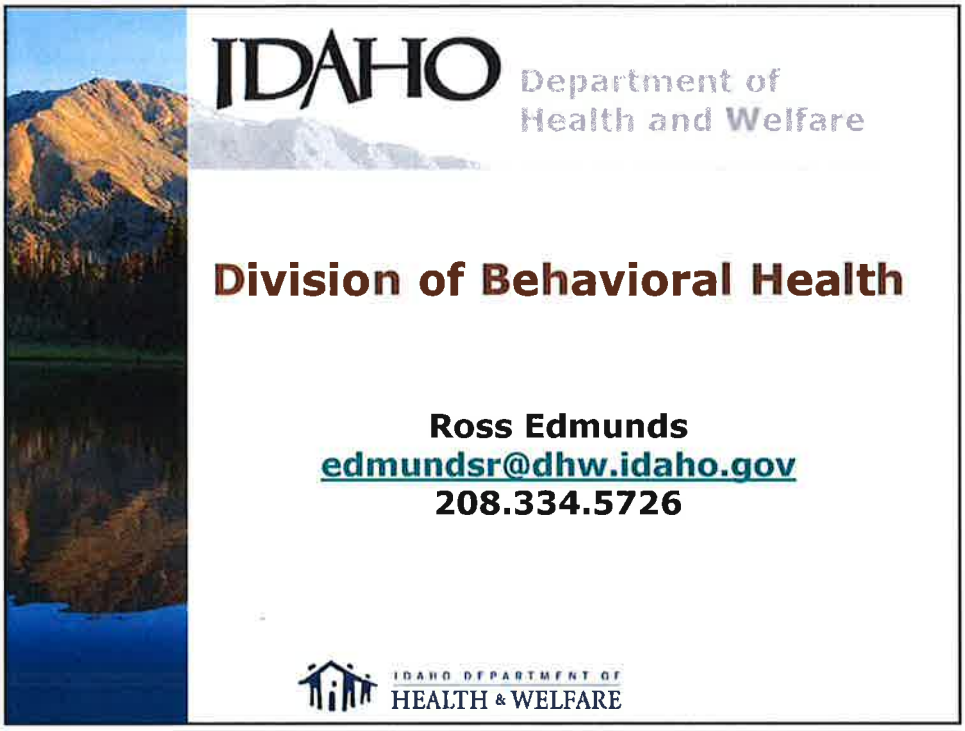
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Defining Behavioral Health Crisis Centers vs. Recovery Community Centers

What is a Behavioral Health Crisis Center?

Behavioral Health Crisis Centers are an unrealized component of the Idaho Behavioral Health System. Once established, these centers will be accessible to all citizens on a voluntary basis. Established as a brick and mortar facility, these centers operate 24/7/365 and are available to provide evaluation, intervention and referral for individuals experiencing a crisis due to serious mental illness or a co-occurring substance use disorder.

Key Points:

- An episode of care at a behavioral health crisis center is no more than 23 hours and 59 minutes.
- Crisis centers are voluntary. Working with law enforcement, these centers are a resource for individuals who are willing to seek services but lack the essential resources. These centers help individuals in crisis get the assistance they need without going to the emergency room or being taken to jail.
- Eligibility for the centers: a) be at least eighteen (18) years of age, b) demonstrated impairment and or symptom(s) consistent with a DSM-V diagnosable condition, c) be medically stable, and d) be in need of frequent observation on an ongoing basis.
- The staff of the center are comprised of three levels of behavioral health professionals: a) Certified Peer Specialists, b) Clinicians, & c) Nurses
- Capacity: The estimated need is approximately 1 bed for every 10,000 Idahoans in the community. As pilot sites launch we will be evaluating the need, capacity and outcomes achieved to help inform additional project outcomes.
- We anticipate local centers leveraging local partnerships once established to assist in the ongoing operation and service needs of those served (for example: donated meals, laundry service).
- There are currently two crisis centers operating in Idaho, one in Idaho Falls and one in Coeur d'Alene. The Department of Health and Welfare is requesting one additional Crisis Center in the 2016 Legislative session to be located in Southwest Idaho. The actual location will be determined through a competitive process.

What Is a Recovery Community Center?

Recovery Community Centers provide a meeting place for those in recovery from alcohol or drug addiction and act as a face for recovery to the community as a whole. Building meaningful and healthy relationships is key to successful recovery and these centers offer the venue for that to happen. Ideally, the centers are located as close to the heart of a community as possible, and are very visible. The center doesn't need to be large to have a huge impact on those who use it.

A variety of activities can originate at the Recovery Community Center:

- A center is a welcoming meeting place where others can be counted on to provide support when an individual's recovery is feeling shaky.
- Reliable information is made available on services needed by those new to recovery, such as housing and transportation assistance.
- Computers with internet services are made available to enhance recoverees' computer skills as well as to provide them with the connectivity that may be needed to do job searches or to stay in touch with family and friends.
- Classes are provided to enhance recoverees' ability to live their lives clean and sober and can cover areas such as job skills and how to socialize with others without getting high.
- Phone banks are provided for volunteers to make requested check-in calls to people in recovery. Knowing someone is going to call every week to see how they are doing may be what it takes to keep an individual in recovery.
- It is a place to give back. These centers rely heavily on volunteers to function. Experience tells us that giving back is as powerful to the person volunteering as it is to the recoveree receiving the help.
- It can become an information source for those who are seeking help for themselves or those they care about.

A Recovery Community Center should not be confused with a 12-step clubhouse, and it is not a drop-in center. It isn't meant to be a place to hang out, but is meant to be a place where a person can go to work on improving their life and that of those around them. It could also be expected to take on the personality of the people who use it and the community that is its home.

Behavioral Health Crisis Center of East Idaho

2,359 Clients

1,536 regular clients + 813 short-term clients

For example, short-term clients may only come in for a referral to a community resource and do not need a nursing assessment.

Referral Source

Hospital 228

Law Enforcement 259

Self 862

1,165 Law Enforcement Time Savings

259 Law Enforcement Referrals × 4.5 hours = 1154.5 Estimated law enforcement time saved.

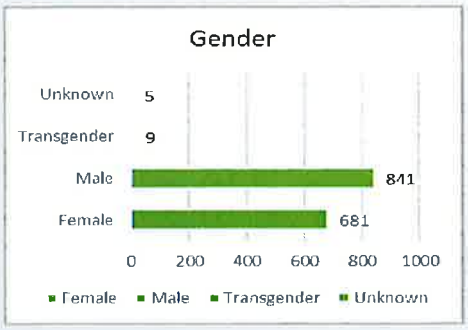
Per law enforcement, 47 people would have been taken to the ER by law enforcement if the Crisis Center were not available.

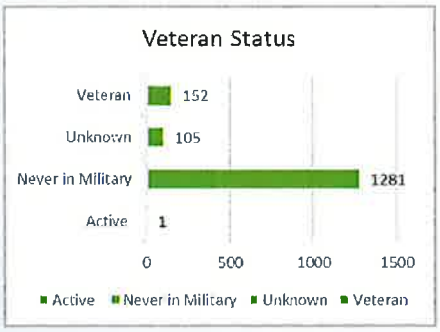
$281,124 Hospital ER Savings

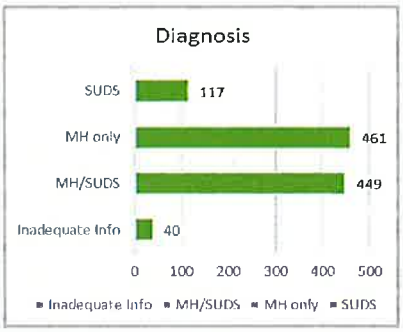
228 referrals from hospitals × $1,223 (average ER visit cost) = $281,124 Estimated Savings.

$483,000 Inpatient Hospitalization Savings

138 diverted inpatient hospitalization = (138 admissions X avg. 5 days) X $700 daily rate = $483,000







Data 12-12-2014 through 12-31-2015

There are a number of clients with multiple episodes. Nearly all of those clients have chronic conditions such as schizophrenia and bipolar disorder. Some clients with substance use disorders have had multiple episodes due to readmission after a relapse.

Number of Days with (x) number of Clients										
# of Clients	1	2	3	4	5	6	7	8	9	10
# of Days	50	63	51	52	53	41	25	17	9	6

14 Hrs 39 Min

Average Length of Stay

Client County	
County Name	Total
ADA	2
BANNOCK	49
BINGHAM	86
BONNER	2
BONNEVILLE	1230
BUTTE	3
CASSIA	1
CUSTER	3
FRANKLIN	3
FREMONT	20
JEFFERSON	40
LEMHI	4
MADISON	36
NEZ PERCE	2
Out of State	40
TETON	9
TWIN FALLS	3
POWER	1
BOUNDARY	1
GOODING	1
Grand Total	**1536**

behavioralhealth
crisis center of east idaho
welcoming empathic hopeful

The Crisis Center has:

- **Diverted 138 people away from inpatient hospitalization.**
- **Received 228 people from community hospitals.**

"The crisis center has empowered law enforcement to take an active role in addressing mental health issues in our community."

Officer Zeb Graham , Bonneville County Sheriff's Office

IDAHO DEPARTMENT OF HEALTH & WELFARE

Division of Behavioral Health

Approximately 1 in 5 Idahoans will experience a diagnosable mental illness in any given year.

Most will talk to friends and family, seek assistance from their primary care provider, or meet with a counselor, and life continues. They may not even consider that what they are feeling might be a mental illness and will chalk it up to feeling a little down or overwhelmed. Even so, many people suffer from chronic, severe mental illness that can be debilitating.

Mental illness can cause difficulty attaining and maintaining employment, housing, and relationships. People who suffer from mental illness may end up in psychiatric hospitals for short stays or need long-term supportive housing. Others can live successfully on their own with the support of their loved ones and the care and treatment of Idaho mental health providers.

For several years, the challenge has been finding an efficient and effective living situation for people with a Serious Mental Illness (SMI) without the ability to live on their own. They require near constant supervision to ensure they eat, take their medication, manage their other health needs, etc. Currently, many live in Residential Assisted Living Facilities, or RALFs. While the owners and staff at these facilities do the best work they can for their residents, it isn't a model precisely designed for this population.

There has been significant legislative, provider, and state interest in appropriate levels of care for people with chronic and serious mental illness. As a result, a work group of providers, advocates, stakeholders and Department of Health and Welfare (DHW) representatives has been formed. The work group is co-chaired by Trista Wolfe (chair of the Idaho Small Providers Association) and Ross Edmunds (DHW Administrator over Behavioral Health). The work group has taken a fresh start on the issue by researching models from around the country and developing an Idaho-specific solution.

By working collaboratively, the work group is developing a solution for Idahoans with serious mental illness that require long-term support to remain stable and out of expensive hospitals. The model is being called an Adult Residential Treatment Home.

Survey Estimates 500-600 Idahoans Affected Statewide

- **500-600 Idahoans** suffering from a severe mental illness currently live in Residential Assisted Living Facilities (RALFs) because they are unable to live on their own, according to a survey conducted by the **Idaho Small Provider Association**.
- RALFs, while not designed for this population, are the least expensive long-term setting for citizens suffering from a mental illness who are unable to live on their own.
- The RALF provider base is quickly eroding because of an ill-fitting licensing structure, by both regulation and reimbursement.
- RALFs are an inexpensive community safety net. By nature of the setting, providers can closely monitor and ensure patients are compliant with psychiatric treatments and medications.

Alternative Environments For This Population

- **Skilled Nursing Facilities**
- **Nursing Home**
- **Publicly Funded System**
  - ◊ Emergency Rooms/Hospitals
  - ◊ Jail/Prison
  - ◊ Homeless

Elements of the Model

- Should be as close to a home environment as possible.
- Will have 16 beds or fewer.
- Designed for people with Serious Mental Illness (SMI) without the ability to live independently.

Objectives

1. More cost effective treatment than currently financed by the state to support Idahoans with serious mental illness that cannot live independently.
2. Adequately reimburse providers for the treatment and support of Idahoans with serious mental illness to save the state more expensive treatment elsewhere.
3. Develop and implement appropriate governance bodies to ensure patient safety and eliminate conflict with current state and federal guidelines.

Steps Taken To-Date

- The work group has established co-chairs to organize and convene the stakeholders.
- A target population/ population description has been developed and is in final stages of approval.
- The work group recognizes the need to fully articulate the model, including requirements, access points, funding mechanisms, treatment modalities, etc.
- The work group also understands the importance of looking at short-term solutions, as many current RALF providers are struggling financially under the current requirements and needs of the patients to the point of going out of business.

YOUTH EMPOWERMENT SERVICES

Implementation of the settlement agreement in the Jeff D. lawsuit

BACKGROUND

- Class action lawsuit from 1980 stemming from allegations of abuse of children who were co-mingled with adults at State Hospital South (SHS), lack of appropriate educational and treatment services at SHS, and lack of community-based mental health services.
- After many hearings over 30 years, the Court encouraged a mediation process to occur in order to identify solutions - occurred 9/13-12/14.
- Mediation resulted in proposed Settlement Agreement which is the result of more than a year of negotiations among key community stakeholders representing parents, advocates and private providers, representatives from DHW, the Idaho Department of Juvenile Corrections, the Idaho State Department of Education and attorneys representing the class members.
- The Settlement Agreement is a high-level description of what the state agrees to do to have the lawsuit dismissed

Pre-Implementation Status Report (milestones achieved and currently in development)

- Branding for new identity to be announced in November
- New state website with shared ownership with partners in development: November launch
- Draft Idaho Implementation Plan developed and scheduled for review and input by partners 10/19/15
- Child Adolescent Needs & Strengths (CANS) Tool developed and in approval process
- Quality Management Improvement & Accountability (QMIA) Workgroup is meeting and is designing a statewide quality review and oversight plan
- Workforce Development Workgroup recruited and invitations to first meeting in November announced
- Speaking engagements:
  - **June:** Presentation to Idaho Federation of Families on Children's Mental Health via webinar
  - **September, 2015:** Presentation to Special Education Directors Advisory Council
  - **October, 2015:** Presentation to Behavioral Health State Planning Council
  - **March-May, 2016:** Presentation to seven Regional Behavioral Health Boards

9,000 Idaho children have been identified as Class Members

Pre-Implementation Milestones on the Horizon

- IDJC, Child Welfare and DBH participating in Georgetown University Multi-System Integration Program
- DBH and Child Welfare attending CANS Conference to address implementation strategies
- Exploring how to automate CANS & associated costs
- Reducing the utilization of higher-cost services through the expansion of respite
- CANS Workgroup to develop profile for Class Membership and develop criteria for Intensive Care Coordination level of care (January)

See Back of Page
Detailing commitments of the settlement agreement with exit criteria and cost implications.

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Agreement Commitments (scope of work with implication for costs)

Work Objectives in Development	Exit Criteria	Implications for Changes in System Infrastructure, Processes and Products
Continuum of care development	A service package is developed and implemented in sufficient quantity to meet the annual service utilization by Class Members and is delivered to identified Class Members based on Class Members' strengths, needs and medical necessity.	• Medicaid waiver would leverage federal dollars — otherwise reliance on general fund dollars increases • Calls for integration across child-serving agencies/units to ensure smooth transitions and eliminate duplicative efforts • Need staff resources to design and operate new methodologies for cross-system integration • Redefining of roles/responsibilities
Adoption of new ideology	Agencies and providers in the new system of care demonstrate fidelity to the Principles of Care and Practice Model in the delivery of services and supports.	• Switch from medical model (currently the Optum/Medicaid model) to recovery model that eliminates "fail first" approach to authorization of services • Relies on child/family team model of decision-making • Need to adjust printed materials and other communications to reflect new ideology
Creating Access	Class Members are identified, assessed and served using the specified models and tools. This process and informative materials are communicated statewide to the community, stakeholders, and families.	• Creation of screening tool & assessment to identify Class Members • Adoption of CANS tool • Automation of CANS tool • Training staff and community stakeholders to CANS tool • Adoption of evidence-based Wrap Around practice
Workforce Training and Development	Agency staff, providers, and other community and system partners use and follow the Access Model, Practice Model, Practice Manual and CANS tool as appropriate and with sound fidelity.	• Workforce capacity to be assessed • Gaps in access and quality performance to be addressed • Development of Practice Manual • Must train staff and community stakeholders on Practice Manual
Due Process	Class Members', their families, and caregivers' concerns, related to their dissatisfaction with a process, provider or agency action, will be addressed. Such process and associated outcomes will be documented and tracked for continuous quality improvement. This information is made available through reports.	• Development and operation of complaint and grievance process that functions to be responsive in a timely manner and corrective of problems cited by complainant and plaintiffs. • Continuous quality improvement activities • Development of data reporting system
Governance	The identified child-serving agencies establish and use an Interagency Governance Team (IGT) including adoption and use of operational guidelines for the purpose of coordinating and overseeing implementation of the Agreement. The IGT includes specific membership as described in the Agreement.	• Resources: Staff time
Quality, Management, Improvement, & Accountability	The identified child-serving agencies conduct reviews, publically report the outcomes of the reviews and demonstrate the ongoing maintenance and improvement of the quality of the system and client outcomes.	• Department workforce to conduct oversight and quality improvement activities on a large scale statewide • Development of automation processes • Reports to be generated for public information on system and client outcomes and the state's adherence to lawsuit requirements
Implementation Plan: Sustaining the new system of care	The identified child-serving agencies develop an Implementation Plan that meets the requirements set by the Agreement, gain approval of the Plan from the District Court, execute the Plan within four years and sustain the Plan for a three year period.	• Staffing resources to be determined