Southwest District Health Crisis System Assessment

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Executive Summary

In 2018, Southwest District Health submitted a grant request to Blue Cross of Idaho Foundation for Health to "take advantage of the opportunity presented with the implementation of the new crisis center" for a project that would include a readiness assessment, system mapping, gap analysis, roadmap, data parameters, and a business plan.

Southwest District Health serves six (Adams, Canyon, Gem, Owyhee, Payette and Washington) counties with a focus on preventing premature death and disability, protecting the population from emerging health threats, and promoting behaviors that contribute to healthier and longer lives.

The following report contains a review of previous assessments conducted; reviews of crisis systems from other States; exploration of Region 3 data related to social determinants of health, mental health, addiction, and suicide; results of the readiness assessment survey; and data collection considerations and recommendations.

Results of this review demonstrated significant interest in system improvement, as noted in the provider and stakeholder readiness assessment, but challenging to implement due to a lack of resources, financial support, and no centralized system to coordinate care or hold service the care delivery system accountable for patient outcomes. The current delivery of care is inhibited by a fragmented system that struggles in the absence of adequate funding, care coordination, and care management structures to meet the behavioral health needs of its residents.

Given the complexities of statewide system change, recommendations were focused on activities that could be undertaken within Region 3. This was not meant to discourage efforts at the State level but rather to allow for more immediate options for change efforts. Final recommendations include:

1. Utilize a structure similar to the one used for Sequential Intercept Mapping (SIM) for crisis and pre/post crisis systems mapping.
2. Develop detailed letters of agreement between system partners, including rapid post crisis access for treatment.
3. Support community education regarding crisis and other behavioral health resources
4. Use the *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step by Step Guide* to inform data collection
5. Engage multiple insurance companies as sources of data.
6. Work with insurance companies to establish value-based contracting with service providers that includes pre and post crisis response requirements.
7. Focus on prevention, community outreach and education

BSU Ethnography Report Summary: Boise State University (BSU) performed a targeted ethnography of behavioral health (TEBH) in Emmett, Idaho and Grand View, Idaho for Southwest District Health Department in 2019 as a supporting assessment for behavioral health services specifically related to the Crisis Center. The primary research method utilized was contextual, in-depth interviews targeting key organizational and community contacts. Interviews were typically at least 30 minutes in duration and conducted in an interview subject's home, place of work, or community where they could feel most comfortable. The BSU TEBH team conducted 48 interviews in total for the project, 39 of which could be considered contextual, in-depth. Interviewees included clinical providers, community members

managing mental illness and/or substance use, agency administrators, law enforcement, and general community members. Both assessed locations were analyzed for general community ethnographic features, non-patient/provider experience ("outer-circle of care"), and patient experience. Both communities prefer to meet local needs with local resources and either alternative transportation systems or funding support for emergency transport. Crisis Center services may be available, but distance and travel pose significant barriers to utilization. The report found issues with:

1. finding regular therapy and crisis care.
2. having affordable behavioral health services at a low or reduced cost and a combined approach between peer support and professional therapy.
3. law enforcement being utilized as a gateway to obtain treatment for substance use and co-occurring disorders.
4. lack of awareness of the Crisis Center services.
5. needing crisis services at a low-cost as a partnership between the peer support center and professional therapists and the establishment of a "crisis room" locally.
6. Need for community upskilling and education on behavioral health services

Atlas Market Research Report Summary: Atlas Communications performed a market research report for Southwest District Health in order to assess opportunities to increase utilization of the Crisis Center. The report indicates a significant lack of resources related to behavioral health in the state of Idaho despite a high need for services. This is likely related to lack of funding for behavioral health services. Insufficient funding results in high cost to the counties for indigent/crisis care and a heavy reliance on volunteers. Another barrier to care includes stigma regarding mental health and substance use. A perception of stigma may prevent patients from seeking more information regarding their behavioral health needs. The report suggests several established strategies in order to manage the aforementioned challenges in increasing appropriate utilization of the Crisis Center. These include public awareness outreach efforts to reduce stigma and educate individuals about behavioral health, relationship development with referral partners, follow-up with patients after an event and patient education/word of mouth. The conclusion of this report suggests that the optimal opportunity to build patient contact is through relationship development with local providers to increase referrals. In addition, a community relations campaign to increase pre-crisis event awareness of the Crisis Center and self-referrals is advised.

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BlueCross Idaho Foundation Project Description
Southwest District Health and Region 3 Crisis Center

Project Goal

As the region prepares to provide behavioral health crisis services in a community-based model, now is an opportune time to evaluate and understand the gaps in the services to rural areas, identify a workable model that will address rural needs and position the community to engage in the transformation that will improve access to appropriate and quality crisis psychiatric care to all populations.

Southwest District Health, in partnership with Lifeways, Inc. and BlueCross of Idaho Foundation for Health, aims to improve the behavioral health crisis psychiatric delivery system for adults and specifically the delivery and coordination of crisis services, in the six-county region of southwest Idaho.

Project Justification

Problems Statement and Business Need

The southwest region of Idaho is predominantly rural and frontier and encompasses the populations of Adams, Canyon, Gem, Owyhee, Payette, and Washington Counties. A combination of dispersed populations with unique cultural norms and sparse access to behavioral health resources creates a complex challenge to assuring access to crisis system that are culturally appropriate across the region. Southwest District Health and community stakeholders across the region aim to identify the many critical gaps and barriers impacting affordable, accessible quality crisis psych care in order to better inform response.

- Phase 1: Create the master project plan that identifies the current and proposed new crisis system model to address rural needs.

- Phase 2: Execute the monitoring plan including regular reporting of progress, identified barriers, solutions, timelines and plan alterations as needed.

Scope of Work

1. Assess stakeholder readiness for change in the current environment. Stakeholders include, but are not limited to:
    a. Behavioral health providers
    b. Dispatchers
    c. Law enforcement
    d. Prosecuting attorneys
    e. Indigent fund coordinators
    f. Hospitals
    g. Primary care providers

h. Health insurance providers, public and commercial
i. Families
j. EMS/CHEMS
k. Suicide hotline

2. Map out the current system, connections and coordination points, and identify gaps in the system.

3. Assess gaps in the current behavioral health delivery system by:
    a. Identifying gaps in the current behavioral health delivery system that inhibit care coordination, access to care, availability of services, and ability to demonstrate value.
    b. Identifying gaps and needed modifications in the crisis system to address the needs of rural and vulnerable populations with an emphasis on equity for all communities.

Components

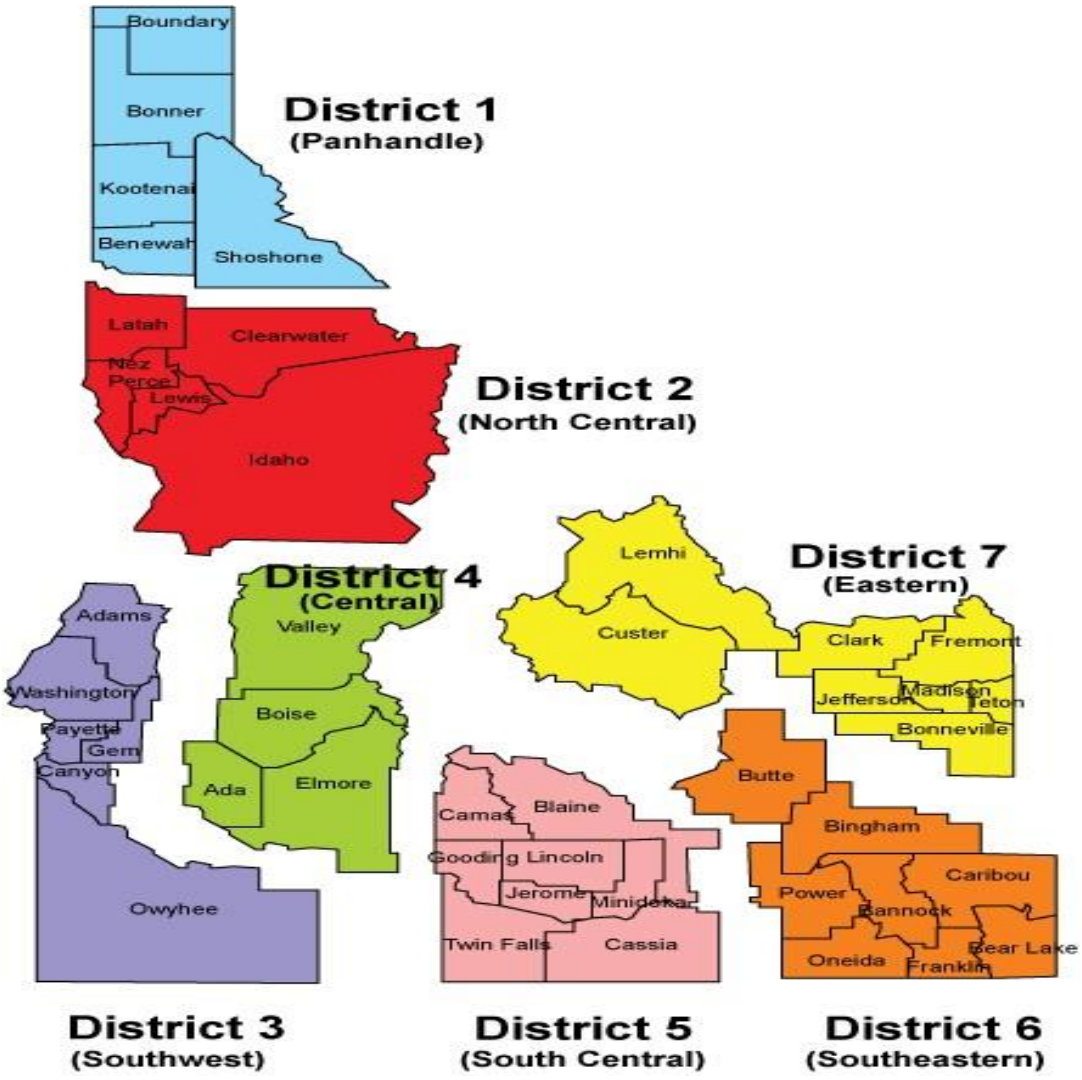
1. Readiness Assessment: To implement this system, it is important to assess general readiness throughout the southwest region of Idaho.

2. System Map: A part of coordinating existing resources includes mapping out the current system and identifying gaps in the system.

3. Gap Analysis: It is crucial to identify gaps against desired vision in order to develop a more coherent system of care.

Introduction to Southwest District Health (SWDH)

Map of Idaho's Public Health Districts



According to the United States Census Bureau (US Census Quick Facts, n.d.), Idaho covers 82,747 square miles, with a population of 1.75 million people. Average number of persons per square mile is 21.2. U.S. Census Bureau population breakdown: 93.0% of the state's population is white, 1.6% is Asian, .9% is Black, 1.7% is American Indian and Alaska Native, and 12.7% is of Hispanic origin. There are 115,437 veterans living in Idaho. The average per-capita income for Idahoans is $25,471 with a median household income of $50,985. Persons living in poverty is estimated at 12.8%. Persons, under the age of 65, living with disability is estimated to be 9.3% of the population. Education levels include 90.2% having graduated from high school and 26.8% with a Bachelor's degree or higher.

Southwest District Health County Demographics
Region 3 Public Health District

Adams County

According to the United States Census Bureau (US Census Quick Facts, n.d.), Adams County covers 1,363 square miles, with a population of 4,250 people. Average number of persons per square mile is 3.1. U.S. Census Bureau population breakdown: 94.5% of the county's population is white, 0.8% is Asian, 0.4% is Black, 1.5% is American Indian and Alaska Native, and 4.2% is of Hispanic origin. There are 488 veterans living in Adams County. The average per-capita income for residents is $24,315 with a median household income of $42,727. Persons living in poverty is estimated at 14.5%. Persons, under the age of 65, living with disability is estimated to be 11.9% of the population. Education levels include 89.1% having graduated from high school and 20.3% with a Bachelor's degree or higher.

Canyon County

According to the United States Census Bureau (US Census Quick Facts, n.d.), Canyon County covers 587 square miles, with a population of 223,499 people. Average number of persons per square mile is 380. U.S. Census Bureau population breakdown: 93.3% of the county's population is white, 1.1% is Asian, 0.8% is Black, 1.7% is American Indian and Alaska Native, and 25.6% is of Hispanic origin. There are 13,228 veterans living in Canyon County. The average per-capita income for residents is $19,765 with a median household income of $46,426. Persons living in poverty is estimated at 15.5%. Persons, under the age of 65, living with disability is estimated to be 10.4% of the population. Education levels include 84.6% having graduated from high school and 18.1% with a Bachelor's degree or higher.

Gem County

According to the United States Census Bureau (US Census Quick Facts, n.d.), Gem County covers 561 square miles, with a population of 17,634 people. Average number of persons per square mile is 31.4. U.S. Census Bureau population breakdown: 95.1% of the county's population is white, 1.1% is Asian, 0.3% is Black, 1.2% is American Indian and Alaska Native, and 8.4% is of Hispanic origin. There are 1,867 veterans living in Gem County. The average per-capita income for residents is $20,041 with a median household income of $42,888. Persons living in poverty is estimated at 13.5%. Persons, under the age of 65, living with disability is estimated to be 13.4% of the population. Education levels include 87.7% having graduated from high school and 16.9% with a Bachelor's degree or higher.

Owyhee County

According to the United States Census Bureau (US Census Quick Facts, n.d.), Owyhee County covers 7,665 square miles, with a population of 11,693 people. Average number of persons per square mile is 1.5. U.S. Census Bureau population breakdown: 91.9% of the county's population is white, 0.8% is Asian, 0.9% is Black, 4.4% is American Indian and Alaska Native, and 26.3% is of Hispanic origin. There are 722 veterans living in Owyhee County. The average per-capita income for residents is $19,909 with a median household income of $36,092. Persons living in poverty is estimated at 15.9%. Persons, under the age of 65, living with disability is estimated to be 10.0% of the population. Education levels include 75.1% having graduated from high school and 9.7% with a Bachelor's degree or higher.

Payette County

Payette County is the smallest county in land area in Idaho. According to the United States Census Bureau (US Census Quick Facts, n.d.), Payette County covers 407 square miles, with a population of 23,551 people. Average number of persons per square mile is 57.9. U.S. Census Bureau population breakdown: 94.1% of the county's population is white, 1.0% is Asian, 0.5% is Black, 1.8% is American Indian and Alaska Native, and 17.4% is of Hispanic origin. There are 1,603 veterans living in Payette County. The average per-capita income for residents is $23,361 with a median household income of $48,447. Persons living in poverty is estimated at 13.0%. Persons, under the age of 65, living with disability is estimated to be 12.3% of the population. Education levels include 86.9% having graduated from high school and 14.2% with a Bachelor's degree or higher.

Washington County

According to the United States Census Bureau (US Census Quick Facts, n.d.), Washington County covers 1,453 square miles, with a population of 10,161 people. Average number of persons per square mile is 7.0. U.S. Census Bureau population breakdown: 94.4% of the county's population is white, 1.0% is Asian, 0.5% is Black, 1.7% is American Indian and Alaska Native, and 16.9% is of Hispanic origin. There are 857 veterans living in Washington County. The average per-capita income for residents is $20,435 with a median household income of $37,521. Persons living in poverty is estimated at 15.7%. Persons, under the age of 65, living with disability is estimated to be 11.913.7% of the population. Education levels include 83.9% having graduated from high school and 16.4% with a Bachelor's degree or higher.

US Census Quick Facts

Table 1. The following table contains more extensive United States Census Bureau data for Region 3 counties and Idaho (US Census Quick Facts, n.d.)

People Quickfacts–Demographics & Indicators, U.S. Census	Adams County	Canyon County	Gem County	Owyhee County	Payette County	Washington County	Idaho
Population, 2018 estimate	4,250	223,499	17,634	11,693	23,551	10,161	1,754,208
Population, 2010 (April 1) estimates base	3,978	188,922	16,719	11,529	22,622	10,198	1,567,652
Population, percent change, April 1, 2010 to July 1, 2018	6.8%	18.3%	5.5%	1.4%	4.1%	-0.4%	11.8%
Persons per square mile	3.1	380.5	31.4	1.5	57.9	7.0	21.2
Persons under 5 years	4.0%	7.5%	6.0%	6.4%	6.5%	5.7%	6.6%
Persons under 18 years	17.7%	28.5%	22.8%	26.0%	26.2%	22.7%	25.5%
Persons 65 years and over	28.7%	13.8%	21.9%	17.8%	18.4%	25.1%	15.9%
Female persons	48.0%	50.5%	50.0%	49.0%	50.1%	50.2%	49.9%
White persons, percent	94.5%	93.3%	95.1%	91.9%	94.1%	94.4%	93.0%
Black persons, percent	0.4%	0.8%	0.3%	0.9%	0.5%	0.5%	0.9%
American Indian and Alaska Native persons, percent	1.5%	1.7%	1.2%	4.4%	1.8%	1.7%	1.7%
Asian persons, percent	0.8%	1.1%	1.1%	0.8%	1.0%	1.0%	1.6%
Native Hawaiian and Other Pacific Islander persons, percent	0.4%	0.3%	0.2%	0.2%	0.1%	0.1%	0.2%
Persons reporting two or more races, percent	2.4%	2.7%	2.2%	1.8%	2.5%	2.2%	2.5%
Persons of Hispanic or Latino Origin, percent	4.2%	25.6%	8.4%	26.3%	17.4%	16.9%	12.7%
White persons not Hispanic, percent	91.1%	70.1%	87.6%	68.6%	78.3%	79.1%	81.7%
Living in same house 1 year & over, percent, 2013-2017	86.4%	81.3%	88.0%	85.1%	79.3%	88.5%	82.6%
Foreign born persons, percent, 2013-2017	1.8%	7.9%	3.5%	10.5%	6.4%	7.3%	5.9%
Language other than English spoken at home, percent age 5+, 2013-2017	4.2%	18.0%	8.9%	22.9%	12.7%	14.8%	10.7%
High school graduate or higher, percent of persons age 25+, 2013-2017	89.1%	84.6%	87.7%	75.1%	86.9%	83.9%	90.2%
Bachelor's degree or higher, percent of persons age 25+, 2013-2017	20.3%	18.1%	16.9%	9.7%	14.2%	16.4%	26.8%
Veterans, 2013-2017	488	13,228	1,867	722	1,603	857	115,437
Housing units, 2018	2,695	77,867	7,407	4,941	9,533	4,668	735,672
Owner-occupied housing units, 2013-2017	79.8%	67.6%	74.8%	68.4%	74.0%	73.1%	69.2%
Households, 2013-2017	1,736	69,303	6,404	4,190	8,571	3,979	609,124
Per capita money income in the past 12 months (2017 dollars), 2013-2017	$24,315	$19,765	$20,041	$19,909	$23,361	$20,435	$25,471
Median household income, 2013-2017	$42,727	$46,426	$42,888	$36,092	$48,447	$37,521	$50,985
Persons below poverty level, percent, 2013-2017	14.5%	15.5%	13.5%	15.9%	13.0%	15.7%	12.8%
Disability, under age 65, 2013 - 2017	11.9%	10.4%	13.4%	10.0%	12.3%	13.7%	9.3%

IDAHO SYSTEM ASSESSMENT

I. Review of Previous Systems and Health Assessments

In recent years, there have been several needs assessments completed in Idaho and/or within SWDH region, but there are no evaluations or assessments on specific programs or demonstration projects resulting from needs assessment recommendations. The previous needs assessments provided pertinent information regarding the problem, this report aims to avoid duplicating these reports but at the same time, highlight the useful information captured in the needs assessments to inform the general system assessment for meaning action steps. Summaries of the needs assessment findings related to behavioral health services in Region 3.

1.) Western Interstate Commission for Higher Education's Mental Health Program (WICHE)

In 2006, the Idaho legislature adopted House Concurrent Resolution No. 63 which appointed a Mental Health and Substance Abuse Interim Committee. The Committee was tasked with reviewing the current mental health and substance abuse treatment system, reviewing alternant ways to provide services, and produce a report on findings back to the Legislature. The Committee held four (4) meetings across Idaho and heard testimony from various stakeholders, individuals and families. One of the conclusions drawn by the Committee was that Idaho needed to conduct an "objective and more thorough review of Idaho's current mental health and substance abuse treatment delivery systems in order to address possible solutions".

Based on this recommendation, the 2007 Legislature brought forth Senate Concurrent Resolution No. 108 directing engagement of an independent contractor. Areas of focus were to include assessment of treatment capacity, cost, eligibility standards, and areas of responsibility, as well as making recommendations for improving the system. The Resolution listed study areas and components to include:

- Creation of a mental health and substance abuse treatment system specifically designed for children and their families to receive immediate treatment
- Determine whether there is a lead agency in Idaho responsible for paying for and coordinating services regardless of where an individual enters the mental health and substance abuse and study the possibility of restructuring the current system via the creation of a separate agency combining mental health and substance abuse services in Idaho
- The need for voluntary commitments
- Beds for children in psychiatric crisis
- The need for State Hospital services in Treasure Valley
- Review the need for crisis intervention training at all levels of public safety
- Regarding the offender population:
    - study the creation of one specific agency responsible to conduct a range of assessments prior to sentencing in order to coordinate treatment and support alternatives to incarceration.

    - Increase the number of probation officers in order to shrink caseloads
- Evaluate the concept of a regionally based mental health and substance abuse treatment delivery system

The Western Interstate Commission for Higher Education's Mental Health Program (WICHE) was selected as the independent contractor.

The WICHE Mental Health Program focuses on "improving behavioral health systems of care… By providing technical assistance, education, consulting and research services, the Program works to continually improve the qualifications of the behavioral health workforce".

WICHE conducted the original system assessment over a seven (7) month timeframe and produced a final report in 2008 and a subsequent follow up assessment in 2018 (WICHE, 2008) (Tupa & Koch, 2018). The original 2008 assessment included meetings with stakeholders across the State, use of a web-based survey, comparison of other states, and review of other relevant health data. Areas of focus were:

- Management structure
- Existing efforts of system integration and transformation
- Delivery systems, including access to services and system capacity for adults and children
- System accountability
- State hospital and forensic mental health bed needs and capacity
- Data systems and information sharing
- Financing
- Workforce

These efforts resulted in thirty (30) final recommendations across the following seven (7) categories:

1) Executive Branch Structure/Transforming the Structure and Roles of the Division of Behavioral Health
2) Creation of Regional Authorities
3) Identifying Gaps in the Intersection of the Justice System
4) Increasing Access to Care through Changes to Financing, Eligibility and the Use of Waivers
5) Enhancing the Efficiency of the State's Hospital Capacity
6) Increasing the Accountability through Information and Data
7) Enhancing Workforce Capacity

In 2018, WICHE released the System Redesign Status Update and Mental Health Service Array Assessment report which addressed Idaho Division of Behavioral Health's desire to:

- "Understand the status of each of the recommendations in the 2008 Report and facilitate planning for updated action on any of the recommendations".
- "Engage third party consultation in regard to maximizing the efficiency and efficacy of mental health funding for Idaho adults with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI) via the configuration of DBH-funded mental health services. This task was circumscribed to primarily mental health services (with less of an emphasis on substance use services) for primarily adults with SMI and SPMI".

The report found that "significant changes" had occurred since the 2008 report. Some of the biggest changes were:

- The transition to a managed care model for Medicaid utilizing Optum as the managed care organization.
- The Jeff D. Lawsuit settlement and subsequent Youth Empowerment Services (YES) plan as this served to trigger changes within the children's mental health system.
- The national recession which adversely impacted funding for the behavioral health system. Impacts which stakeholders report are not yet fully recovered from.

The report noted that "while numerous positive changes have been made to the mental health service delivery system in Idaho, the overall system remains fragmented within DBH and across agencies, resulting in inefficiencies in service delivery".

The 2018 report provided an update on the status of progress made for each of the 2008 recommendations. The following contains the thirty (30) 2008 recommendations and excerpts of the 2018 status updates [2018 excerpts are contained within].

1. Executive Branch Structure/Transforming the Structure and Roles of the Division of Behavioral Health

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
1.1 Transform the Division of Behavioral Health (DBH) into a Division that directly and promptly improves the quality of care at the point of care. 1.1.1 Becoming a guarantor of care rather than a deliverer of care by administering, monitoring and ensuring the quality of care; 1.1.2 Leading collaborative efforts that include key community stakeholders and other departments, divisions and agencies to improve systems; and, 1.1.3 An integration of operations within DBH; across divisions within the Department; and amongst executive	1.1.1 "Moderate action" - Creation of the Regional Behavioral Health Boards (RBHBs) pushed "some planning, coordination and input functions out to the various regions, however DBH declined to completely divest from centrally contracting for and providing care for adults with Serious Mental Illness (SMI) and Serious and Persistent Mental Illness (SPMI)". Reasons for this were noted to include: "political issues, lack of Medicaid expansion, the need to remain the providers of the "safety net" of care, the need to ensure a stable rural workforce, and the ability to act as "gate-keepers" for the state hospitals". The development of the Youth Empowerment System (YES) resulted in the DBH Children's Mental Health Program "working toward divesting from providing direct care services and putting a robust quality monitoring system in place for child, adolescent, and family treatment and services." DBH created a Quality Assurance (QA) Unit in order to "monitor a variety of types and levels of care". An internal sub-committee provides voluntary QA oversight to providers. DBH does not directly monitor the "quality of Medicaid-funded and Optum-provided care and lacks authority to make changes or improvements specifically within the Medicaid system and network". The Medicaid Idaho Behavioral Health Plan (IBHP), does allow for collaboration between DBH and Optum "on some aspects of monitoring quality of care". 1.1.2 & 1.1.3 - "Significant action" WICHE gave the following as examples of activities that lead to a finding of "significant action": • The development of the RBHBs was seen as "a key accomplishment" • DBH's "contributions to recent crisis center planning" • DBH's involvement in the State Innovation Models Integration grant, and Involvement in the children's systems QMIA Plan

branch agencies, including the Office of Drug Policy (ODP).	• DBH's establishment and participation in a multi-agency, multi-stakeholder Idaho Behavioral Health Cooperative

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
1.2 Create a statewide transformation workgroup to identify and address barriers to transformation by utilizing an existing collaborative, such as the Interagency Substance Abuse Prevention and Treatment Committee.	1.2 "Recommendation enacted". "Governor Otter created the Behavioral Health Transformation Workgroup (BHTW) through Executive Order in 2009". Between May 2009 through October 2010 the BHTW "worked to generate a plan that would guide the overall transformation of Idaho's behavioral health system". The BHTW was discontinued in 2011 and the Idaho Behavioral Health Cooperative took over the function.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
1.3 Consolidate statutory requirement regarding designated evaluations for involuntary commitment into a single-step, community-based evaluation and determination proves.	1.3 "Significant action" – DBH made the decision "not to fully enact" this recommendation". DBH chose to keep administration of the process "more centralized". In 2008, changes were made to statute §66-329. In 2010, "DBH promulgated rules for appointment of Designated Examiners and Designated Dispositioners [Idaho Administrative Code (IDAPA) 16.07.39 "Appointment of Designated Examiners and Designated Dispositioners"]. The rule chapter defines the qualifications, appointment requirements, and appointment process. Additional statute changes were made to provide for outpatient commitment."

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
1.4 Establish new staff positions to invest in a transformed Division	1.4 "Significant action" – DBH had not hired a Medical Director as of the writing of the 2018 report however, "Policy and Operations positions were created within DBH. The Web Infrastructure for Treatment Services (WITS) Help Desk was established", as well as an increase in other staff positions. "Robust oversight and monitoring of community behavioral health provider data reporting remains a gap".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
1.5 Formalize the criteria for community grants, which must include an official method for selecting program: and adjust the community grants program to ensure its use as a mechanism for funding innovative programs and practices.	1.5 "Significant action in response to this recommendation, with some modification". The RBHBs "were developed and funded in part to serve this coordinating function". "RBHBs serve a slightly different role from one another based upon community needs" which results in varying levels of need for grant funding across the region.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
2.0 Creation of Regional Authorities 2.1 Create a regionally operated, integrated mental health and substance abuse authority – or district – in each of the existing seven regions to plan, administer, and manage and/or deliver services for children and adults.	2.0-2.1 "Significant action" - DBH chose not to push full authority out to Regional Behavioral Health Boards (RBHB). In 2014, the Regional Mental Health Services Act created RBHBs. Despite the creation of the RBHB "DBH remains the Behavioral Health Authority ultimately responsible for DBH-funded behavioral health services. RBHBs have local authority to coordinate and plan services, provide input to central DBH administration, and potentially to provide community family support and recovery support services."

WICHE 2008 Recommendation	**WICHE 2018 Report Found**

2.2 Ensure that the boards of the regional behavioral health authorities/districts comprise members who represent the various stakeholders; and ensure that the membership of the boards does not exceed fifty percent elected officials, providers and other professionals.	2.2 "Moderate action" – The Regional Behavioral Health Services Act does not ensure the 50% recommendation, instead it outlines twenty-two members of which 36% are not "elected officials, providers and other professionals". For a variety of reasons this group is noted as "underrepresented in the RBHBs.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
2.3 Collaboratively establish a statewide, prioritized package of services to be delivered within regional behavioral health authorities/districts.	2.3 "Significant action" – RBHBs "are not independently delivering these services, DBH, with assistance from the Behavioral Health Transformation Workgroup, did develop a prioritized package of services, or Core Services (Idaho Code 39-3131) for adults with SMI and SPMI". "Knowledge and understanding of this service package varies…".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
2.4 Transform the existing county behavioral health funding (e.g., CAT and general funds currently expended on behavioral health services) into a fixed match that preserves a maintenance of the current funding for the regional behavioral health authorities.	2.4 "Minimal to moderate action" - Recommendation "was not fully accepted for enactment by DBH. While county indigent funds do assume a risk of up to $10,000 per patient before general funds are used for community services, a fixed match has not been established". DBH continues to "look for more effective use of CAT and County Indigent funds and maximize federal funding".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
2.5 Use a transformed DBH to fund regional behavioral health authorities utilizing formulized funding, based on factors including historical utilization and population.	2.5 "Moderate action" - RBHBs were not established as the behavioral health authorities, however "DBH does fund them for some activities and some provision of services". A challenge identified is that "the appropriation process for these funds has not been updated in some time" and "there is little formulization based upon past or predicted future expenditures"

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
3.0 Identifying Gaps in the Intersection of the Justice System 3.1 Review the mental health and substance abuse programs within the criminal and juvenile justice systems to ensure integration with regionally based behavioral health authorities.	3.0-3.1 "Moderate action" – This recommendation was not "fully adapt" and was considered to be "out of DBH's sole scope of control". "DBH did establish and does participate in the multi-agency, multi-stakeholder Idaho Behavioral Health Cooperative, (established in 2016 per legislative direction [39-3124]), which is charged with improving coordination of behavioral healthcare across DHW, the Idaho state judiciary, IDOC, IDJC, ODP, IAC, the BHPC; but the body may lack either the political will or the high-level decision makers to enact more impactful and transformative changes to the behavioral health service delivery system".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
3.2 Collect and share regional practices that have resulted in providing appropriate care to children in the custody of juvenile corrections.	3.2 "Significant action" – As a result of the 2015 Jeff D. settlement, "the children's behavioral healthcare system has undergone a major overhaul, with improved access to services a central focus".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
4.0 Increasing Access to Care through Changes to Financing, Eligibility and the Use of Waivers	4.0-4.1 "Minimal to moderate action" WICHE's report concluded that "the current configuration of prioritized DBH-funded services and associated eligibility criteria does not include prevention and

4.1 Identify clinical and financial eligibility criteria that support the delivery of timely, quality, cost-effective screening, assessment, early intervention and prevention services.	early intervention". It was felt that "crisis centers will help to some extent with early intervention of adult onset SMI, but not in any systematic way". The YES system of care was seen as "a notable improvement" but not without some challenges.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
4.2 Amend eligibility criteria for public mental health and substance abuse services to support access to screening, assessment, early intervention, and recovery.	4.2 "Minimal action" DBH was reported to have "limited funds for assessments only". IDOC reported a $9,479,170 disparity between "the numbers of moderate to high risk individuals that are in need of mental health and/or substance use treatment and the funding that IDOC needs to provide those services".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
4.3 Continue the current effort to identify possible waiver or demonstration programs, including those that will result in integrated providers (mental health and substance abuse); in continuing these efforts, conduct a study of the per capita costs of providing appropriate services, basing this study on any new eligibility criteria and including services funded by Medicaid.	4.3 "Moderate action" In 2013 a 1915b(1) waiver was obtained and United Behavioral Health (Optum Idaho) was established as the managed care contractor. The majority of individuals interview regarding this change felt that there remains "significant access problems" for individuals on Medicaid. "There are no current DBH plans to conduct a study of per capita costs of providing appropriate services based on new eligibility criteria and services funded by Medicaid, although as a managed care company, Optum reviews this type of information regularly".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
4.4 Integrate the current efforts towards credentialing providers with the transformed DBH and regionally-based behavioral health authorities.	4.4 "Minimal action" DBH released a Request for Proposals in order to gain an organization to "administer a peer credentialing program". "Credentialing and monitoring efforts remain at the State level and systems remain separate for mental health and substance use."".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
4.5 Consider reinstituting targeted funds for the school-based counseling program.	4.5 "Moderate action" "Medicaid eligible children with documented disabilities can receive school-based services prescribed/approved by their physician as part of an Individual Education Plan (IEP)."

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
4.6 Revise the existing eligibility screening and service delivery contracts for substance abuse to: 4.6.1 Create an adequate, risk-based contract for service delivery, preferably a capitated style contract with more local planning and control of service delivery; 4.6.2 Clarify eligibility requirements by removing any uncertainty on eligibility decisions; and, 4.6.3 Separate the eligibility determination function from the service assessment, planning and financing functions.	4.6.1. "Minimal action" The report indicated that the perceived need for this changed had reduced since the 2008 report. RBHBs have "input into identifying substance use needs and planning for service delivery in their regions". However, DBH's "contract with BPA Health to manage the provision of substance use DBH-funded services is not risk-based". Optum's Medicaid contract is risk based and does include "some substance abuse services". 4.6.2. "Significant action" While substance use services eligibility requirements are considered "clear", funding was considered to be "severely insufficient". Availability of services is reported to change "depending upon how much of the Substance Use Disorder (SUD) funding budget has been expended". It was reported that "certain higher cost services may be suspended for parts of the year due to budget considerations, so eligibility becomes somewhat confusing and/or moot".

	4.6.3. "Moderate action" "BPA Health handles eligibility, and clinical assessments are performed by their provider subcontractors". "The general stakeholder consensus at this time is that BPA Health has significantly improved its efficiency". An ongoing challenge was considered to be the various eligibility, assessment, and other requirements from IDOC, the Idaho Court System, Medicaid, and DBH.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
5.0 Enhancing the Efficiency of the State's Hospital Capacity 5.1 Conduct a review of State Hospital utilization data (both sites) to identify: 5.1.1 Valid mean (average) and median lengths of stay by age group and by region over a year; 5.1.2 The number of individuals who would benefit from community-based services and the types of services required; 5.1.3 The costs accrued per day by these individuals in the state hospitals; and, 5.1.4 The potential State Hospital cost avoidance that could be realized by decreasing inpatient stays and increasing community tenure.	5.1.1 "Moderate action" State Hospital information includes length of stay and regional data, however information on age was not available. 5.1.2. The report indicated that both state hospitals "have a clear understanding of the individuals in their care who may be able to make use of a less restrictive setting". The availability of adequate community-based care was seen as a challenge. 5.1.3. "Costs per day are routinely examined and used in budget planning as well as exploring the best ways and various levels of care to meet the needs of SMI and SPMI adults in the state." 5.1.4. "Cost avoidance by LOS has been examined by the state hospitals. Both state hospitals, as well as DBH administration see few remedies to the issue of waiting lists and lengths of stay with the shortage of appropriate community placements and the increase of court ordered admissions, much of which has historically been beyond their control."

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
5.1 Allocate specific, acute bed capacity to the regional behavioral health authorities.	5.2 "Moderate action" State Hospitals are reported to be utilized "largely geographically". There is no allocation methodology for the individual regions.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
5.2 Achieve and maintain accreditation for both state hospitals.	5.3 "Moderate action" "cost/benefit analysis" has impacted decisions to pursue this objective.

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
5.3 Utilize deliberate planning and program development in secure facilities, ensuring that civilly committed persons treated in these facilities are served in the least restrictive settings based on their clinical and legal circumstances.	5.4 "Moderate action". "Co-mingling" of forensic and civil patients continues, however, State Hospitals have a process for requesting transfer of patients "identified as Dangerously Mentally Ill to secure beds in IDOC".

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
6.0 Increasing the Accountability through Information and Data 6.1 Fully implement the recent budget initiative to design and implement a statewide data system that: 6.1.1 Has utility at the 'point of care' (e.g., is helpful in clinical planning and treatment); 6.1.2 Collaboratively addresses and incorporates 'legacy' (systems in use	6.1 "Moderate to significant action" "DHW developed and implemented the Web Infrastructure for Treatment Services" (WITS) system. 6.1.1. The WITS system is reported to have some point-of-care utility, however "primarily only DBH Adult Mental Health staff use it as such. For DBH staff, the WITS system serves a variety of functions, including procurement of forms, billing assistance, assessment, and alerts." The majority of providers use it "as a portal or vehicle to submit required data to DBH". 6.1.2. Has not occurred.

currently by providers and other public agencies) systems currently in use by stakeholders; and, 6.1.3 Supports the implementation of electronic medical records.	6.1.3. The WITS system "does not interface or extract data out of EMRs" which results in Providers entering "similar data twice".

WICHE 2008 Recommendation 6.2 Conduct a study to determine 'population in need', i.e. those who have serious mental illness or substance abuse/use disorder who are in need of publicly funded, community services.	**WICHE 2018 Report Found** 6.2 "Minimal action" "To date, there has not been a "Population in Need" (PIN) study preformed in Idaho since the 2008 report."

WICHE 2008 Recommendation 6.3 Revamp and improve the accessibility and utility of the DHW website.	**WICHE 2018 Report Found** 6.3 "Moderate to significant action" A new website was established which is mostly reported to be "easier to navigate, with the information they needed more accessible".

WICHE 2008 Recommendation 6.4 Implement a system of evaluation and reporting for transformation activities, with an emphasis on identifying and analyzing the impacts of change on service recipients.	**WICHE 2018 Report Found** 6.4 "Moderate action" "Governor Otter created the BHTW through Executive Order in 2009. During the time that the BHTW (comprised of a variety of government departments, including DHW and other stakeholders) was active", they provided an interim report and a final report of their goals, activities, and accomplishments. Currently, there is no central location or process by which the DHW or DBH report on their numerous transformation activities, although numerous separate work groups and task forces do report on their activities. DBH leadership plans to explore the use of a process to record these activities and accomplishments similar to that used by YES, which has made some advances in organizing this type of information necessitated by the Jeff. D lawsuit settlement."

WICHE 2008 Recommendation 7.0 Enhancing Workforce Capacity 7.1 Create a Workforce Collaborative to manage and coordinate a statewide behavioral health workforce study which will inform the development of a statewide strategic workforce plan.	**WICHE 2018 Report Found** 7.1 "Moderate action" "As a part of the YES framework, a workforce analysis for children's behavioral health services is being conducted by Boise State University, but no such study has been conducted for services for all ages or adults in particular."

WICHE 2008 Recommendation 7.2 Design and implement applied mental health and substance abuse educational programs that translate into a job in the workforce system.	**WICHE 2018 Report Found** 7.2 "Minimal action" "With the exception of significant Health Resources and Services Administration (HRSA)" activities, "no formal mental health and/or substance abuse educational programs have been created." "DBH has requested Governor's budget funds to assist with the development and establishment of an accredited psychology internship consortium".

WICHE 2008 Recommendation 7.3 Design and implement applied mental health and substance abuse educational programs that translate into a job in the workforce system.	**WICHE 2018 Report Found** 7.3 "Moderate activity" "With the establishment of the RBHBs, regions have a mechanism by which to identify and plan for behavioral health workforce training needs, although funding is

	often piecemeal or collaborative between agencies. Additionally, Optum, has had the resources to identify training needs and provide training to providers in their networks, and sometimes beyond."

WICHE 2008 Recommendation	**WICHE 2018 Report Found**
7.4 Provide incentives for the recruitment and retention of behavioral health professionals trained to deliver evidence-based treatment interventions	7.4 "Moderate activity" "In 2014, legislation was amended (I.C. §67-5339) to add an education loan repayment program to draw medical doctors, psychiatrists, nurse practitioners and physician assistants to the two state hospitals. There "is currently no other systematized, ongoing, DHW sponsored or funded recruitment and retention incentive program."

2.) United Way Community Assessment

In 2017, United Way of Treasure Valley (UWTV) completed a Community Assessment of their region (included Ada, Canyon, and Gem Counties) focused on education, health, and financial stability as these were considered to be the "most critical building blocks of a stable life" (United Way of Treasure Valley: Community Assessment, 2017). Maslow's Hierarchy of Need was used as a foundational concept looking at the basic human need for food, housing, safety, and financial stability. The following data was included in the report as a means of assessing their communities.

Minimum Wage:

The UWTV noted that "Idaho's minimum wage jobs do not provide financial stability". They report that Idaho is one of fourteen (14) states where the minimum wage is at the Federal $7.25 per hour and that this has not changed since 2009. It was reported that 72% of jobs in Idaho pay an hourly rate of $20 or less which would place a family of four in the Alice Gap.

Homelessness:

The UWTV report states that "the Great Recession of 2008 had a significant impact on homelessness among children, which has yet to reverse course" and that the number of homeless students in the region had grown each year for the past ten (10) years. While the primary cause of homelessness is loss of housing there were other risk factors identified in the report:

- job loss/income los,
- illness
- domestic violence (precipitating factor for many unsheltered individuals)
- substance abuse
- mental health issues
- physical disabilities
- changes in family status

Transportation

While the percent of individuals who own a vehicle is reported to be "unchanged in recent years". Stakeholders and residents interviewed as part of the UWTV assessment reported access to transportation to be "one of the largest challenges plaguing all three counties" in the region. It was noted

that “utilization of health care services decreases as the travel distance increases”. This has implications for both short- and long-term health outcomes for residents.

General Health and Wellbeing

The UWTV report indicated that “access to healthy food choices, medical care, and mental health services” were a top concern. The Gallup-Heathway’s Well-Being Index shows Idaho’s rankings for Community, Purpose, Social, Physical, and Financial as being:

Idaho Rank	Topic	Description
4	Community	Liking where you live, feeling safe and having pride in your community
17	Purpose	Liking what you do each day and being motivated to achieve your goals
25	Social	Having supportive relationships and love in your life
38	Physical	Having good health and enough energy to get things done daily
44	Financial	Managing your economic life to reduce stress and increase security
18		Overall Index

Mental Health

Mental Health was reported as a top issue in both the 2014 and 2017 UWTV Community Assessments. This was noted as being consistent with previous reports that had “identified Idaho as having one of the highest mental illness rates in the nation, along with low numbers of facilities and service providers and high rates of suicide”. Suicide was noted to be the second most common cause of death in Idaho for individuals age 10 to 19 years old.

3.) Farley Report

The Farley Health Policy Center (FHPC) “advances policy to integrate systems that address the wholeness of a person, their physical, behavioral and social health in the context of family, home, community and the healthcare system. The FHPC works with states to understand achievable policy actions to improve the integration of behavioral health across health and healthcare systems”. The FHPC worked with the Idaho Department of Health and Welfare-Division of Behavioral Health on advancing behavioral health integration in Idaho. The Farley Report entitled Aligning and Advancing Behavioral Health Across the State of Idaho: A Stakeholders Report was produced in January 2018 (Gilchrist, et al., 2018).

One result of the Farley Center’s work with stakeholders was the creation of the following vision statement and values statement:

Vision:

All Idahoans are able to receive affordable and quality care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.

Values:

- Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services across the state, including rural and frontier areas.

- Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
- Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
- Providers sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
- Organizations and providers should remain open to innovation and collaboration to best meet the needs of patients and families.

4.) The Southwest Idaho Community Health Assessment 2016

The Southwest Idaho Community Health Assessment 2016 was developed by the Southwest Health Collaborative and is modeled after the Regional Health Assessment conducted by the Central Oregon Health Council in central Oregon (SWHC, 2016). The Assessment looked at social, health, economic, and demographic data associated with the region's six counties: Adams, Canyon, Gem, Owyhee, Payette, and Washington. One goal of the assessment was for it to function as a "starting point" for developing system improvement strategies.

In addition to the compilation of data from a variety of sources, the assessment process included holding community outreach events in order to "assess congruency between the quantitative report and the experiences and perceptions of community groups".

The report reviewed data associated with demographics, mortality, environmental health, access to healthcare, health behaviors, chronic disease, communicable disease, maternal & infant health, child & adolescent health, oral health, mental health, alcohol, tobacco, and drug use.

Data summary includes:

- Demographics reflecting that the Southwest region contains the second largest population in the state. Approximately one-fourth of this region is living in poverty or is considered part of the ALICE (asset limited income constrained employed) gap population. While the average is one-fourth, it is important to note that some communities are as high as 79%.
- Chronic diseases and suicide account for 50% of the top 10 most common causes of death in the region. The suicide rate for the region is 21 per 100,000 residents.
- Environmental health concerns include transportation challenges, less access to grocery stores, and approximately one-third of houses have at least one substandard condition.
- Access to healthcare and service is an ongoing challenge for the region due in part to the "significant lack" of healthcare providers, including behavioral health providers. Language barriers adds another layer of restricted access for some residents. Lack of insurance is also an issue for approximately 22% of the region's residents.
- Lower income was found to have an adverse impact on health behaviors such as eating adequate levels of fruits and vegetables. There was also concern regarding the "lack of incentives for health eating" in the SNAP (Supplemental Nutrition Assistance Program)
- Chronic disease is a significant challenge for the region including having the highest rate of overweight and obese adults in the state (70% versus the state average of 64.5%). Rates for children were reported to be 35% (20% obese and 15% overweight). Diabetes is self-reported among adults at 8.7% with increased percentages related to poverty and age.

- The region has the highest rate of teen pregnancy at 13.9 births per 1,000 females compared to a state average of 9.5 per 1,000. Annual incomes of less than $15,000 was found in approximately one-fourth of mothers in the region and just under half of pregnant women rely on Medicaid for prenatal care and delivery.
- Oral health is a concern in the region with 42% of adults not having seen a dentist in the past year. Additionally, 30% of lower income adults ($15,000 or below) have lost six (6) or more teeth due to decay.
- Tobacco use is reported to be approximately one (1) out of five (5) adults. The region reports lower levels of binge and heavy drinking than the state average.

5.) Get Healthy Idaho: Measuring and Improving Population Health

January 2018: Year Three (3) Update

Get Healthy Idaho assessment, developed under the Population Health Workgroup, is considered to be "the most comprehensive review of the health of Idahoans". The PHWG functioned as a workgroup of the Idaho Healthcare Coalition and served two roles: 1) advancing the population health work of the Statewide Healthcare Innovation Plan and 2) providing oversight and approval of the Get Healthy Idaho plan. The first health assessment was completed in 2015 and information was compiled to align with the local Public Health Districts. The information contained within the assessment was meant to provide "the foundation for understanding the health of our residents and communities". The 2018 report included updated data tables and new data. The stated intention of *Get Healthy Idaho* is "to improve the health of all Idahoans through broader partnerships to deliver the outlined strategies" (Idaho Department of Health and Welfare, 2018).

The assessment process included prioritization of health issues. The top 10 priorities were:

- Obesity
- Tobacco Use
- Diabetes
- Mental Health/Behavioral Health
- Suicide
- Physical Activity
- Cardiovascular Health
- Access to Care/Uninsured
- Substance Abuse
- Nutrition/Food Insecurity

It is interesting to note that three behavioral health elements were scored separately: mental health, suicide, and substance abuse. Their combined score of 50 is more than double any other item on the top ten list. The combination of mental health and suicide, without substance use, scores over 50% higher than the number one item.

The four health priorities chosen were:

1. Access to Care
2. Diabetes
3. Tobacco
4. Obesity

Each target area included a five-year goal, SMART objective, strategies, activities, measures, and a review of challenges and opportunities.

Access to Care

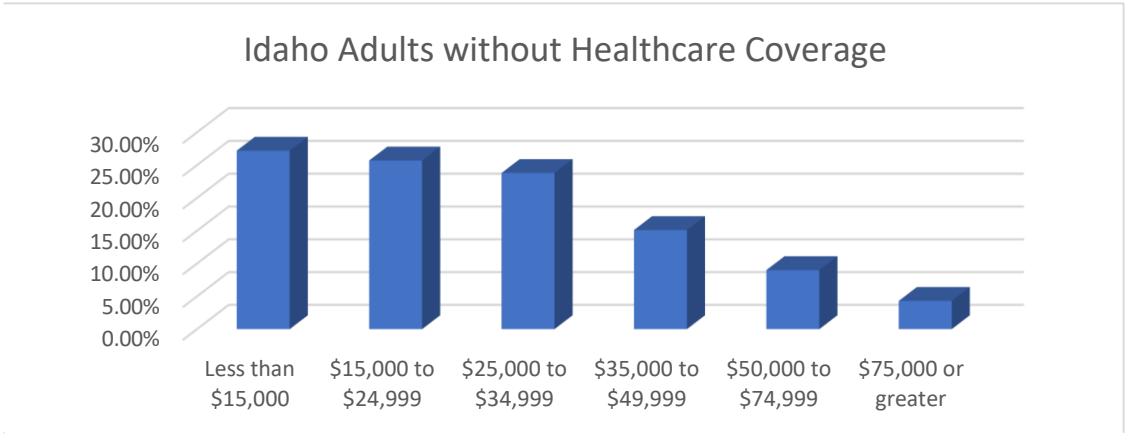
Five Year Goal: Increase access to healthcare services

> Strategy 1: Review and renew healthcare shortage areas to maximize funding and healthcare provider recruitment efforts in rural and frontier counties.
>
> Strategy 2: Develop and implement virtual patient-centered medical homes (PCMH) through Community Health EMS (CHEMS), community health workers (CHW), and Telehealth.
>
> Strategy 3: Recruit new and existing PCMHs to participate in the SHIP.

Access to Care – Challenges and Opportunities

While Idaho is the 11th largest state, it is only 39th for size of population. Thirty-five (35) out of the 44 counties are defined as "rural" with 18 of the 35 meeting the definition of frontier. Idaho per capita income is "significantly less than the national average ($24,280 compared to $29,829)". Idaho's level of poverty is 14.4% while the U.S. rate is 12.7%. The report summarized access to care considerations across primary care, dental, and mental health.

In addition to issues with the number of healthcare providers in Idaho, access to healthcare coverage can adversely impact access to care. In Idaho 15.5% of adults did not have healthcare coverage. In Public Health District 3 that percent rises to 21.9%, the highest percent of non-covered adults across the seven regions.



Diabetes

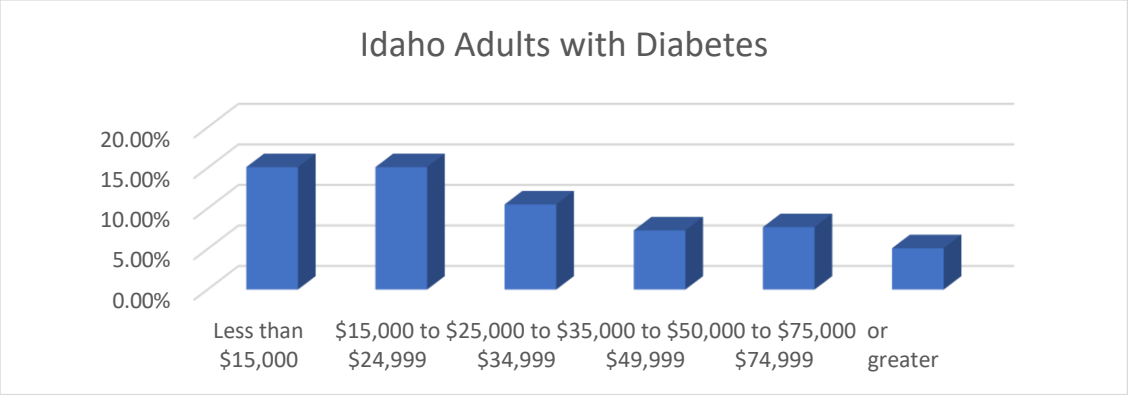
Five Year Goal: Reduce the economic burden of diabetes in Idaho and improve the quality of life for those who have or are at risk for diabetes

> Strategy 1: Increase the number of CDC-recognized Diabetes Prevention Programs (DPP) and American Diabetes Association (ADA) or American Association of Diabetic Educators (AADE) Diabetes Self-Management Education (DSME) Programs.

Strategy 2: Increase referrals to CDC-recognized Diabetes Prevention Programs and ADA/AADE Diabetes Self- Management Education Programs.

Diabetes – Challenges and Opportunities

The report estimates that 110,000 adults (9%) in Idaho have diabetes and approximately one-third of adults do not know that they have the disease. Pre-diabetes rates are estimated by the CDC to be at 560,000 (35%) of Idaho adults. Diabetes ranks seventh as cause of death in Idaho. The cost of diabetes is estimated at $172 million annually. Complications related to improperly managed diabetes is reported to have a "tremendous impact on Idaho's Medicaid program as well as other Idaho health insurers". When considering health behaviors, it is important to note that addressing risk factors such as physical inactivity, unhealthy diet, tobacco use, and alcohol misuse can prevent or delay diabetes.



Tobacco Use

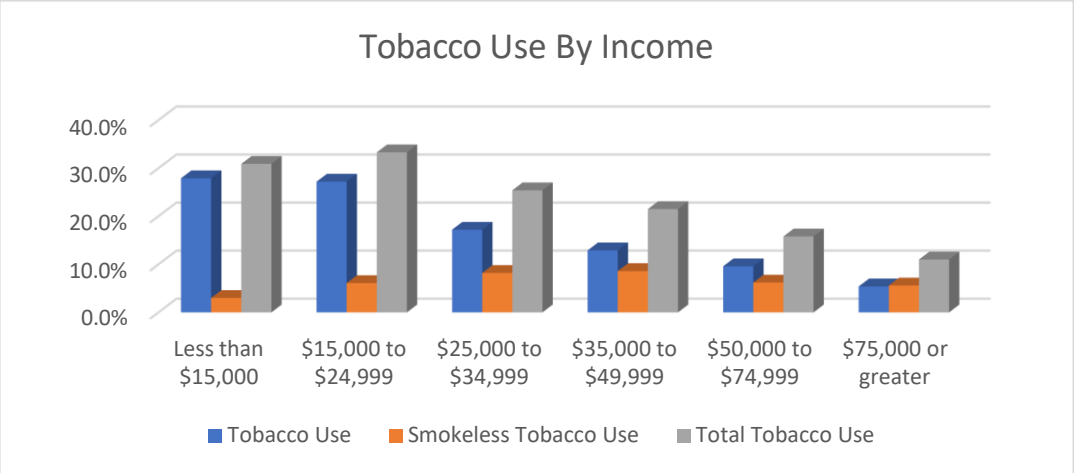
Five Year Goal: Reduce tobacco use in Idaho

Strategy 1: Increase referrals to cessation services.

Strategy 2: Promote the use of Nicotine Replacement Therapy (NRT) for appropriate individuals enrolled in cessation services.

Tobacco Use – Challenges and Opportunities

"Tobacco use is the single most preventable cause of disease, disability and death in the United States, resulting in an estimated 480,000 people dying prematurely from smoking or exposure to secondhand smoke (U.S. Department of Health and Human Services, 2014). Smoking kills more people than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined." Tobacco use is noted to be the "leading preventable cause of death and disease in Idaho". Medicaid pays for $100.5 million of the medical costs each year. "Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, the lesbian, gay, bisexual, transgender (LGBT) community, those of low socio-economic status, those living with mental illness, Medicaid enrollees, and veterans represent Idaho population groups that experience tobacco-related health disparities." Idaho's rate of adult smokers is 14.5%, with Public Health District 3 showing a rate of 19.5% (highest rate across the seven districts). Smokeless tobacco use was 6.1% for Idaho and 7.5% for Public Health District 3.



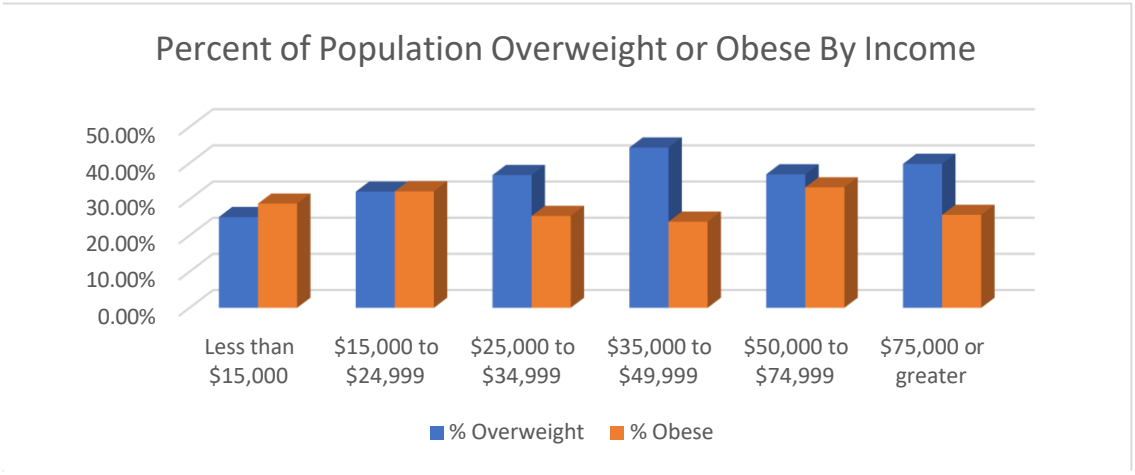
Obesity

Five Year Goal: Reduce the burden of obesity in Idaho

> Strategy 1: Increase healthy options for infants and children through awareness, education, and collaboration.

Obesity – Opportunities and Challenges

The report indicates that Idaho is showing an ongoing increase in the percent of the population that is overweight or obese. The 2016 BRFSS reports that 64.5% of adults are overweight or obese. Males have a higher rate (72.1%) versus females (56.6). Public Health District 3 reports an overweight or obese rate of 70.8%. The 2016/2017 Idaho 3rd Grade BMI Assessment found that 28.6% of 3rd graders were overweight or obese. "Many of the leading causes of preventable disease and death, including heart disease, stroke, type 2 diabetes and certain types of cancer are obesity related. A 2012 Robert Wood Johnson Foundation Trust for America's Health Report estimated that Idaho spends more than $2.7 billion in costs due to obesity, which are projected to rise to more than $3 billion by 2030. The Report also estimates that a five percent decrease in obesity would save Idaho $1.2 billion by 2020 and $3.3 billion by 2030".



II. Review of National Crisis Systems

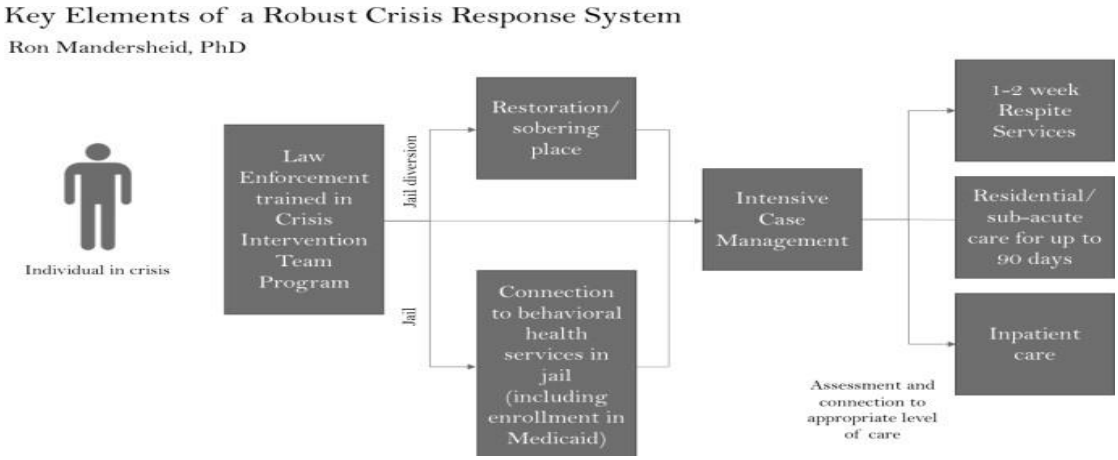
In 2017, Population Health Partners, Loveland Consulting LLC, and TCN Consulting, LLC conducted a crisis system assessment in Montana that included review of crisis systems from different states and National Associations. That information has been approved for use in this report in order to support Idaho system assessment efforts. The following pages include information based on semi-structured interviews with national, regional and state experts, summarizing their insights and lessons learned.

1.) National Association of County Behavioral Health & Developmental Disability Directors

Ron Manderscheid, PhD, served as the executive director of the National Association of County Behavioral Health and Developmental Disability Directors (NACHBDD). With 40 years of experience working in all aspects of mental health, Dr. Manderscheid has extensive knowledge of best practices in behavioral health crisis and jail diversion systems and describes the following as key components of a high-functioning system:

- Crisis Intervention Team (CIT) training for law enforcement
- Intensive case management
- A robust data system that enables warm hand-offs among community partners
- Outreach and enrollment in Medicaid inside of jails
- Respite services for consumers and family members for one day to two weeks
- A restoration/sobering place in lieu of a jail such as a room in a jail or other facility where the primary purpose is to link consumers with services
- Residential or sub-acute care where people can access care for up to 90 days
- Care in an inpatient setting

Dr. Manderscheid is well-aware that not every community, county or region can have all or even most of these components and rural areas in particular, will need to develop unique, innovative, and practical approaches based on their realities and resources. To begin this work, Dr. Manderscheid recommends that county leaders join the National Association of Counties' Stepping Up Initiative and pass a resolution to reduce the number of people with mental illnesses in jails.



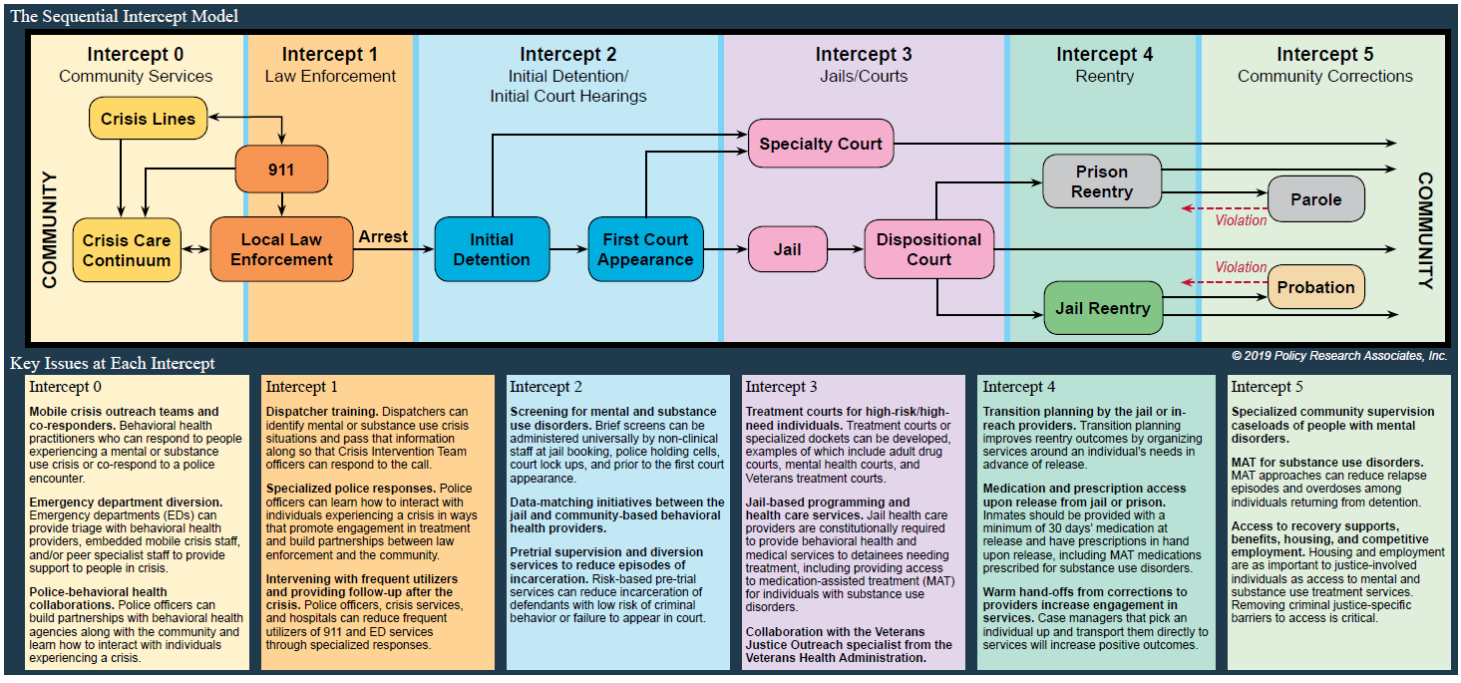
2.) Stepping Up

The "Stepping Up" program, was created because the National Association of Counties, The Council of State Governments Justice Center, and the American Psychiatric Association Foundation came together to lead a national initiative to help advance counties' efforts to reduce the number of adults with mental and co-occurring substance use disorders in jails. The program involves the following six steps and provides toolkits with resources to support this work:

1. Convene or draw on a diverse team of leaders and stakeholders
2. Collect and review data on the prevalence of people with mental illnesses in jails and assess their treatment needs
3. Examine treatment and service capacity and identify policy and resource barriers
4. Develop a plan with measurable outcomes
5. Implement research-based approaches
6. Create a process to track and report on progress.

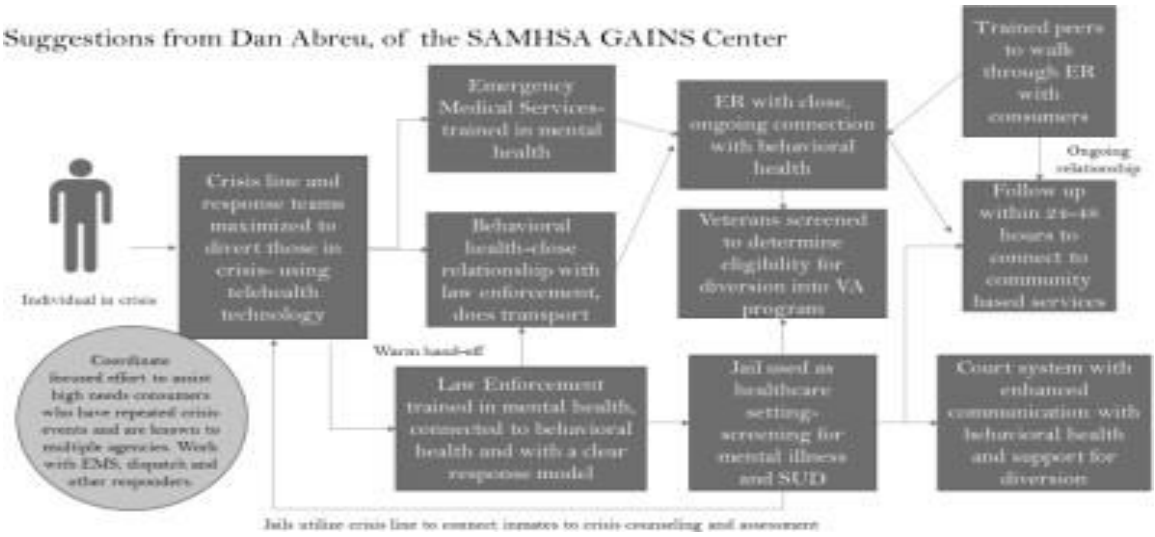
3.) SAMHSA GAINS Center

Dan Abreu, MS, CRC, LMHC, is employed by Policy Research Associates, Inc., and serves as a senior technical assistance specialist with SAMHSA's GAINS Center. Through technical assistance to professionals and communities, the GAINS Center is focused on expanding access to services for people with mental health and/or substance use disorders who come into contact with the justice system. In this capacity, Mr. Abreu provides assistance to SAMHSA grantees, including helping communities use the Sequential Intercept Model (SIM). Please refer to the graph below:



When asked about crisis intervention and jail diversion models that could work in a vast, frontier area, Mr. Abreu noted that it is not possible for any community to duplicate another community's model, but that it is possible to use components from other systems. Mr. Abreu advises communities to build on what they already have in place and develop multiple levels of response. Touching on key aspects of each intercept in the SIM, he offered these suggestions:

- EMS are underutilized in terms of mental health calls and crisis response. Mental health training for these professionals is important, as they can make crisis situations better or worse.
- Emergency Departments (ED) need support from and a close, on-going connection with behavioral health.
- Trained peers are a workforce that could be developed in a rural area. These peers have been used to "walk through" the ED experience with consumers. Once that contact is established, maintaining it can be helpful to the consumer moving forward.
- Once a person leaves the ED, follow-up within 24-48 hours is critical to assure a consumer is connected with community-based services.
- It is essential to have a close connection between law enforcement and behavioral health and this connection should aim to avoid law enforcement transports, assure officers know how to make referrals, and facilitate "warm hand-offs."
- While CIT can be helpful, the time commitment for training may be difficult for rural areas. Still, rural law enforcement agencies can learn important lessons from CIT such as the necessity of mental health training for law enforcement, the need to engage behavioral health and law enforcement to develop and refine a response model, and the need for stakeholders to meet regularly to work through case studies and refine protocols.
- Maximize the use of a crisis line as the first point of contact. Crisis lines can even be used by the jails to connect prisoners with crisis counseling and assessment.
- Mobile crisis response teams can help to get the most out of the first intercept with law enforcement, but rural areas should maximize the use of phone and video technology.
- Jails should be considered healthcare settings and behavioral health providers should communicate with them as they do any other provider. This is particularly important given the frequency of suicide in the jails.
- Screen for mental illness and substance abuse in the jails using evidence-based screening tools and engage with behavioral health as soon as possible. One small rural community has developed a simple system to fax a list of prisoners to the community mental health center each morning.
- Screen veterans early in the process of being booked to determine who is eligible for diversion to a veteran's program.
- Enhance communication with the court system. Even without a specialty court it is possible to divert people with mental health issues if there are programs in place that court officials trust
- Coming out of jail, timely behavioral health and other community services, connection with benefits, and assurance that necessary medications are available are critical to avoid consumers reverting to substance use and psychiatric flare ups.
- Consideration should be given to assisting high need consumers who repeatedly have crisis events. In small communities, these individuals are often known to multiple agencies. Working with 9-1-1 dispatchers and other responders, it may be possible to better understand the numbers and needs of this population and to put in place supports to avoid repeat events.



III. Review of State and Regional Models

1.) Eastern Montana

Like many places in the country, counties in rural Eastern Montana struggle to respond effectively to individuals in acute behavioral health crisis. In a frontier region like Eastern Montana, an individual experiencing a behavioral health crisis may present hundreds of miles from a hospital, and the nearest hospital may not have licensed behavioral health staff available to properly assess the patient and determine how to respond.

As is true nationally, the first point of contact for individuals in crisis is often law enforcement. Without adequate training or community-based resources for referral, law enforcement officials who encounter an individual in crisis may have no option but to take the individual to a jail or call 911 so that he or she can be transported to the nearest hospital. Law enforcement agencies (LEAs) and Emergency Medical Services (EMS) in Eastern Montana report that behavioral health crisis calls are a routine part of their work. Sheriffs and city police chiefs in Eastern Montana estimate that 22% of the calls they respond to are related to mental health crises and 60% are related to substance abuse. Individuals in behavioral health crisis who are not sent to jail may be taken via ambulance or patrol car to an emergency department or transported over long distances to an inpatient behavioral health unit in a hospital.

The burden of transportation in Eastern Montana to the Montana State Hospital (MSH) in Warm Springs is substantial. Warm Springs is in the western portion of the state and is more than 450 miles away from some of the largest communities in Eastern Montana including Wolf Point, Glendive and Sidney. Round trip, the drive from these communities is more than 14 hours. And yet, most LEAs and EMS services report that transport to the MSH is an established part of their work. Seventy five percent of LEAs and 50% of EMS organizations in Eastern Montana report transporting individuals in behavioral health crisis to the MSH.

When a person in Eastern Montana is transported to the MSH or Billings before being fully assessed by a mental health professional, and causing a local law enforcement officer to leave his or her jurisdiction

for up to two full days, it is clearly a drain on human and financial resources. However, without a clear plan and system to respond to mental health crises in the region, this "worst case scenario" can be the only option. Though some patients in behavioral health crisis in Eastern Montana likely experience the "worst case scenario", there are also many organizations in the region working to provide adequate crisis services. Supporting resources and services are highlighted below.

24/7 Crisis Line

After 5:00 pm and on weekends, hospitals and law enforcement agencies can receive consultation from Eastern Montana Community Mental Health Center (EMCMHC) staff through their crisis line. After normal business hours, office lines re-direct calls to the hotline number and EMCMHC staff provide telephonic triage services to individuals, family members or hospitals who call needing assistance with a behavioral health crisis. Those who call may have their concerns addressed over the phone, be directed to the nearest emergency department for care or may be referred to EMS or LEAs. Whenever possible and necessary, EMCMHC staff are dispatched the next day to the individual's location for face-to-face assessment and follow up care.

Hospital Based Secure Behavioral Health Room

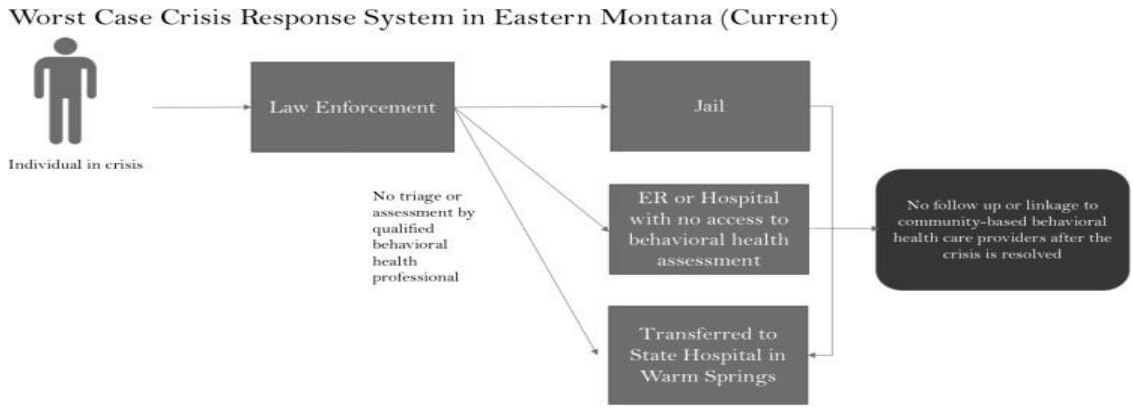
Frances Mahon Deaconess Hospital in Valley County has a secure crisis room, the only such room in Eastern Montana. In 2011, Valley County was awarded a grant from the state to retrofit a room in their hospital as a secure crisis room, to train law enforcement officers, and to pay for costs related to commitment proceedings. In subsequent years, the county has received additional county matching grant funds to continue these efforts. From July 1, 2015, through June 30, 2016, the room was used 16 times. Four of the clients who used the room were sent to the MSH, two received community commitments, one went to an acute psychiatric facility and nine went home.

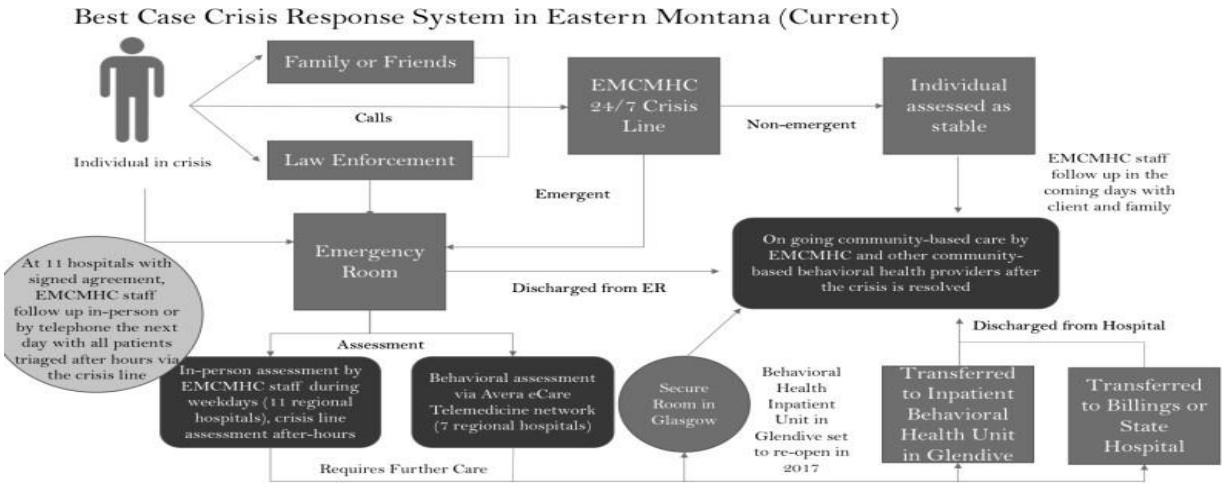
Crisis Services in Hospitals

The EMCMHC currently provides a number of behavioral health crisis services for clients in the region. The EMCMHC has an agreement with 11 hospitals across the region to provide face-to-face or telephonic consultation and assessment for clients who present in their emergency departments in behavioral health crisis during weekday business hours.

Telehealth Assessment for Crisis

In 2014, the Leona M. and Harry B. Helmsley Charitable Trust provided three-year staggered grants to a number of hospitals in Eastern Montana to purchase telemedicine equipment for their Emergency Departments and cover fees for utilizing the Avera eCare Telemedicine Network. Using this money, 12 of the 16 hospitals in the region now have access to the 24/7 medical assessment services provided by board certified emergency room physicians and nursing staff in Sioux Falls, South Dakota through the Avera eCare Telemedicine Network. Through this network, rural emergency departments can access a range of medical assessments including stroke, trauma and heart attack. Recently, Avera has also added behavioral health assessments to their suite of services. Some sites in the region, such as GMC, report that they rely heavily on the Avera system for crisis behavioral health assessments. According to Avera data, in the month of March 2017, GMC utilized the system for four assessments, all of which were for behavioral health. Providers at other sites in the region interviewed for this project report rarely using the Avera system, despite having access to the equipment, or being unaware of its capacity to support behavioral health assessment.





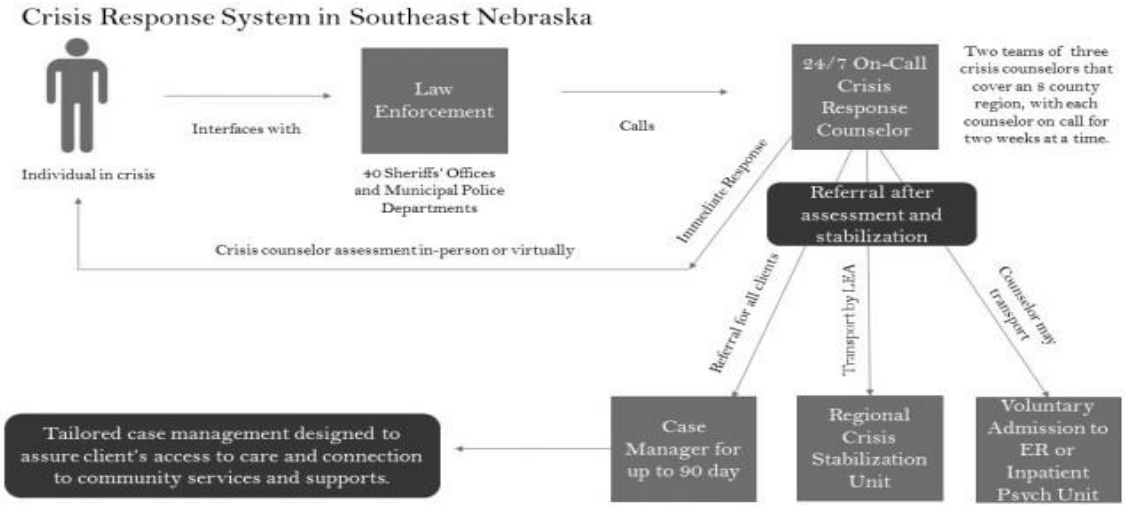
2.) Southeast Nebraska

The state of Nebraska passed legislation in 2004 to downsize the number of state hospital beds and increase community-based behavioral health services with the goal of Nebraskans receiving treatment closer to home, family, and support services. State funding was redirected to create regional crisis services intended to divert clients from state hospital beds and jails, and with the requirement to provide service to any individual in need. The Regional Behavioral Health Authority used this opportunity to create a crisis system for the sixteen-county region in southeast Nebraska that has diverted 84% of its involuntary emergency protective custody placements since its inception in 2005. The region is primarily rural with the exception of Lincoln. Key components of this regional system include:

- Mobile crisis response counselors who assist law enforcement in 40 Sheriff offices and municipal police departments on a 24/7 basis.
- Case managers who provide 24/7 emergency community support beginning with the crisis event.
- Law enforcement officers who have received Crisis Intervention Team (CIT) training.

There are six mobile crisis response counselors within the region and each is on call two out of every six weeks. While on duty, a counselor covers eight counties. When law enforcement calls the crisis response team, a call may be handled in one of two ways. In one option, a counselor may respond face-to-face with a drive that can take up to two hours. If the urgency of the situation is deemed by the officer to require a more rapid response, the counselor can provide a virtual crisis response. This is accomplished using iPads equipped with the secure interface, OmniJoin. Law enforcement can use this technology with either their onboard or office computers. While a crisis counselor is working with a client, the client is also connected with emergency community support via a 24/7 case manager. Regardless of where a client is placed following a crisis event, these resource experts begin working with the client during the event and may continue for up to 90 days. The case manager's goal is to assure clients access and stay connected with community services and supports. These services can vary widely. For some, the need might be for gas money to stay with a friend or for an overnight hotel stay. Following a crisis event, services might include treatment with a counselor and/or prescriber, housing, physical health services or supported employment. Many clients are able to remain in their communities or return to their communities more quickly because of this intensive and immediate case management service. If a client is in need of a voluntary admission to the inpatient psychiatric unit in Lincoln and does not have another means of transport, under certain circumstances a crisis counselor will perform the transport. For those placed in emergency protective custody, there is a crisis stabilization unit in the region specifically for involuntary commitments, and these transports are performed by law enforcement. Travis Parker, MS, LIMHP, CPC, has been a crisis counselor in this system since its inception. Parker says there are two factors that have been critical to the success of the system:

- Crisis counselors are willing to travel with law enforcement, and in some cases provide patient transport. This has been particularly important in this rural region since it is not uncommon for an officer to be the only one on duty in an entire county, especially on third shift.
- Warm hand-offs to case managers are available 24/7 and are part of the initial crisis response. When they have a choice, officers are less likely to take a person into custody when they know there is a plan in place for that individual.



3.) Missouri

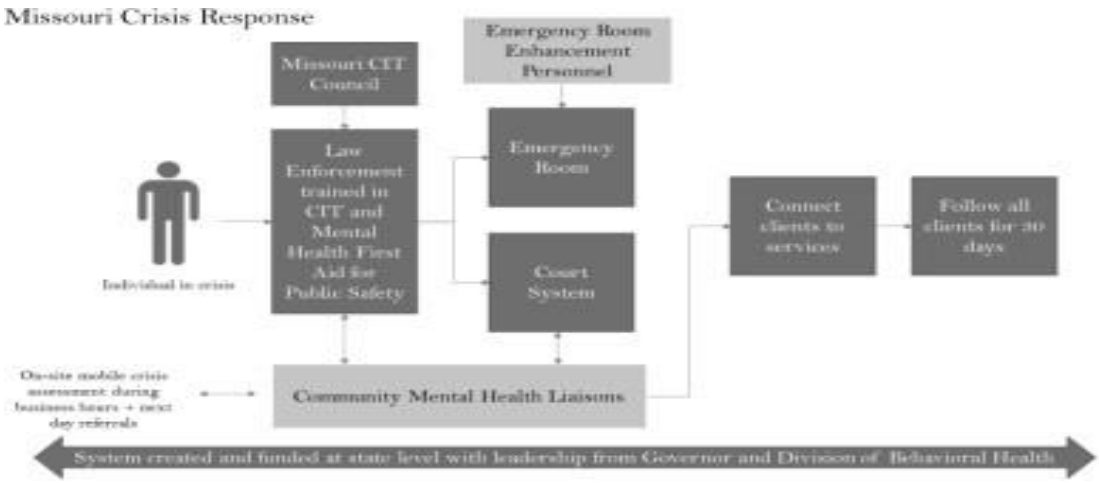
After the Sandyhook school shootings in December 2012, then Missouri Governor Jay Nixon decided he wanted to strengthen Missouri's mental health system. According to Rick Gowdy, Director of the Missouri Division of Behavioral Health, the Governor directed the Missouri Department of Mental Health to develop Missouri's Strengthening Mental Health Initiative and provided $10M toward its development. The Governor asked that a proposed approach be developed in time for his State of the State Address in January 2013, and in time to request additional funding from the legislature that winter. Missouri's Strengthening Mental Health Initiative includes three major components:

- Community Mental Health Liaisons (CMHLs) are trained behavioral health professionals that are dedicated to support law enforcement and courts
- Emergency Room Enhancement personnel (EREs) are trained behavioral health professionals that are dedicated to support hospital emergency rooms
- A robust statewide CIT initiative

In partnership with Community Mental Health Centers (CMHCs), the state created 31 CMHL positions that cover 114 Missouri counties. These individuals are mental health professionals employed by the CMHCs who only take referrals from law enforcement and the courts. They are expected to be available during business hours, provide on-site mobile crisis counseling and assessment, and connect consumers with services. The CMHLs work in any location they are needed – people's homes, jails, at law enforcement staffing meetings, and occasionally they ride along with law enforcement. If an event occurs when they are off duty, law enforcement or the court can make a referral for services to be provided the next day. CMHLs follow each consumer for 30 days and assure clients, who are often high service utilizers, do not fall through the cracks. Mr. Gowdy said when consumers don't show up for appointments, CMHLs will go to their homes or if they are homeless, will find them and find out what is happening in their lives. Sgt. Jeremy Romo is an officer with the St. Louis Police Department and Director of Missouri's statewide CIT initiative called the Missouri Statewide CIT Council. According to Sgt. Romo, "CMHLs are the best thing that ever happened to law enforcement." Sgt. Romo has noted that that while it may be ideal to have mental health professionals who are dedicated to ride along with law enforcement as is done in large cities, the CMHL approach is more realistic and doable even in smaller jurisdictions. He reported this approach is working, as they have seen a dramatic decrease in crises among people who previously had repeated events. Similarly, EREs are mental health professionals that are dedicated to assisting in emergency rooms in seven areas of the state, some of which are rural. This has resulted in fewer admissions to hospitals and greater attendance in treatment according to Mr. Gowdy.

Before the Strengthening Mental Health Initiative, Missouri had a begun a significant emphasis on CIT, according to Mr. Gowdy. With the Strengthening Mental Health Initiative, the state built on this by creating the Missouri CIT Council. Mr. Gowdy has noted that for credibility with law enforcement, it is important to have commissioned, uniformed law enforcement lead this effort. Within one year of having the CIT Council, the state went from 22 local CIT Councils to 37, and attendance at the statewide annual CIT conference grew from 300 attendees to 450. While CIT started in some of Missouri's larger areas, Sgt. Romo is now charged with working to reach rural areas. "Collaboration is the most important part of the work," Sgt. Romo said. "There is so much liability involved in police work that mental health training is really important now." He said that he believes among some officers mental health stigma

may be exaggerated due to their interactions with people during crises and the misperception that people with mental illness are often or always in crisis. The officers who are most against the training initially, often find it the most valuable and rate it the highest by the end of the training, according to Sgt. Romo. Sgt. Romo indicated that having a local multi-disciplinary CIT Council is the way to operationalize this collaboration. It provides a forum for behavioral health, law enforcement, medical and other professionals to work through system issues and develop protocols.



4.) Oregon

The state of Oregon has pioneered crisis intervention and jail diversion services. Regional Coordinated Care Organizations (CCOs) manage the state's Medicaid program in partnership with counties who are the local mental health authorities. Each county has a designated Community Mental Health Program (CMHP) who functions as the behavioral health safety provider. Contracts with the CCOs disincentivize the use of higher levels of care and incentivize development and use of community-based options by providing innovation funds that are based on performance. With this funding mechanism, many rural counties have been able to develop crisis intervention and jail diversion services. For example, Lifeways, in addition to being the provider operating Western Idaho Community Crisis Center, is the community mental health program for two rural counties in Eastern Oregon with a population of approximately 100,000.

The Lifeways crisis intervention and jail diversion initiative in this area is robust and includes:

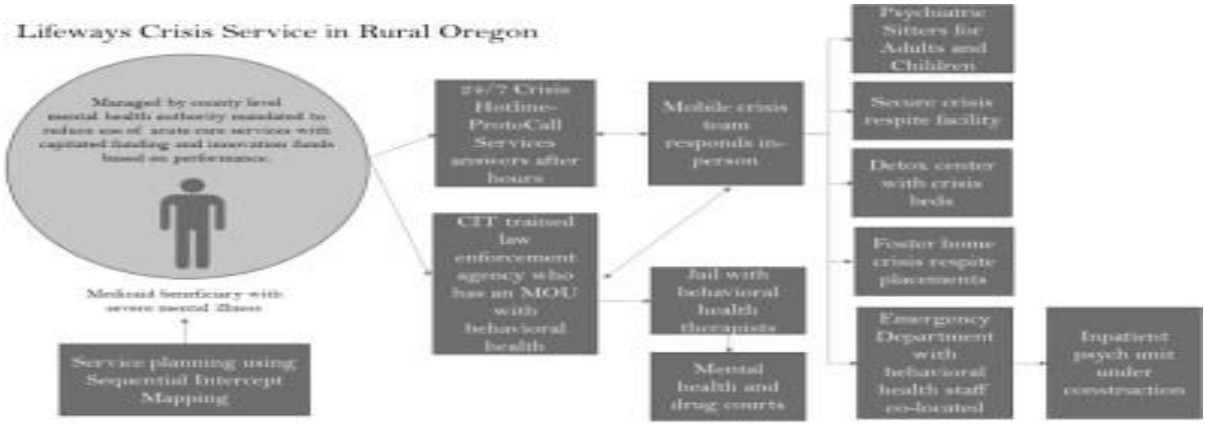
- Use of Sequential Intercept Mapping as a planning tool
- 24/7 mobile crisis response
- Crisis Intervention Team (CIT) trained law enforcement, memoranda of understanding with law enforcement agencies, and regular joint meetings among law enforcement and behavioral health staff to discuss protocols and other issues.
- Foster home crisis respite placements
- Psychiatric sitters for adults and children
- Behavioral health therapists who spend time in the jails to work toward shorter stays, reduced recidivism, and to ensure treatment continues upon release
- Problem solving courts, including a mental health and drug court

Ray Millar, former COO of Lifeways notes this region had also invested in primary care settings and ensuring that providers have training to screen for substance abuse and mental health issues and to refer timely to appropriate services. Mr. Millar says two keys to jail and hospital diversion are:

1) having a strong continuum of outpatient services that prevent crises, such as assertive community treatment, outpatient wraparound services, intensive case management and peer supports; and
2) having settings to which people can be diverted/

Based on his extensive experience in behavioral health, Mr. Millar offered the following insights into helpful approaches to crisis services and jail diversion in rural areas:

- use of telehealth for crisis response and psychiatry services
- behavioral health support 24/7 provided to hospitals and law enforcement
- mental health training for law enforcement and regular communication between law enforcement and behavioral health professionals
- a basic place to keep a person in crisis in a safe space overnight, perhaps staffed with a paraprofessional or nurse with a master's level behavioral health professional consulting remotely
- agreement regarding a balanced approach to jail diversion from prosecutors and defense attorney, and securing MOUs among behavioral health, law enforcement, probation and parole, and the courts is helpful.



5.) Remote Alaska

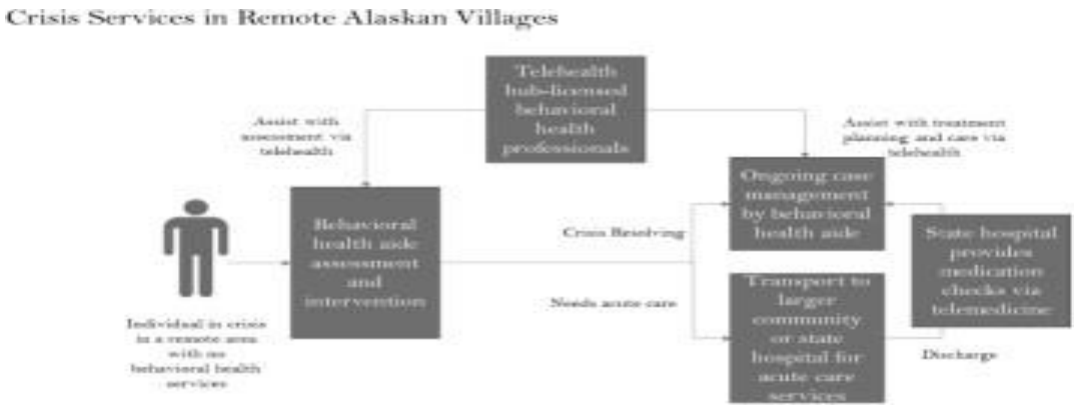
Dennis Mohatt, Vice President for Behavioral Health (at the time of the interview) at the Western Interstate Commission for Higher Education (WICHE) has assisted states and localities across the West with mental health system development. While he cautioned about trying to directly overlay models for crisis intervention from one area to another, he offered valuable insights from his work in various locations, especially Alaska.

Use of trained paraprofessionals to provide basic primary care and dental services in remote Alaskan villages is widespread, and this concept is now being used in behavioral health. Behavioral health aides

are trained to provide case management, routine care and support, and to help people stay on medications and intervene during mental health crises in these villages. According to Mr. Mohatt, for any rural and remote area, "it is important to train local people to be able to assess and resolve crises and refer. But, there has to be some 'boots on the ground,' some capacity to respond. That is what these aides provide." The state of Alaska has created a statewide "health hub," that provides telehealth capacity to remote areas. This technology allows behavioral health aides and other paraprofessionals to be supported by professionals in larger communities. This technology also allows patients to be seen without professionals ever traveling to the villages. If a situation becomes too difficult to handle locally, patients are transported for acute care services in larger communities or to the state hospital in Anchorage.

The state hospital has also arranged for a robust telepsychiatry program to reach out to villages to provide medication checks. Mr. Mohatt described the behavioral health aide as something along the lines of a community health worker, home visitor or a community mental health professional extender. He said the model may have some relevance to rural areas with more roads than in Alaska, but that Medicaid would have to allow for billing of services to make it work. The examples of use of paraprofessionals supported with technology are many, according to Mr. Mohatt. The military uses platoon level medics to perform behavioral health assessments, and high-end technology to connect people in the field with hospital settings. Also, in Alaska, he described a project that involved the state hospital and a rural community, in which case managers were given iPads to interface with people in crisis and receive consultation from state hospital professionals. But key to the success of any technology is the training. Mr. Mohatt said he has "been in many rural clinics that had dusty video hookups in the corner." When asked about key elements to shore up behavioral health services in extremely rural areas, Mr. Mohatt offered the following for consideration:

- Train all responders in Mental Health First Aid (MHFA)
- Train those most interested in CIT
- Train and support place-committed people, rather than trying to continuously recruit for behavioral health professionals that you must convince to move to and stay in your community
- Maximize the use of mid-level providers supported by telehealth, even in inpatient settings
- Consider the use paraprofessionals and EMTs with supports, but know that reimbursement will be necessary



IDAHO CRISIS CENTER SYSTEM

I. Regional Crisis Services

Over a seven-year period, Idaho observed an increasing number of involuntary mental health holds by law enforcement, while civil commitments remained flat over the same period. Many of those put on a hold were spending time in emergency departments and jails but did not meet criteria for commitment. Using the SIM Framework to guide the discussion, the state convened relevant stakeholders to work on solutions to this problem. The group recommended crisis centers be developed in seven regions that cover the state's 44 counties. This solution was supported by the Governor and in 2014, the Behavioral Health Crisis Centers Act was passed by the Idaho Legislature.

The state provided funding to establish these centers but required that the centers have a plan after two years to reduce the state's commitment by 50% over the following two years. The state contracts with various entities to operate these regional facilities. For example, in Idaho Falls, funding is provided to Bonneville County and the county contracts with a private behavioral health care provider, Rehabilitative Health Services (RHS), to operate it with local law enforcement to provide security. In Coeur d'Alene, the state contracts with Kootenai Health, the major health system in the region that also provides emergency room services and inpatient psychiatric services, to operate the regional crisis center.

In the region that includes Idaho Falls and Pocatello, the crisis center is estimated to have saved $750,000 in emergency department costs by the end of its first year of operation, and the region saw its number of involuntary mental health holds flatten rather than increase. The center in Coeur d'Alene estimated a 25% reduction in emergency department usage due to mental illness and inpatient psychiatric hospitalizations in its first year.

In the absence of crisis center services, the state of Idaho provides state-funded outpatient behavioral health services for indigent clients through seven state-run regional offices, but contracts for Medicaid services with the exception of very high needs clients who are also served by the regional offices. State and county funding are used to pay for indigent clients' medical care, including behavioral health care – with counties paying for events costing less than $10,000 and the state picking up the higher cost events. While Medicaid mental health providers are reimbursed on a fee-for service basis, the state contracts with Optum, a managed care company, to manage and pre-authorize outpatient services (excluding pharmacy).

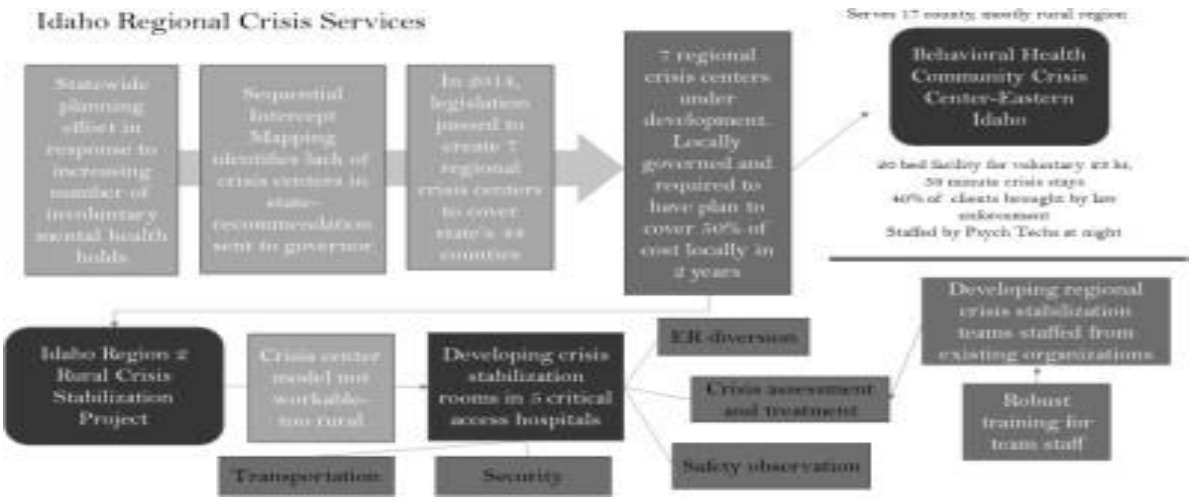
Key issues for sustainability were reported to be working to get more coverage from Medicaid and private insurance, and ensuring counties realize savings in indigent care dollars by using the centers.

1.) Behavioral Health Community Crisis Center of East Idaho

The Idaho regional crisis centers began with a pilot project located in Idaho Falls that serves 17 primarily rural Eastern Idaho counties. The Behavioral Health Community Crisis Center of East Idaho is

a 20-bed facility that provides voluntary, 23-hour 59-minute stays (in part, to avoid certain licensure requirements for facilities that allow longer stays). Staffing includes 24/7 nursing services. All clients are assessed and if clients are deemed medically stable, they are voluntarily admitted. Bachelor's level social workers staff the center during the day and "psych techs" are on duty 24/7. DeVere Hunt of RHS is a master's level clinician that provides clinical supervision. A master's level clinician is also in the center once per week to work with clients with substance abuse issues. Hunt estimates that 50% to 60% of clients have a substance abuse history in addition to a mental illness. An amnesty box allows clients to dispose of drugs and paraphernalia at the center with no questions asked. Clients can be walk-ins; come with family or friends; referred by local providers, often as an alternative to the emergency department; and an estimated 40% are brought to the center by law enforcement. At the center, clients receive mental health assessments and are linked to services in the community.

While a goal of the center is stabilization, and the center is for 23-hour 59-minute stays, clients are often discharged and readmitted, allowing them to receive services on site for three to five days. Nine beds are organized in each of two rooms, with two additional single rooms. Clients can come and go as they please; however, those who are a threat to themselves or others are put on holds by law enforcement. The region has CIT trained officers including those contracted for security in the center. The center works closely with law enforcement and has offered an alternative to incarceration for those who would previously have been charged with lesser crimes such as trespassing and disorderly conduct. Additional crisis services in the region include a 24/7 crisis call center and separate transitional residential homes for men and women.



<u>Currently there are six Crisis Centers in Idaho</u>:

- Boise: Pathways Community Crisis Center of Southwest Idaho
- Coeur d'Alene: Northern Idaho Crisis Center
- Idaho Falls: Behavioral Health Crisis Center of Eastern Idaho
- Twin Falls: Crisis Center of South-Central Idaho
- Pocatello: South East Idaho Behavioral Crisis Center (opened April 2019)
- Caldwell: Western Idaho Community Crisis Center (opened April 2019)

SOUTHWEST DISTRICT HEALTH: CRISIS SYSTEM ASSESSMENT

I. Western Idaho Community Crisis Center (WICCC)

Western Idaho Community Crisis Center (WICCC) opened April 23, 2019 and is the sixth of seven regional crisis centers in Idaho. The other crisis centers are in Boise, Coeur d'Alene, Idaho Falls, Lewiston, Twin Falls, and Pocatello. The crisis centers are designed, in part, to decrease arrests, involuntary mental health holds, and emergency room utilization. Gov. Brad Little was quoted at the WICCC open house as stating that providing adequate mental health care has been one of Idaho's most "vexing problems," and each crisis center was part of "a big solution" (Simmons & Idaho Press, 2019). WICCC provides crisis services for adults 18 and older experiencing a crisis due to mental health and/or substance abuse. The center is open 24 hours a day, seven days a week, 365 days of a year. Services include outpatient acute stabilization, peer support, recovery coaching, and being connected to community resources. Individuals can stay at the crisis center for 23 hours and 59 minutes. WICCC is operated by Lifeways, Inc (www.lifeways.org).

Sarah Andrade, Lifeway's Idaho program manager, was interviewed for an article in the Idaho Press Tribune newspaper (Simmons & Idaho Press, 2019). Ms. Andrade spoke to ongoing efforts to develop partnerships with other organizations in order to strengthen the array of services and supports available to clients. Examples included partnering with Canyon County Community Clinic to provide peer support specialists/recovery coaches and with the Idaho Food Bank to create a "closed-door" food pantry. The center is also a resource for local law enforcement. Law enforcement officers have checklists to help them determine when it is appropriate to take someone to WICCC.

In a virtual tour, created by Lifeway's, Ms. Andrade provided an overview of the facility, programing, and resources. Individuals seeking services at WICCC begin the process by being screened by security to ensure that they are safe to enter the facility. The individual then enters the facility where they receive a medical screening to ensure they are not in need of a higher level of medical care. Once medically clear individuals are brought to the "main floor" where there are clinical offices, male and female resting mat areas, showers, and a laundry. An assessment is conducted to determine the individual's service and support needs. The main floor also has two "quiet rooms" for individuals who feel the need to be secluded from others. The staff breakroom includes space for the "closed food pantry" supported by the Idaho Food Bank. Individuals who screen positive for food insecurity are provided a food box when they leave.

Liz Johnsen, Lifeway's Director of Business Development was also interviewed as part of this project in order to gather additional information regarding WICCC. While WICCC had been in operation for less than a month at the time of interview, initial client demographics included women escaping domestic violence, young adults between 18 and 25, and some older homeless individuals. Staffing of the center includes licensed clinicians, peer support specialists, and support staff employees as well as EMS staff provided through a contract with Victory EMS Services. Funding is being sought to support the hiring of Community Navigators.

Ms. Johnsen identified system needs as including improving the continuum of care in order to avoid crises, having a safety net system in place, improving general community understanding of behavioral health, addressing stigma, increasing the number of primary care physicians, and increasing funding for

prevention services. Sustainability after the first two years is seen as a challenge with initial thoughts including the need for payment for the wrap-around services provided by the center, shifting cost savings from other parts of the system to the crisis centers, and increased ability to bill insurances for services provided.

Crisis systems cannot be evaluated in a vacuum. They function as part of a larger ecosystem that is interdependent upon all of its parts. Challenges in one part of the system create ripple effects in other parts of the system. Crisis services are services of last resort when an individual has reached a point of significant risk and vulnerability and other community resources are unable to address the level of need. However, service delivery, efficacy, and availability are impacted by postvention, prevention, and primary care resources.

Long term outcomes post-crisis are significantly influenced by the services and supports that are received throughout the event and after. Given the rural/frontier nature of the SWDH region, access to post crisis service and support can be especially difficult. Challenges include the distance an individual must travel to reach needed services, lack of access to consistent transportation, limited number of providers available to provide these important services, and limitations in specialized post-crisis service provision among available providers.

Another consideration when assessing the crisis system is prevention and early intervention services. What services and supports are in place to avoid or minimize a crisis event before it occurs? If there is not an adequate system in place for early identification and intervention to avoid crises, then a crisis system can quickly become overwhelmed and limited resources exhausted. As with post-crisis services, distance, transportation, and access to a provider are also important considerations for the success of prevention. There are a variety of settings in which early identification and intervention can occur such as outpatient behavioral health, education settings, and job sites.

However, when one considers that approximately 45% of individuals who died by suicide visited their primary care physician within the previous month it becomes clear that the primary care setting is a critical player in both pre and post crisis intervention (Reed J. , 2012).Individuals that are post crisis may not be willing to engage in treatment at a behavioral health agency but may be willing to go to their primary care physician. One issue that can contribute to this is stigma. Fear and misperceptions regarding mental illness and substance use disorders results in avoidance of behavioral health agencies and their associated treatment. Primary care is a significant stakeholder in the behavioral health system especially when considering that almost 70% of physician visits involve behavioral health issues as well as the immense economic impact of these patients whose behavioral health needs go undiagnosed or untreated (ICER, 2015) (Reiss, et al., 2016). The cost associated with health conditions comorbid with behavioral health issues are astoundingly high and can increase the annual cost per patient by 124% for diabetes, 76% for chronic lung disease and 186% for heart failure (CIVHC, 2013).

Clearly, there are a multitude of factors that can create a supportive or inhibitive context for behavioral health. This report considers not only the Western Idaho Community Crisis Center services but the broader environment for behavioral health in the service region.

II. Demographics Impacting Physical and Behavioral Health

*Data throughout the Demographics Impacting Physical and Behavioral Health section are drawn from data tables compiled by Blue Cross of Idaho.

Rural health and access to providers. In the U.S., nearly a quarter of the population, or 62 million people, live in rural areas that cover 75% of the land mass. Recent estimates suggest that 15 million rural residents have significant mental and/or substance use disorders. Suicide attempts and death rates are markedly higher in rural areas, particularly for rural elderly, whose rate is three (3) times that of the national average for non-rural settings. The Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that, "… a likely factor in explanation for this startling discrepancy is the dearth of health care in general and behavioral health care specifically in non-metropolitan areas" (Hutchings & King, 2009).

Despite the fact that a quarter of the U.S. population lives in rural communities, only 9% to 11% of the nation's physicians' practice in rural areas, and the greater their specialization, the less likely their presence in a rural setting. The behavioral health field suffers similar discrepancies, as psychiatry positions are disproportionately vacant in federally funded rural community health centers, and chronic low salaries and poor reimbursement rates make it difficult for rural agencies to attract and retain behavioral health care professionals (What's different About Rural Health Care?, n.d.).

Chronic disease. Chronic diseases are now the major cause of death and disability worldwide, responsible for 59 % of deaths and 46 % of the global burden of disease (WHO, Global Strategy on Diet, Physical Activity, adn Health, 2003). Despite advances in the effectiveness of treatment, research shows that patients frequently do not get the care they want or need (McGlynn, et al., 2003). In the Southwest Region of Idaho, 13.8% of the population is over 65. In, Payette, Gem, and Washington Counties that number is much higher with over 65 percent of population at 17.7%, 21.9%, and 24.2% respectively (U.S. Census Bureau, 2011-2015). This suggests that the burden of chronic disease may be elevated for these populations.

A snapshot look at mental health in Idaho shows:

- No Medicaid Expansion but will have January 2020
- Medicaid patients can self-refer for mental health services (2013)
- Most counties lack community mental health that provides a full range of services
- Ranked 48th in Mental Health (consistently in bottom 4 states)
- 2015, 5th highest suicide rate in the U.S. (57% higher than national average)
- Suicide 2nd leading cause of death for Idahoans ages 15-34 (males up to age 44)

III. Social Determinants of Health Data and Health Data

The concept of social determinants of health (SDH) is not new. The Heckler Report, published by the US Department of Health and Human Service in the early 1980s, is considered to be one of the landmark reports that brought forth the SDH concept. This report documented health disparities among minority populations in the United States and is considered to be one of the triggering events for SDH research and policy change.

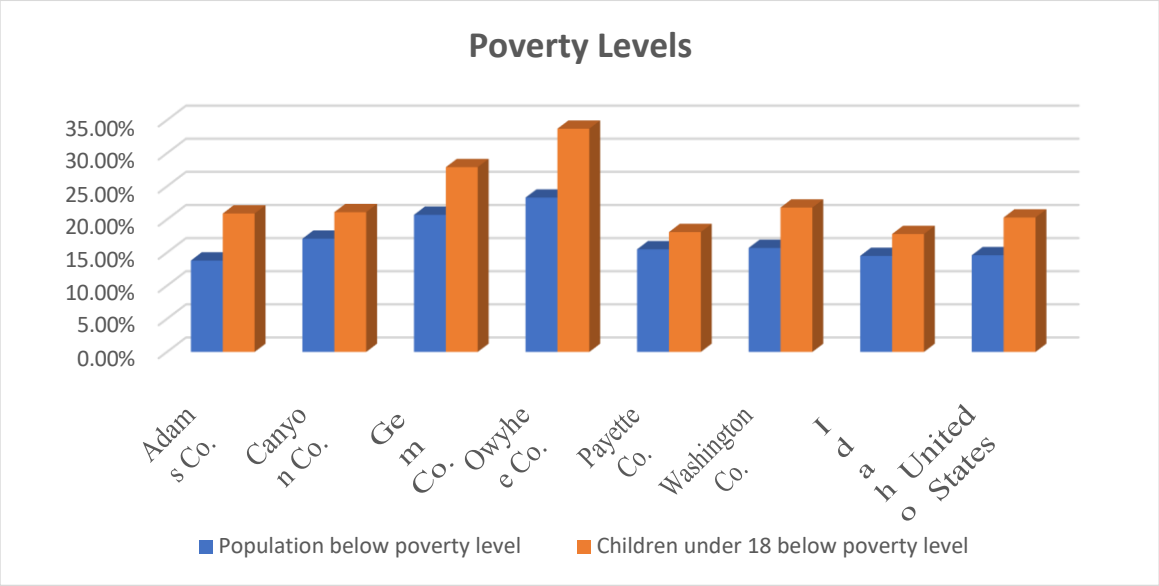
According to the Thirteenth Annual Report to the Secretary of the United States Department of Health and Human Services and the Congress of the United States, "an increased focus on SDH presents the best option for improving health outcomes and reducing healthcare costs in the United States".

The World Health Organization (WHO) has identified SDH as "the conditions in which people are born, grow, live, work and age". In 2014, the WHO published the Social Determinants of Mental Health report which examined "1) the social determinants of common mental disorders (including substance use disorders); and 2) action on social determinants that can prevent mental health disorders and/or improve population mental health". One of the main findings of the report was that "certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavorable social, economic, and environmental circumstances, interrelated with gender. Disadvantage starts before birth and accumulates throughout life". The report further notes that "the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences" (WHO, Social Determinants of Mental Heath report , 2014).

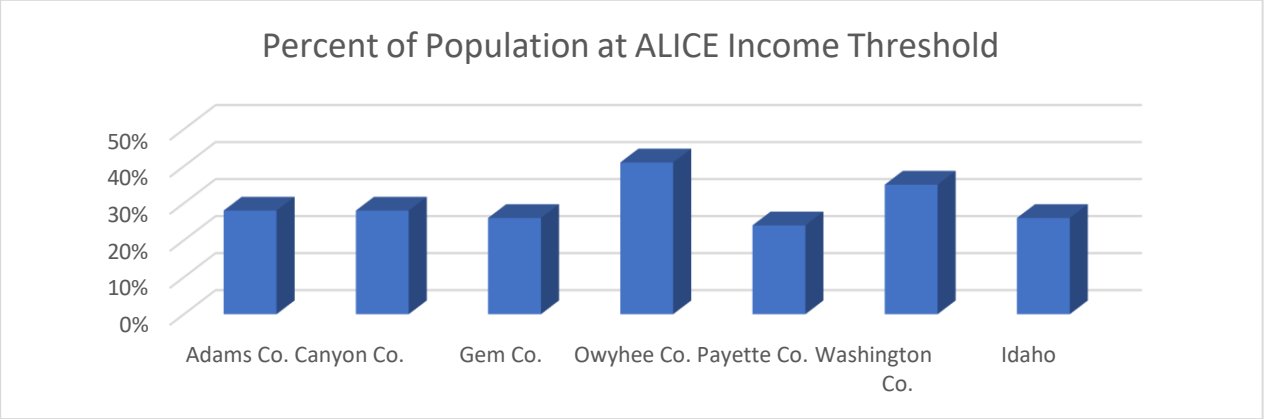
The WHO report reflected that the relationship between mental health and socioeconomic status was interconnected with each impacting the other. It was noted that "a mental disorders lead to reduced income and employment, which entrenches poverty and in turn increases the risk of mental disorder" (WHO, Social Determinants of Mental Heath report , 2014).

When evaluating the health needs of the Southwest District Health region and developing plans to address those needs it will be important to be aware of impacting elements, including SDH.

Poverty. According to the US Census, residents living below the federally established poverty line within SWDH counties ranges from 13.8% in Adams County to 23.3% in Owyhee County. The overall average across Idaho is 14.5% and 14.6% is the national average. Percentages of children living below the poverty line range from 18.1% in Payette County to 33.7% in Owyhee County. Idaho's average is 17.9% and the national average is 20.3%.

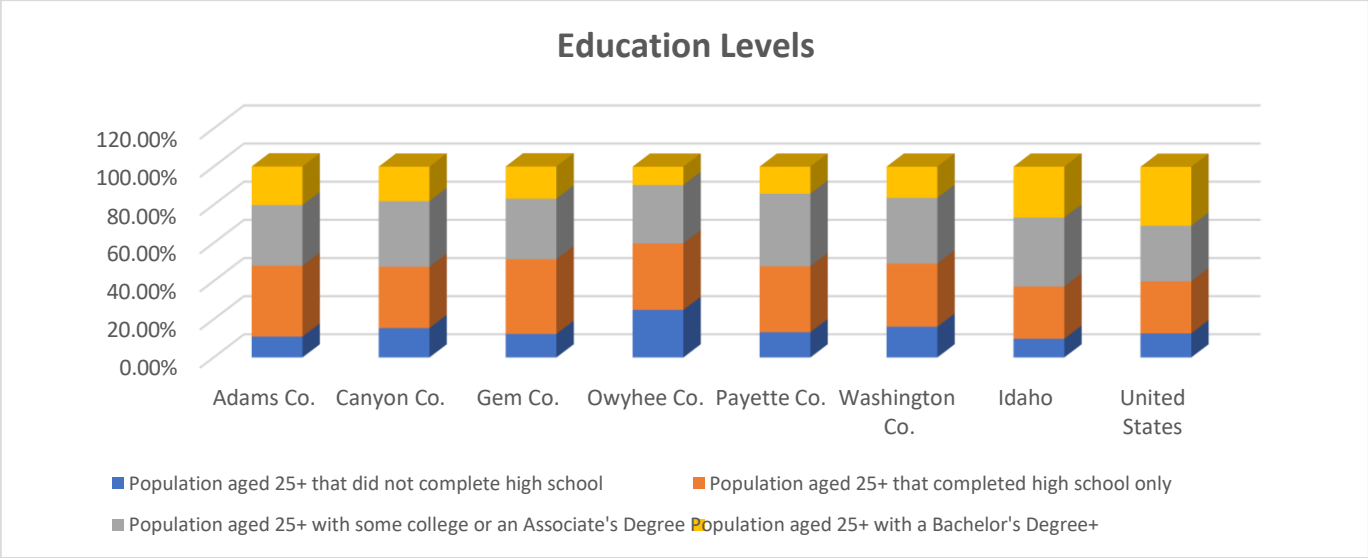


ALICE Gap. ALICE Gap is a phrase coined by United Way in 2009 to describe individuals and families whose income is above the Federal poverty line but who are "Asset Limited, Income Constrained, Employed". This population tends to struggle to afford the basic necessities and often will not have the financial means to address unexpected financial demands such as medical costs or vehicle repairs. The United Way report notes that "ALICE households are forced to make difficult choices such as skipping preventative health care, accredited childcare, healthy food, or car insurance. These "savings" threaten their health, safety, and future" (ALICE: Asset Limited, Income Constrained, Employed, 2009). SWDH counties ranges from 24% in Payette County to 41% in Owyhee County. Idaho's average is 26%.



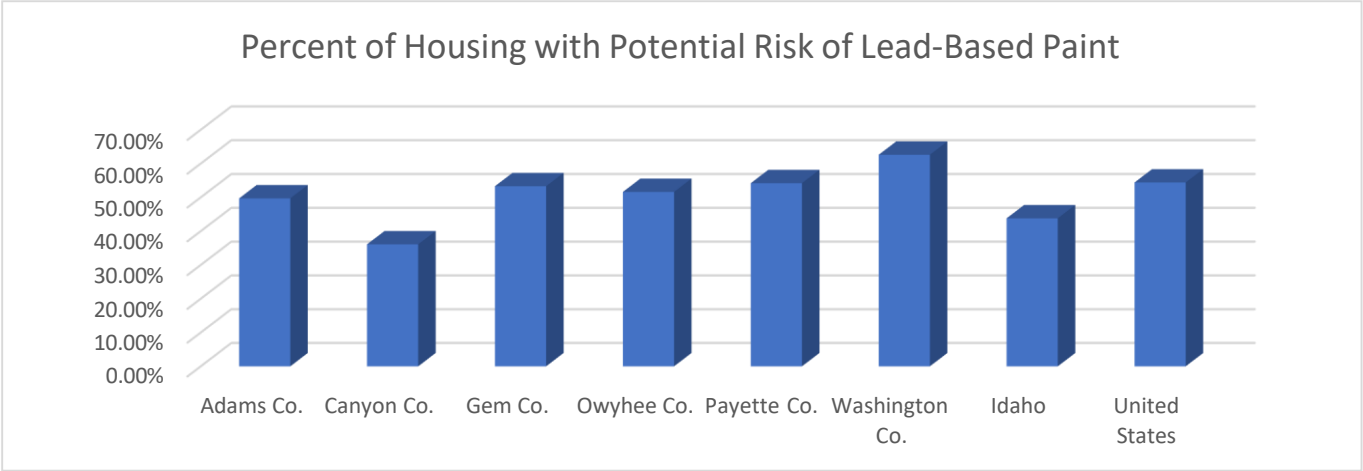
Education. The US Census reports that Idaho falls below the National average (30.9%) for residents who have completed at least a Bachelor's degree. SWDH counties fall below the Idaho average (26.7%) ranging from 20.3% in Adams County down to 9.7% in Owyhee County. Residents who have completed "some college or an Associate's Degree" exceeded the National average of 29.1%, ranging from 30.5% in Owyhee County to 38% in Payette County. Idaho's overall average is 36.1%. When combined, Idaho has a higher percentage of individuals who attended college (62.8% versus 60%) but a lower percent continued through at least a bachelor's degree. SWDH counties ranged from a combined percentage of 40.2% in Owyhee County to 52.5% in Canyon County.

Completion of high school only percentages ranged from 32.1% in Canyon County to 39.2% in Gem county. All counties exceeded both the National (27.3%) and Idaho (27.4%) averages. Ranges for the percent of the population that did not complete high school was 24.9% in Owyhee County to 10.9% in Adams County. These percentages also exceeded the Idaho average (9.8%) and four out of the six counties exceeded the National average (12.6%). Only Adams and Gem Counties were below the National average. Combined totals for graduating high school or less ranged from 47.5% in Gem County to 59.8% in Owyhee County. Idaho is lower than the National average with a combined percent of 37.2% compared to 39.9%.



Housing. In 2011, the Robert Wood Johnson Foundation published a study on How Housing Effects Health. The article noted that the majority of Americans spend approximately 90% of their time inside. Of that time, they estimated that two-thirds was in their home. The study stated that "poor quality and inadequate housing contributes to health problems such as chronic diseases and injuries and can have harmful effects on childhood development". Lead poisoning, which adversely affects the brain and nervous system, is one of the potential health hazards that can be present in older homes.

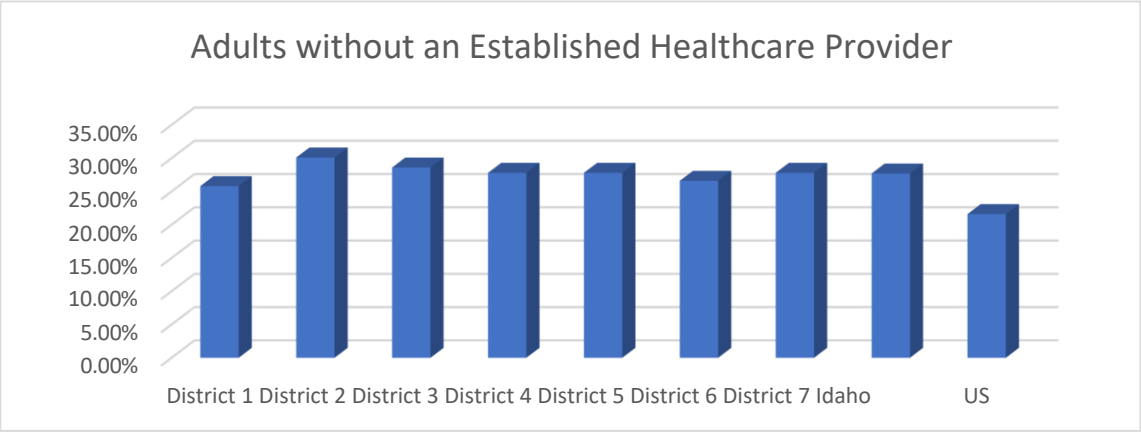
Another consideration regarding housing is affordability. Shortages in affordable housing can limit individuals' and families' choices regarding what neighborhoods they live in and the percent of their income that goes to housing costs. When increased percentages of income go the housing this can inhibit one's ability to afford other expenses. It was noted that "low-income people with difficulty paying rent, mortgage or utility bills were less likely to have a usual source of medical care and more likely to postpone treatment and use the emergency room for treatment".



Access to Care. Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. One analysis found that primary care

physician supply was associated with improved health outcomes including reduced all-cause cancer, heart disease, stroke, and infant mortality; a lower prevalence of low birth weight; greater life expectancy; and improved self-rated health. The same analysis also found that each increase of one primary care physician per 10,000 people is associated with a reduction in the average mortality by 5.3% (HRSA Data, n.d.).

According to the Health Resources and Services Administration (HRSA), the whole state of Idaho qualifies as a Primary Medical Care Health Professional Shortage Area (HPSA) and qualifies with HPSA population groups of *low income*, *migrant farm workers*, and *homeless*. These areas also qualify as a Medical and Mental Health Professional Shortage Area with a *geographic* HPSA designation.



Lack of Mental/Behavioral Health Service Providers. The percentage of Idaho's population facing a high shortage of mental/behavioral health providers in 2006 was 31.6%. This represents the largest percentage shortage of mental health professionals in the nation. In 2006, over 97% of Idaho's population lived in a county with a high shortage of prescribing mental health professionals (SAMHSA, Mental Health 2010 Report, 2010).

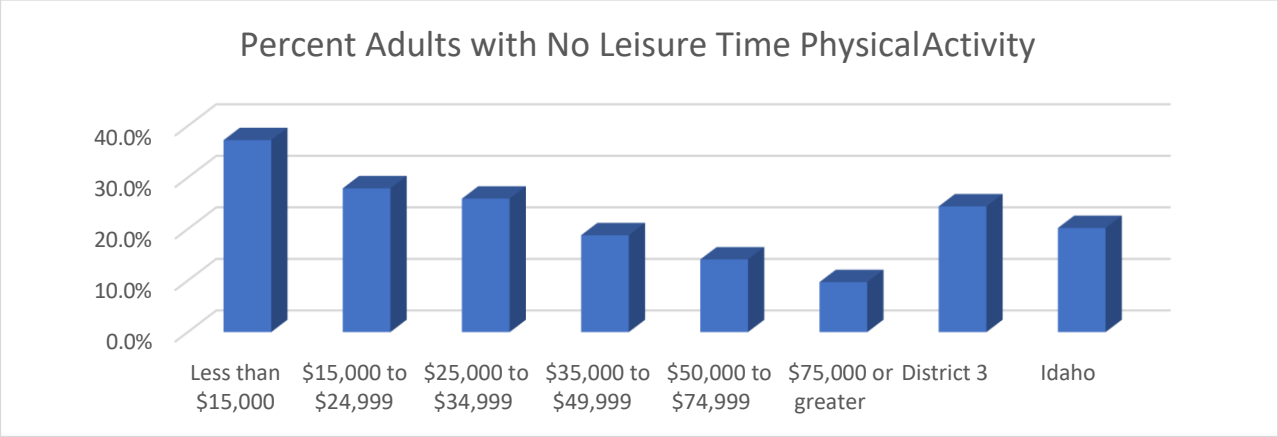
The rate of psychiatrists per 100,000 people in Idaho was 6.6 in 2006. This is the lowest rate of psychiatrists in the nation and less than half of the national average of 14.4 psychiatrists per 100,000 people. Idaho's rate of psychologists was 14.1 per 100,000 which also represented less than half the national average of 30.9. The rate of family therapy counselors and social workers in Idaho was also below the national average (although the rate of general counselors was above the national average) (SAMHSA, Mental Health 2010 Report, 2010).

All of the counties in Region 3 have areas listed as mental/behavioral health professional shortage areas as of March 2012 with 51 mental health providers per 100,000 residents (HSRA, n.d.). The shortage of mental/behavioral health professionals is especially concerning, given the high suicide and mental illness rates in Idaho as documented in regional Community Health Needs Assessment (CHNA)

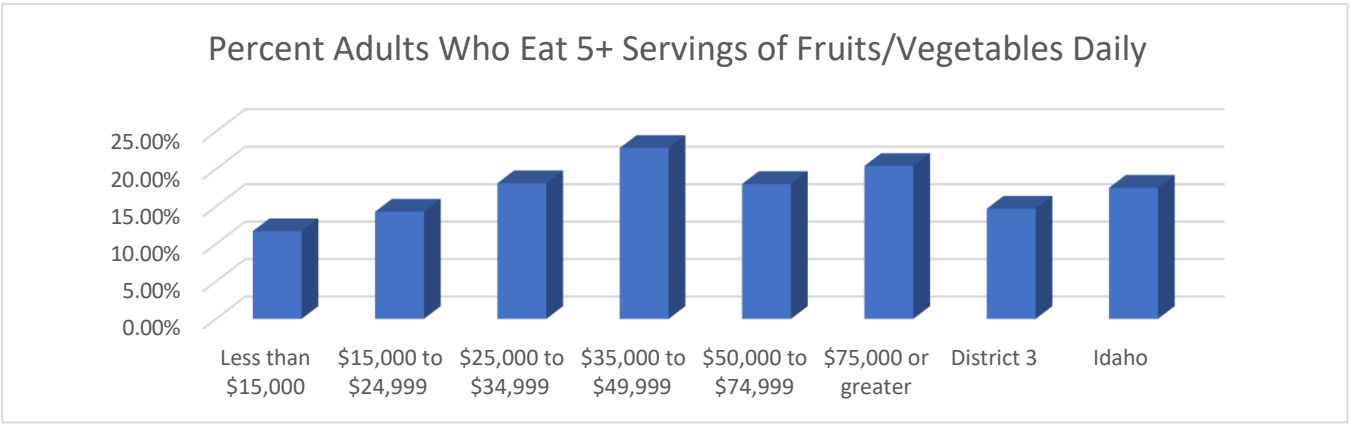
Physical Activity. The Center for Disease Control and Prevention (CDC) looked at the link between physical activity and morbidity and mortality (Physical Activity, 2017). They found that "Getting enough physical activity could prevent 1 in 10 premature deaths". This included decreased risk of dying

from diabetes, cancer, and heart disease. It can also help with healthy bones/muscles/joints and decrease depression and anxiety.

Data for Region 3 shows a clear relationship between income and having non-work-related physical activity.



Healthy Eating. Ng et al, conducted an analysis of the global burden of disease and found that "poor nutrition is a primary contributor to morbidity" and the US Burden of Disease Collaborators report that poor nutrition is associated with more than one in four US deaths. Approximately half of US adults have one or more preventable chronic diseases related to poor-quality dietary patterns or physical inactivity, which disproportionately affect low-income and underserved communities (Ng M, Fleming, Roberson, Thomson, & et al, 2014).

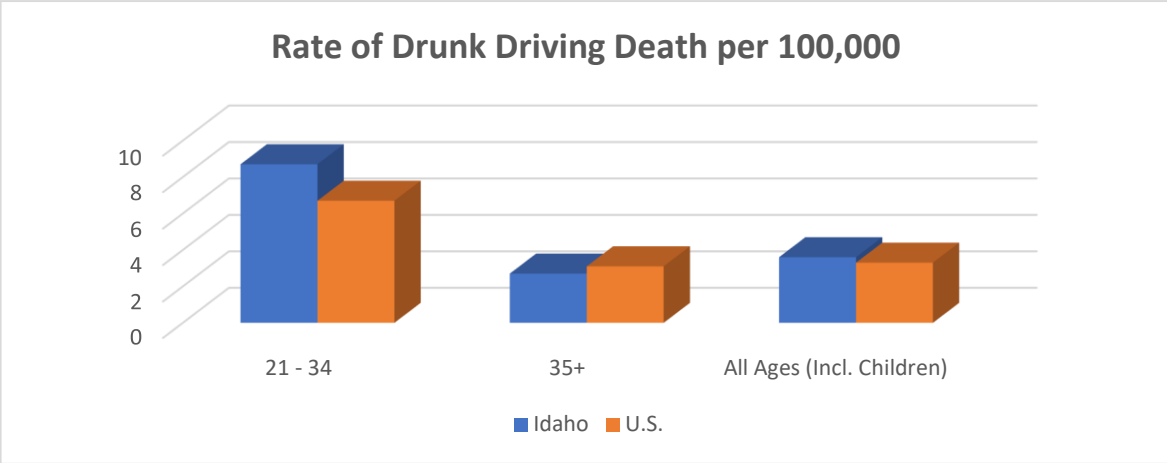


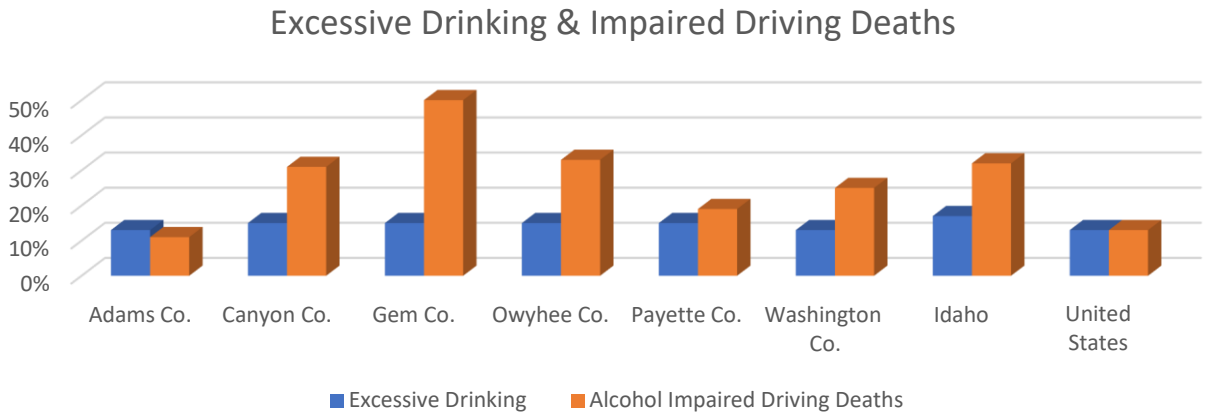
Substance Use. According to HealthyPeople.gov, in 2005, "an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95 percent of people with substance use problems are considered unaware of their problem".

Data indicates that 17% of the adult population engages in "excessive drinking". The SWDH counties have lower averages ranging from 13% (Adams and Washington) to 15% (Canyon, Gem, Owyhee, and Payette). In contrast, five out of the six SWDH counties percentages for "Alcohol impaired driving deaths" exceed the U.S. average of 13%. There are significant differences among the counties ranging

from 11% (Adams) to 50% (Gem). Canyon (31%) and Owyhee (33%) counties have percentages that are close to Idaho's 32% average.

CDC statistics on drunk driving in Idaho reports that 712 people were killed in crashes involving a drunk driver between 2003 and 2012 (Motor Vehicle Safety, 2019). In the U.S. significantly more males die due to drunk driving: 5.2 per 100,000 compare to 1.5 per 100,000 for females. Idaho males exceed the U.S. number with 5.8 per 100,000. Data regarding Idaho females was not produced due to the number being less than 20 deaths total.

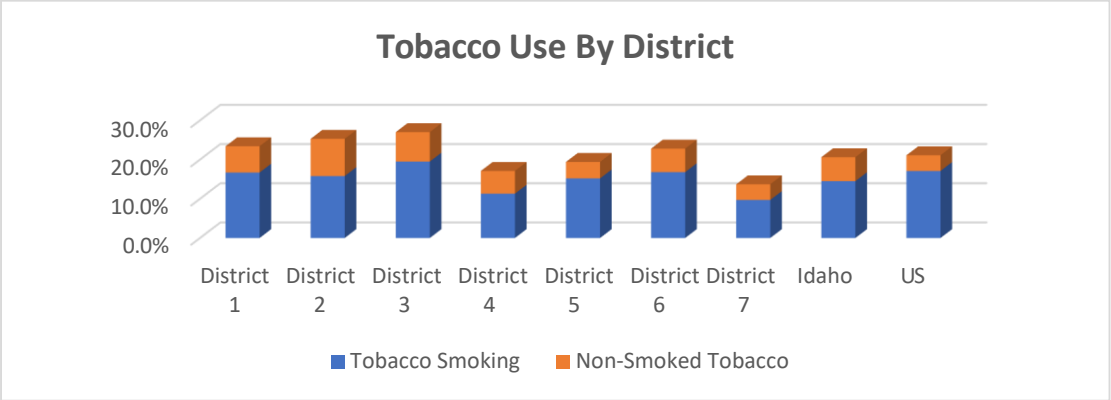


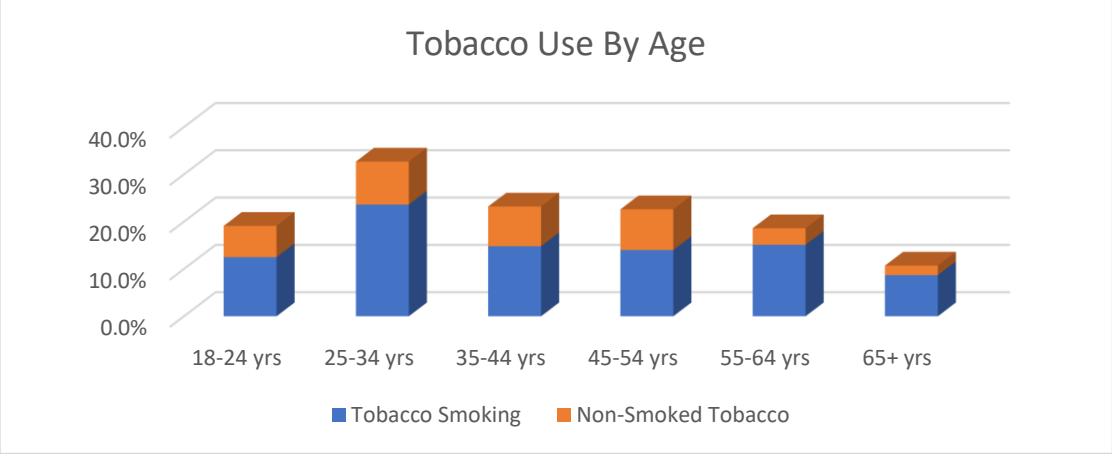


Tobacco Use. According to the Center for Disease Control and Prevention, the prevalence of current cigarette smoking among adults has declined from 42% in 1965 to 18% in 2012. However, more than 42 million Americans still smoke. Tobacco has killed more than 20 million people prematurely since the first Surgeon General's report in 1964. Although the prevalence of smoking has declined significantly over the past one-half century, the risks for smoking-related disease and mortality have not. In fact, today's cigarette smokers—both men and women—have a much higher risk for lung cancer and chronic obstructive pulmonary disease (COPD) than smokers in 1964, despite smoking fewer cigarettes. Just over 20% of adults in the Southwest Region report smoking. This is greater than the state average of 15.9% (IDHW, Division of Public Health, 2016a). Recent surveys monitoring trends in tobacco use indicate that

more people are using multiple tobacco products, particularly youth and young adults. The percentage of U.S. middle and high school students who use electronic, or e-cigarettes, more than doubled between 2011 and 2012 (CDC).

The list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer. These are in addition to diseases previously known to be caused by smoking, including bladder, esophageal, laryngeal, lung, oral, and throat cancers, chronic lung diseases, coronary heart and cardiovascular diseases, as well as reproductive effects and sudden infant death syndrome (CDC).





Mental Health. According to the World Health Organization (WHO) mental health is an integral and essential component of health. The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." One “key fact” put forth by the WHO is that “Mental health is determined by a range of socioeconomic, biological and environmental factors”. This is an important consideration when planning for system improvement (WHO, Global Strategy on Diet, Physical Activity, adn Health, 2003).

Mental health has a significant range of conditions whose severity ranges from mild to severe. Psychosis, one of the more severe conditions, is ranked among the three most disabling conditions worldwide (McFarlane, 2014). Each year, approximately 100,000 young adults in the US experience

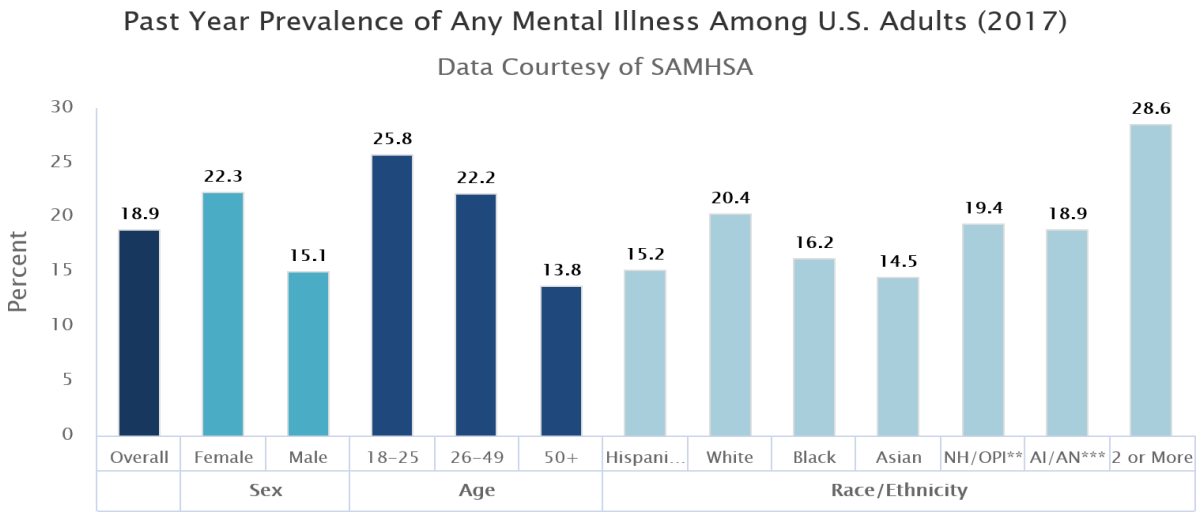
first episode psychosis with onset generally between the ages of 15 and 25 (McGrath et al, 2008). In the US, schizophrenia leads annual mental illness expenditures with $22.7 billion in direct healthcare services. Most of these costs are attributed to acute hospitalizations (Srihari et al, 2012).

Individuals with psychosis have increased rates of suicide and substance use disorders. As many as two-thirds of completed suicides by individuals with schizophrenia occur within six years of diagnosis, with elevated risk one year after the first psychiatric hospitalization (Srihari et al, 2012).
NAMI provides the following breakdown of the Prevalence of Mental Illness in the U.S.:

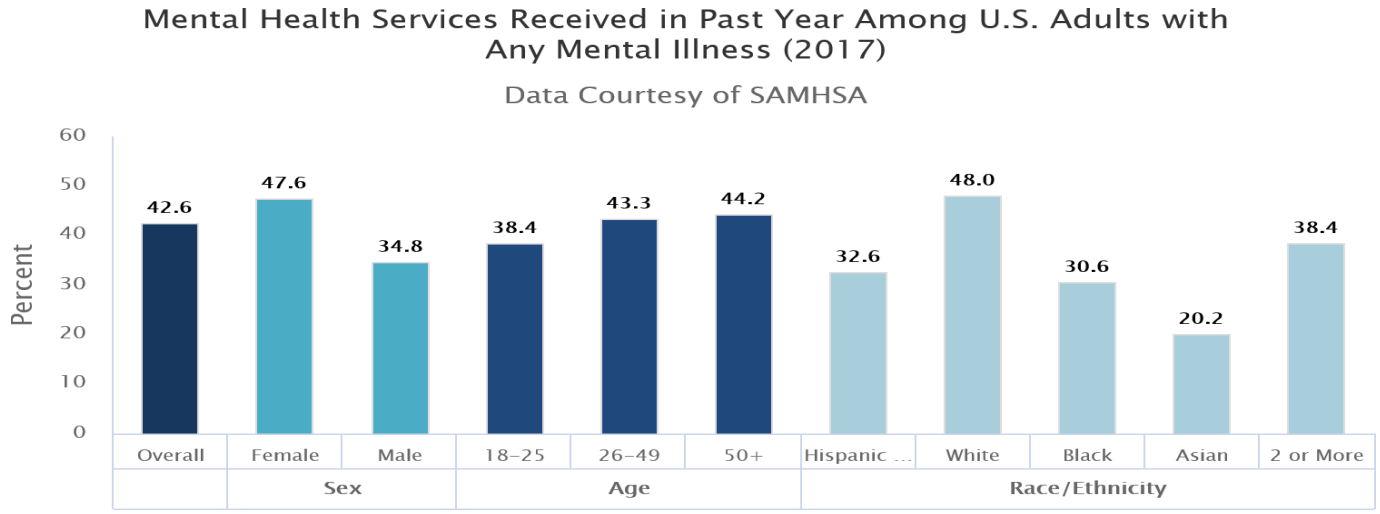
- Approximately 1 in 5 adults in the U.S. (46.6 million) experiences mental illness in a given year.
- Approximately 1 in 25 adults in the U.S. (11.2 million) experiences a serious mental illness in a given year that substantially interferes with or limits one or more major life activities.
- Approximately 1 in 5 youth aged 13–18 (21.4%) experiences a severe mental disorder at some point during their life. For children aged 8–15, the estimate is 13%.
- 1.1% of adults in the U.S. live with schizophrenia.
- 2.6% of adults in the U.S. live with bipolar disorder.
- 6.9% of adults in the U.S.—16 million—had at least one major depressive episode in the past year.
- 18.1% of adults in the U.S. experienced an anxiety disorder such as posttraumatic stress disorder, obsessive-compulsive disorder and specific phobias.
- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5%—10.2 million adults—had a co-occurring mental illness.

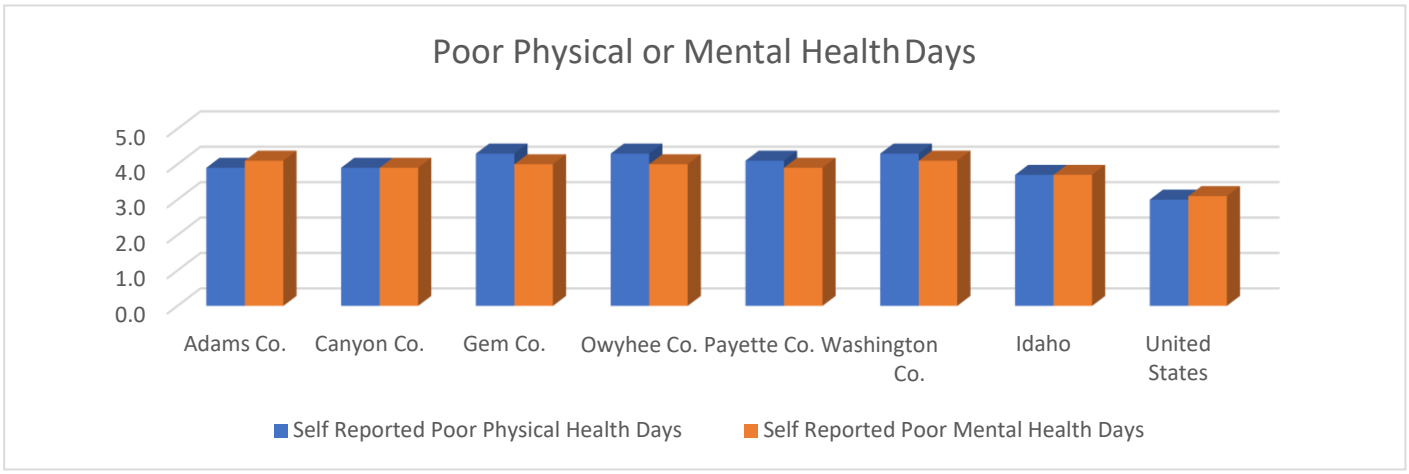
NAMI graded Idaho a "D" average

- ❑ F in Category I: Health Promotion & Measurement
- ❑ D in Category II: Financing & Core Treatment/Recovery Services
- ❑ D in Category III: Consumer & Family Empowerment
- ❑ D in Category IV: Community Integration & Social Inclusion



According to NIMH, in 2017, among the 46.6 million adults with any mental illness, only 19.8 million (42.6%) received mental health services in the past year.



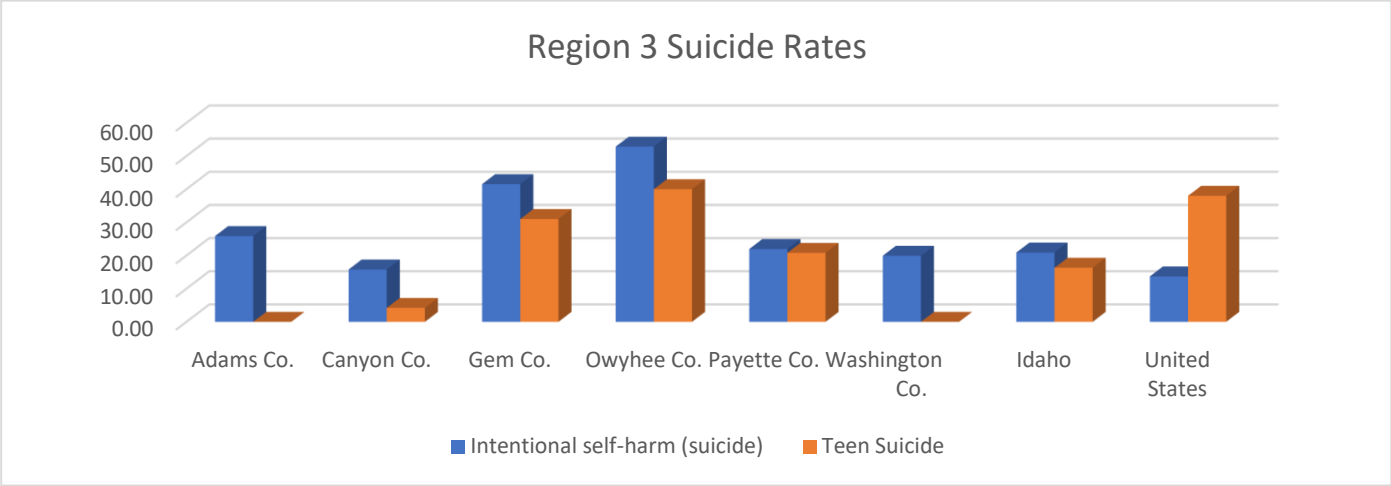


According to NAMI the consequences of lack of treatment include:

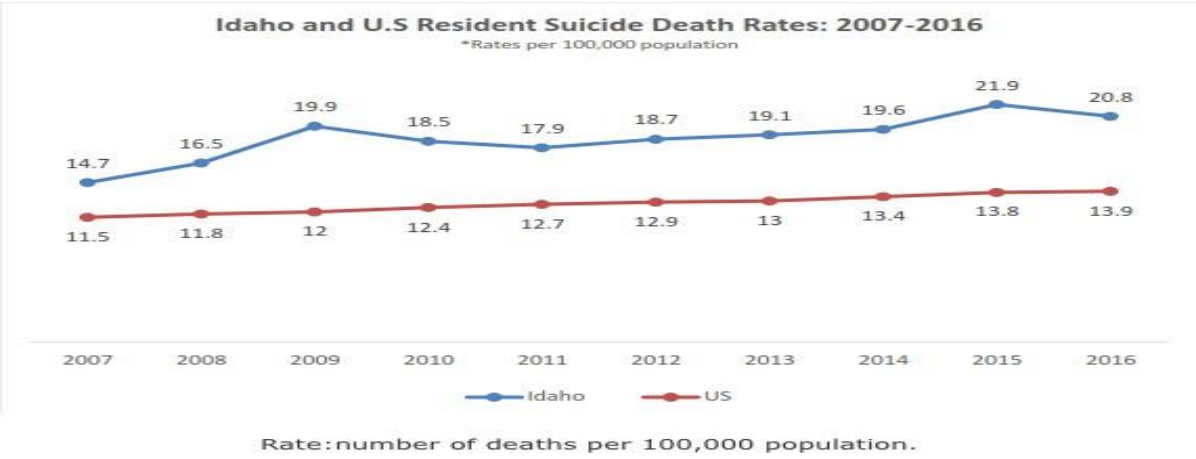
- Serious mental illness costs America $193.2 billion in lost earnings per year.
- Mood disorders, including major depression, dysthymic disorder and bipolar disorder, are the third most common cause of hospitalization in the U.S. for both youth and adults aged 18–44.
- Individuals living with serious mental illness face an increased risk of having chronic medical conditions.
- Adults in the U.S. living with serious mental illness die on average 25 years earlier than others, largely due to treatable medical conditions.
- Over one-third (37%) of students with a mental health condition age 14–21 and older who are served by special education drop out—the highest dropout rate of any disability group.
- Suicide is the 10th leading cause of death in the U.S., and the 2nd leading cause of death for people aged 10–34.

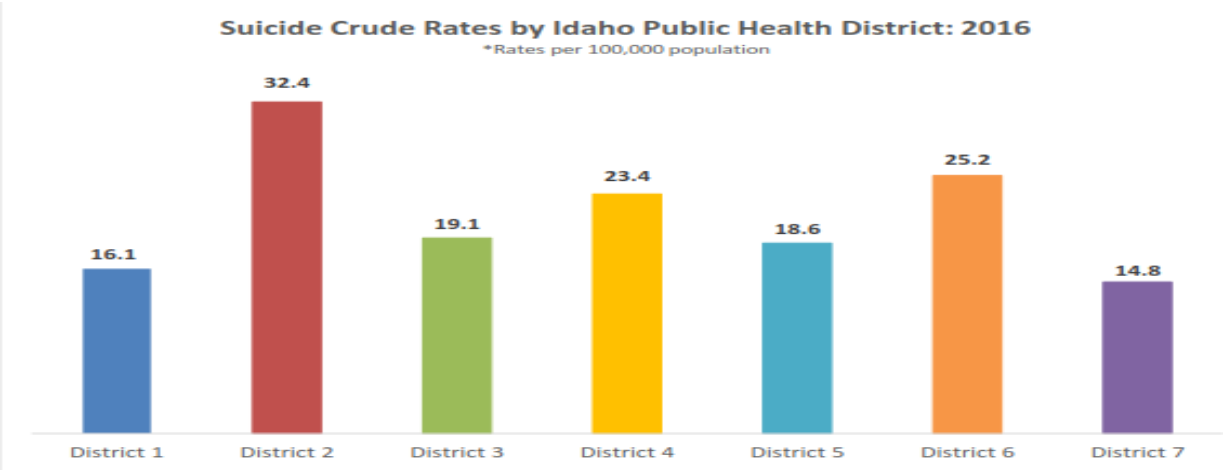
- More than 90% of people who die by suicide show symptoms of a mental health condition. Each day an estimated 18-22 veterans die by suicide.

Suicide. According to Idaho's Bureau of Vital Records and Health Statistics, Idaho's 2009 suicide rate of 19.7 per 100,000 people was the fourth highest in the nation. Suicide is the eighth leading cause of death in Idaho. The suicide death rate per 100,000 people in Idaho was 18.5 in 2010 which is more than 50% higher than the national average rate of 12.2. The suicide rate for our service area was 14.7, which is better than our state's rate but still over 20% higher than the national average. As shown in the chart below, the suicide rate in Boise/Meridian service area, Idaho, and the nation has been trending up for the last few years beginning with the recession in 2008. A strong relationship exists between unemployment, economy, and suicide (IDPH, 2016).

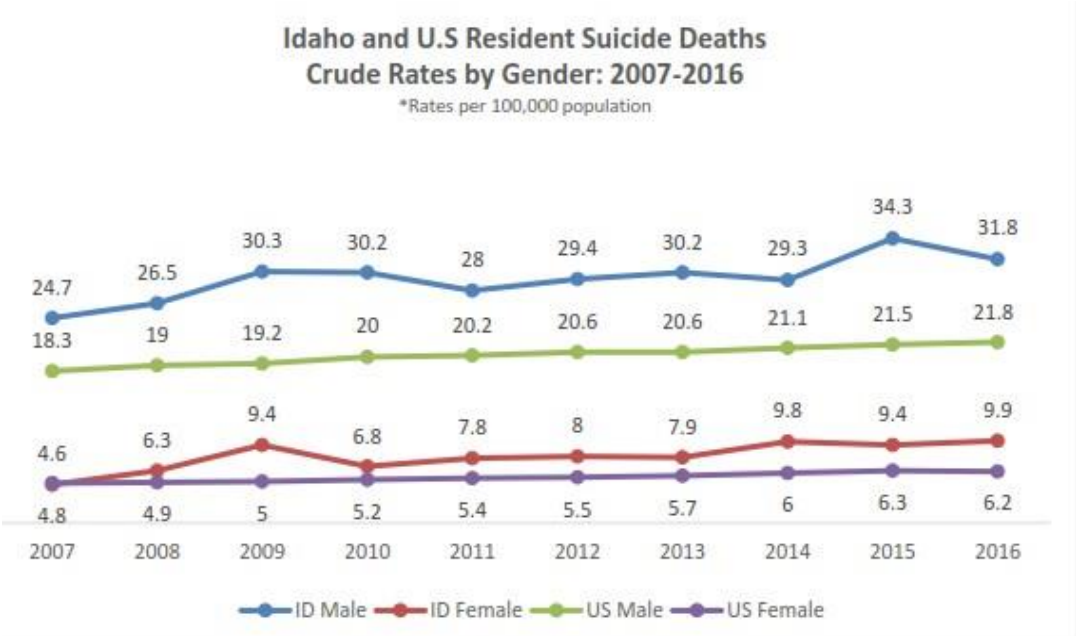


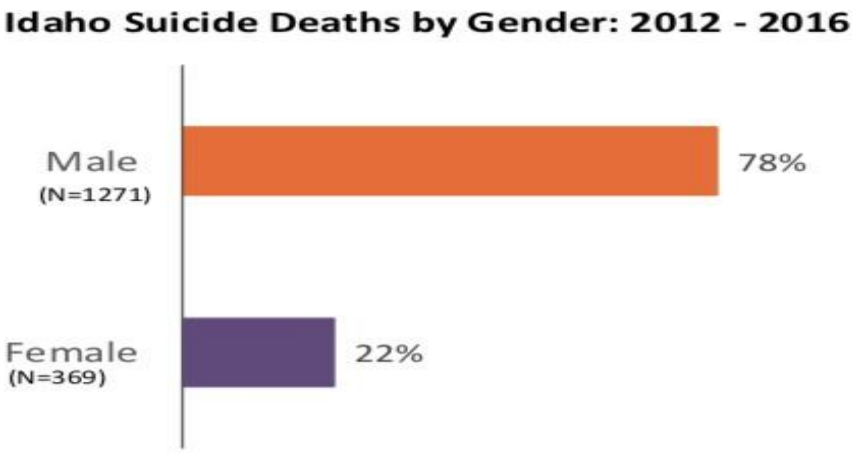
Although completed suicide is statistically rare, Idaho continually has some of the highest suicide rates in the U.S. In 2014, Idaho ranked 9th in number of suicides deaths per capita with a crude suicide rate of 19.6 deaths per 100,000 population. In 2015, Idaho's rate is 21.9. In 2016, Idaho ranked 8th in suicide rate with 20.8. Idaho's 2016 suicide rate is 20.8 suicide deaths per 100,000 populations. The rate of suicides in Idaho per capita may have decreased but continue to stay above the national average rate, as shown below.





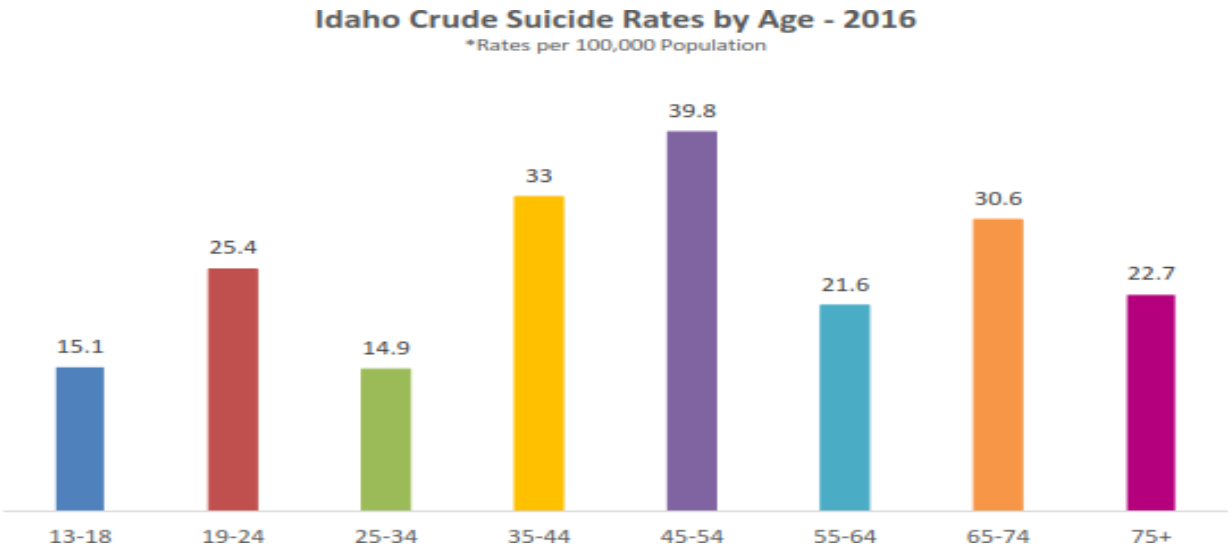
The table below shows that death by suicide is more common among males than females, but both genders surpass the national average in Idaho.



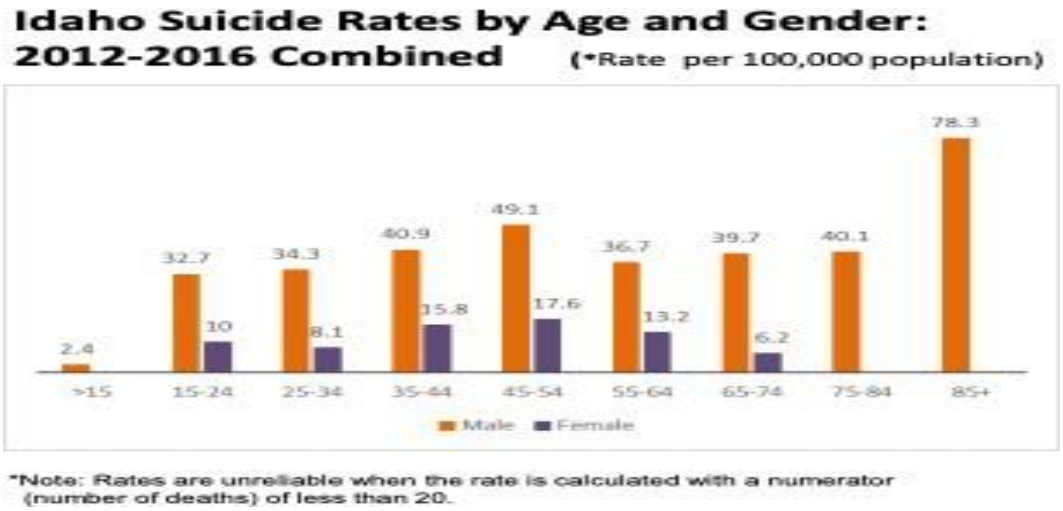


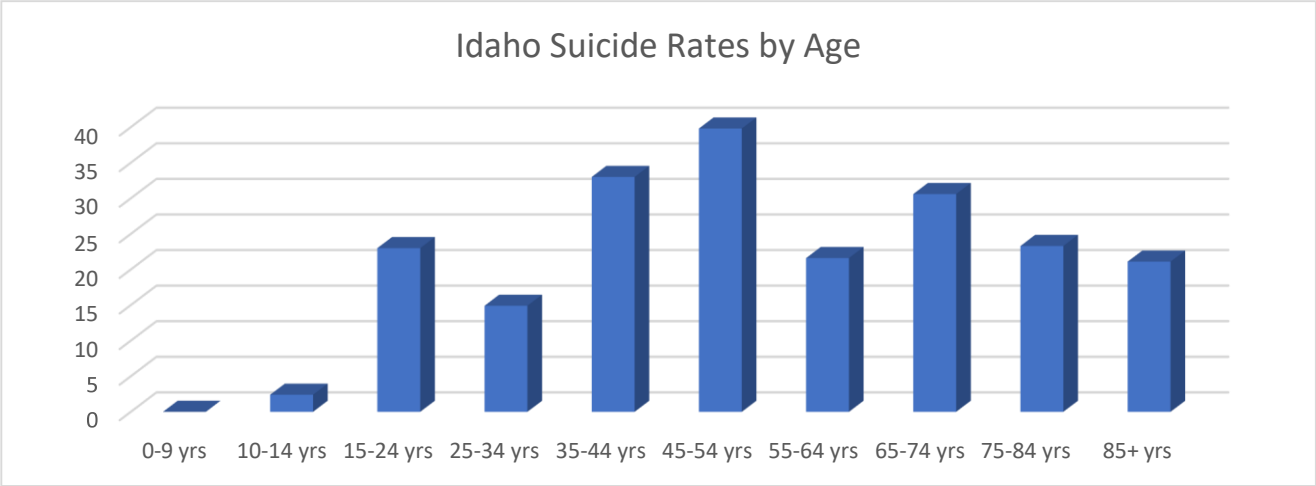
Idaho Suicide Rates by Age and Gender: 2012-2016 Combined (*Rate per 100,000 population)

The table below shows the rate per 100,000 population. Source: Bureau of Vital Records and Health Statistics, 2016 data. Between 2012 and 2016, 105 school-age children died by suicide, 27 of whom were 14 or younger, and in that same span of time, 169 college-age youth (19-24) died by suicide in Idaho.



Rates based on Age and Gender: Significant gender disparity of males in all age categories





While death by suicide among the 65 and older population shows lower on the 10 causes of death, it still represents a notable percentage of rates by age. The Suicide Prevention Resource Center reports that "Suicide rates are particularly high among older men, with men ages 85 and older having the highest rate of any group in the country. Suicide attempts by older adults are much more likely to result in death than among younger persons. Reasons include:

- Older adults plan more carefully and use more deadly methods.
- Older adults are less likely to be discovered and rescued.
- The physical frailty of older adults means they are less likely to recover from an attempt." (Older Adults, 2019)

STAKEHOLDER & PROVIDER READINESS ASSESSMENT

Organizational change is a key component of success in an increasingly dynamic world. However, before an entity can embark upon change it is critical that readiness is assessed and determined. Critical components include leadership buy in and tangible commitment, staff buy in and commitment, and ongoing investment to maintain the change. Buy in is typically the first step, e.g. "this is a good idea and we should do this". However, this is where many good change ideas falter in the absence of ongoing tangible commitment. For example, leaders' and staffs' readiness and willingness to continue may falter when faced with the difficulties and inconvenience of change process. The day to day demands of current programs/systems in combination with the time, energy, and resource demands of change can be daunting.

Organizational readiness for change is complex by itself and when considering an entire system's readiness for change, the matter become even more complex. The organizations that make up the system are likely at different levels of readiness, but organizations need to be aware of their current level of readiness to determine if they want to change and how much. The following are categories for levels of readiness organizations:

- ❑ Level 1: All staff and leadership are fully committed and actively working on the changes necessary within their organization to support the change process.
- ❑ Level 2: Some staff and leadership are fully committed and actively working on the changes necessary within their organization to support the change process.
- ❑ Level 3: All staff and leadership are fully committed but have not begun to actively work on the changes necessary within their organization to support the change process. They may not be sure how to go about effecting the change or may lack the resources and/or expertise.
- ❑ Level 4: Some staff and leadership are fully committed but have not begun to actively work on the changes necessary within their organization to support the change process. They may not be sure how to go about effecting the change and/or there may be staff actively working against the change in favor of the status quo.
- ❑ Level 5: Leadership/staff may believe that the system needs to change, but that it is other organizations that need to change, not them.
- ❑ Level 6: Leadership/staff may believe that the system needs to change, but that it is completely impossible without more money.
- ❑ Level 7: There may not be consensus on what the problem is and/or what change is needed.

Based on the readiness assessments, the providers and stakeholders are currently at level 4 "Some staff and leadership are fully committed but have not begun to actively work on the changes necessary within their organization to support the change process. They may not be sure how to go about effecting the change and/or there may be staff actively working against the change in favor of the status quo."

I. METHODS

Levels of commitment and system readiness assessment tools were difficult to identify and were not appropriate for a crisis system assessment. However, a tool that recommended capacities to consider in implementing mental health/substance use care strategies in a clinic or health center based on the Centers for Disease Control (CDC) Aids Education and Training Center (AETC) Mental Health/Substance Use Care and Clinic/Health Center Readiness Assessment was utilized with modifications. The templates were based on Centers for Disease Control and Prevention (2005).

Domains Measured based on CDC AETC

1. Staff/Clinical Team Readiness
2. Assessment Readiness
3. Capacity Readiness
4. Community Readiness
5. Support Readiness
6. CQI Readiness

Domain Rating Categories based on CDC AETC

1. Not a current priority
2. We have discussed this issue
3. We are developing a plan to address this issue
4. We are evaluating our implemented plan to address this issue
5. We are making adjustments to better address this issue

Systems and Service Gaps

Additional narrative questions were asked in regard to Systems and Service Gaps.

The following questions were asked by the ***providers***:	The following questions were asked by ***stakeholders***:
• The top three (3) gaps in the current behavioral health delivery system that inhibit care coordination, access to care, availability of services, and ability to demonstrate value are? • The top three (3) gaps and modifications in the crisis system that are needed to address rural and vulnerable populations are? • Additional Comments	• What are the top three (3) gaps in the current behavioral health delivery system that inhibit care coordination, access to care, availability of services, and ability to demonstrate value are? • What type of community partner are you representing? • On average, how many hours a week does your agency spend coordinating and/or interacting with: o behavioral health service providers and/or organizations o individuals with behavioral health issues o individuals experiencing behavioral health crises • Additional Comments

Surveys were distributed via email using a SurveyMonkey link, telephonically, and paper via mail or in person. In order to provide insight into Region 3, the two (2) readiness assessment surveys were sent out to 1,033 providers and stakeholders. The response rate was somewhat limited with 31 providers and 27 stakeholders responding.

Due to the limited number of respondents, we added a 2017 Mental Health/Substance Use Disorder (MH/SUD) provider survey to understand current capabilities and to identify behavioral health providers, service location, staffing model, professional license, service types, electronic health records (EHR), access, screening, and capacity.

Below are the three survey results for provider and stakeholder readiness assessments and behavioral health provider capabilities.

II. SURVEY BARRIERS AND ISSUES

The following are barriers and issues encountered by staff while soliciting community response for the Crisis Center Survey:

1) Some stakeholders and providers stated that the "survey did not pertain to them and they could offer no feedback or insight".
2) Other businesses had variable office hours and did not answer the phone and could not leave a message.
3) Private Counseling Agencies are typically set up where a caller must leave a message - there is no front office staff that will take a phone message or provide any additional information to the caller. Websites of these private agencies also typically do not provide email address that a person can send inquiries.
4) Some Medical Clinics were reluctant to receive any survey via email. The rational vocalized by the front desk staff were concerns related to HIPPA. They were willing to complete a mailed survey.
5) Community members not understanding the service and below was a direct response from an agency:
    - "A survey was shared with me to complete. I am not familiar with this resource so I cannot complete the survey. I would like to know more about your services. Thanks"
    - Some community members did not feel competent to answer survey.
    - "I tried to complete the survey but quite honestly, I found myself not able to intelligently answer many of the questions. I just don't have the background, yet, to provide much meaningful feedback with regard to the level of understanding and agreement service providers have as it pertains to providing mental health services. Long story short - I felt my feedback might be uninformed and I did not want to provide you with uninformed feedback. So, I discontinued completion of the survey. I'm sorry that I have not been able to be more help."
    - Municipalities do not typically have email contacts listed on their websites. Typically, if you have a question, or would like to contact someone, there is a section in the website to write a note, typically under the "contact" section of the website.

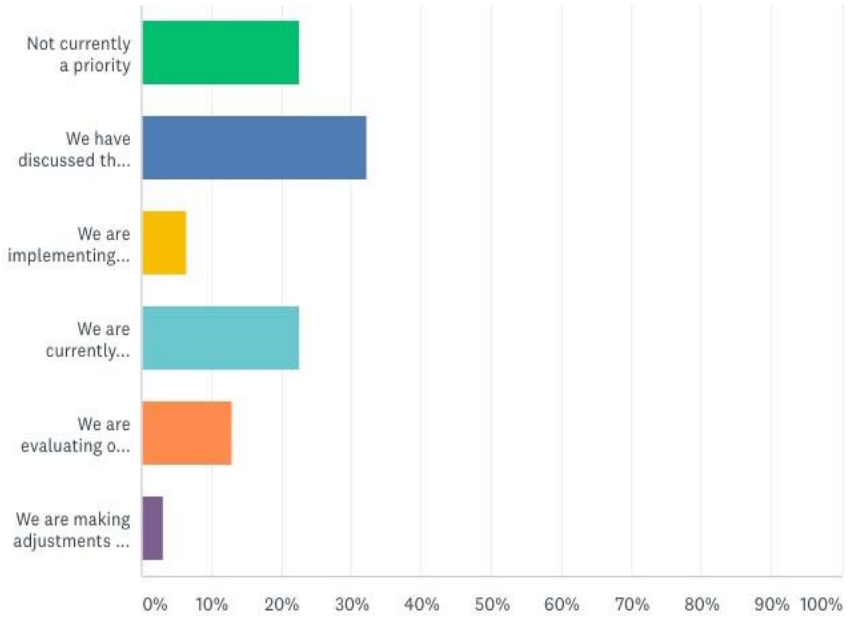
III. PROVIDER SURVEY RESPONSE SUMMARY

A series of 20 multiple-choice questions/sub-questions and four (4) open ended questions were included in the survey. For the multiple-choice questions, respondents had five (5) options:

- Not currently a priority
- We have discussed this issue
- We are implementing a plan to address this issue
- We are currently implementing a process to address this issue
- We are evaluating our implemented plan to address this issue
- We are making adjustments to our plan to better address this issue

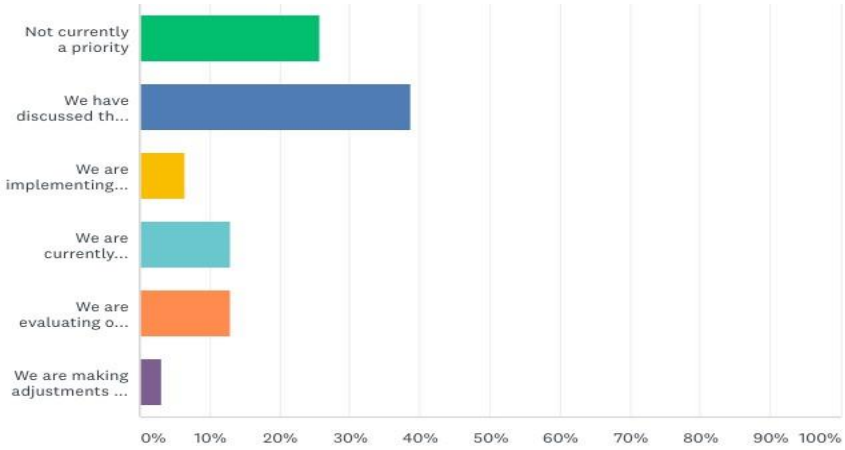
N=31 Respondents

Question 1: Our agency has leadership buy-in to commit resources to improve crisis services and/or post-crisis services



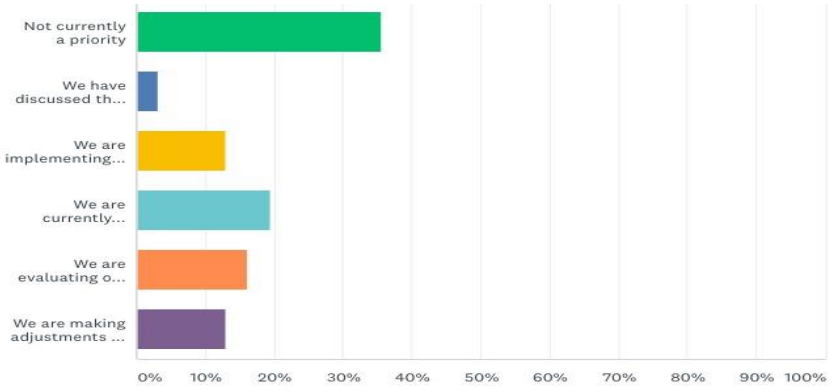
ANSWER CHOICES	RESPONSES	
Not currently a priority	22.58%	7
We have discussed this issue	32.26%	10
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	3.23%	1
TOTAL		31

<u>Question 2</u>: Our agency has an identified champion(s) focused on implementing crisis services and/or post-crisis services within our agencies



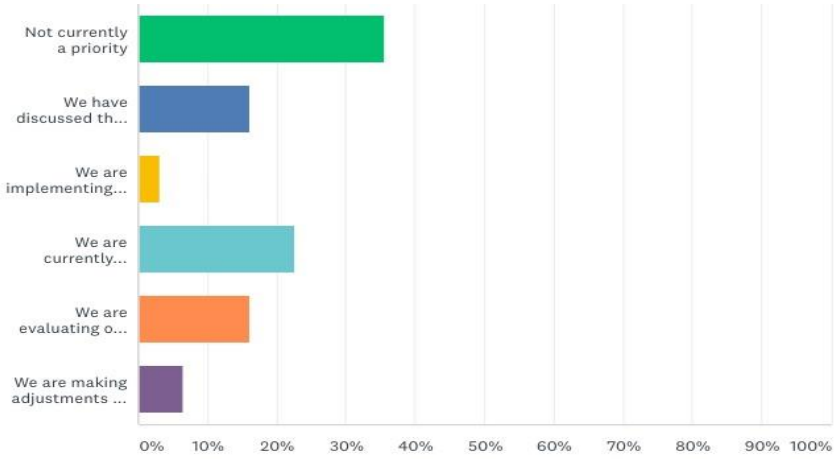
ANSWER CHOICES	RESPONSES	
Not currently a priority	25.81%	8
We have discussed this issue	38.71%	12
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	12.90%	4
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	3.23%	1
TOTAL		31

<u>Question 3a</u>: Our agency has the following capabilities: a) On-call phone access for our clients 7 days a week



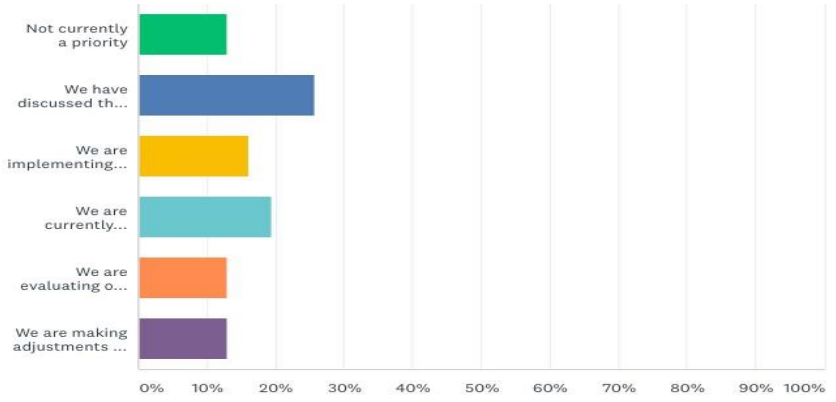
ANSWER CHOICES	RESPONSES	
Not currently a priority	35.48%	11
We have discussed this issue	3.23%	1
We are implementing a plan to address this issue	12.90%	4
We are currently implementing a process to address this issue	19.35%	6
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	12.90%	4
TOTAL		31

<u>Question 3b</u>: Our agency has the following capabilities: b) Access to a prescriber within 24 hours



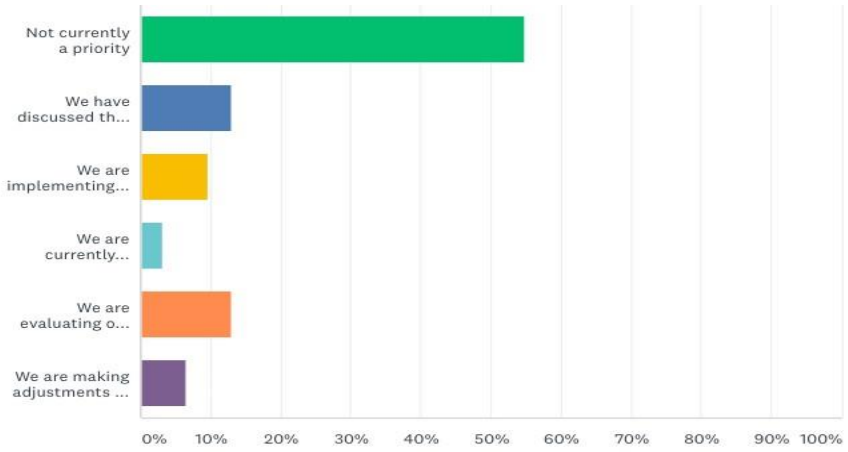
ANSWER CHOICES	RESPONSES	
Not currently a priority	35.48%	11
We have discussed this issue	16.13%	5
We are implementing a plan to address this issue	3.23%	1
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	6.45%	2
TOTAL		31

<u>Question 3c</u>: Our agency has the following capabilities: c) Urgent appts available – within 6 hours of request



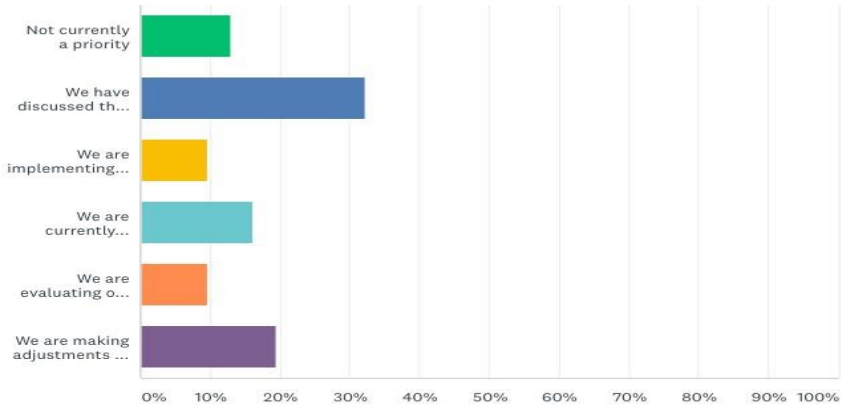
ANSWER CHOICES	RESPONSES	
Not currently a priority	12.90%	4
We have discussed this issue	25.81%	8
We are implementing a plan to address this issue	16.13%	5
We are currently implementing a process to address this issue	19.35%	6
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	12.90%	4
TOTAL		31

<u>Question 3d</u>: Our agency has the following capabilities: d) Meet with a client during a post crisis period 3-4 times a week even on Saturdays or Sundays as needed face to face or by phone



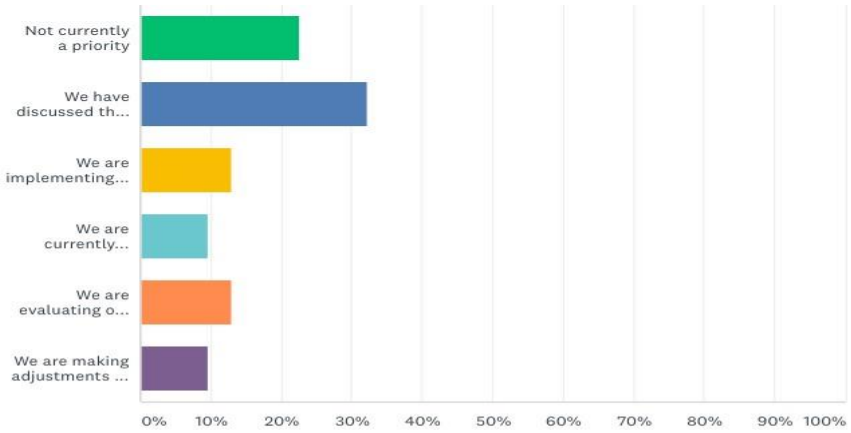
ANSWER CHOICES	RESPONSES	
Not currently a priority	54.84%	17
We have discussed this issue	12.90%	4
We are implementing a plan to address this issue	9.68%	3
We are currently implementing a process to address this issue	3.23%	1
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	6.45%	2
TOTAL		31

<u>Question 4</u>: Our agency routinely get calls or notified when one of our clients is in the ER



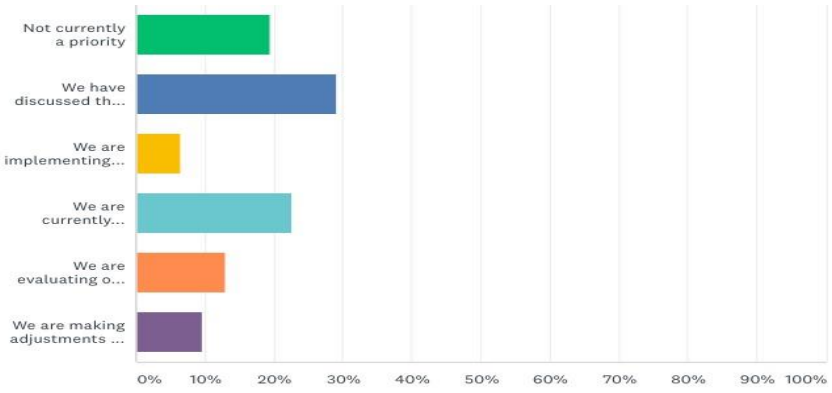
ANSWER CHOICES	RESPONSES	
Not currently a priority	12.90%	4
We have discussed this issue	32.26%	10
We are implementing a plan to address this issue	9.68%	3
We are currently implementing a process to address this issue	16.13%	5
We are evaluating our implemented plan to address this issue	9.68%	3
We are making adjustments to our plan to better address this issue	19.35%	6
TOTAL		31

<u>Question</u> 5: Our agency routinely gets notified when one of our clients enters a behavioral health inpatient facility



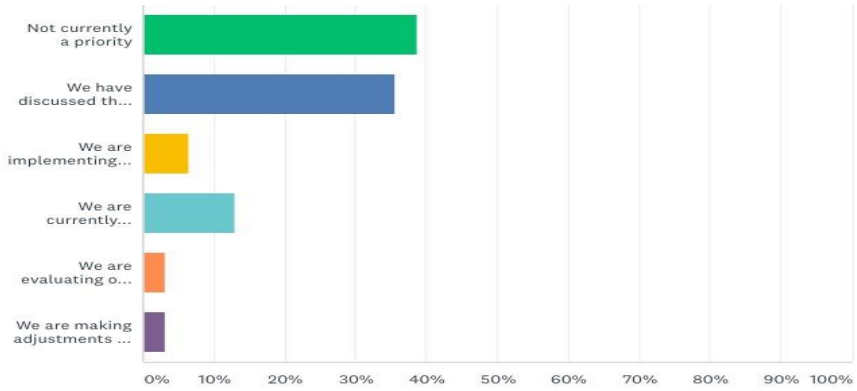
ANSWER CHOICES	RESPONSES	
Not currently a priority	22.58%	7
We have discussed this issue	32.26%	10
We are implementing a plan to address this issue	12.90%	4
We are currently implementing a process to address this issue	9.68%	3
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	9.68%	3
TOTAL		31

<u>Question 6</u>: Our agency routinely gets notified before one of our clients is being discharged from a hospital or residential facility



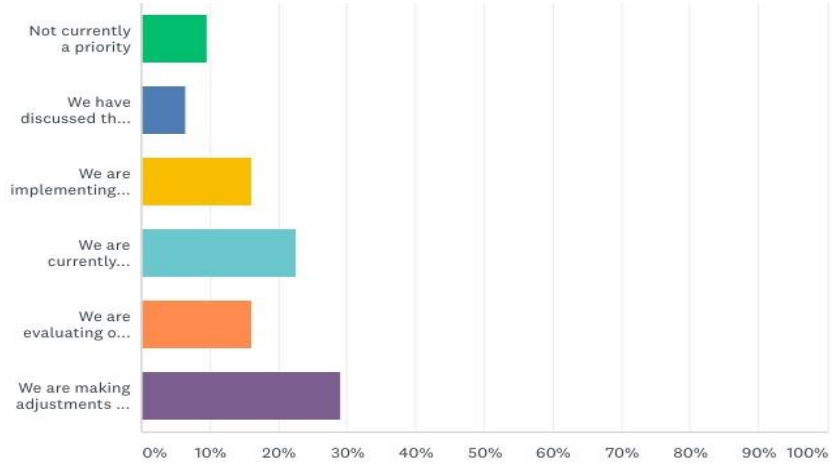
ANSWER CHOICES	RESPONSES	
Not currently a priority	19.35%	6
We have discussed this issue	29.03%	9
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	9.68%	3
TOTAL		31

Question 8 (Q7_was_redundant_to_Q6): Staff believe that our agency will need to change in order to support behavioral health system change



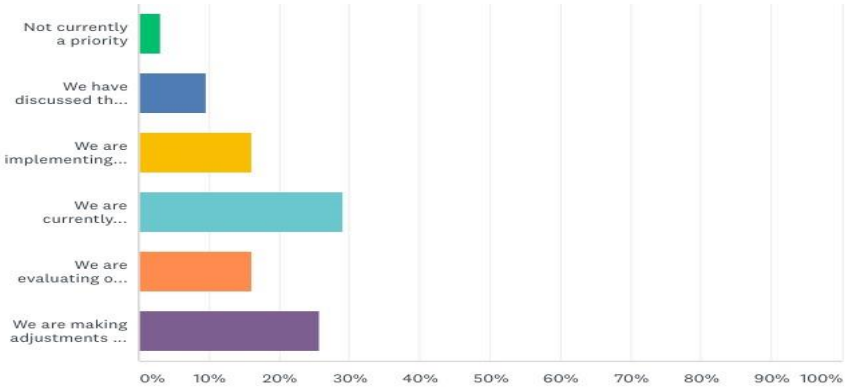
ANSWER CHOICES	RESPONSES	
Not currently a priority	38.71%	12
We have discussed this issue	35.48%	11
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	12.90%	4
We are evaluating our implemented plan to address this issue	3.23%	1
We are making adjustments to our plan to better address this issue	3.23%	1
TOTAL		31

Question 9a: Our agency consistently uses standardized tool(s) to screen/assess for: a) Depression



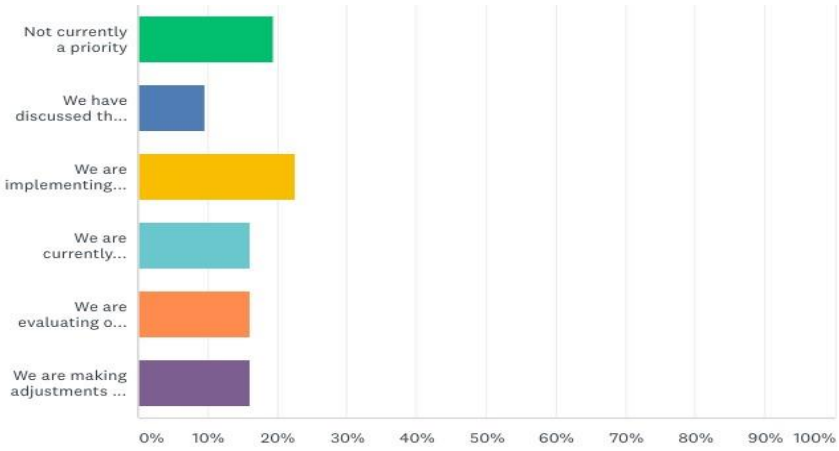
ANSWER CHOICES	RESPONSES	
Not currently a priority	9.68%	3
We have discussed this issue	6.45%	2
We are implementing a plan to address this issue	16.13%	5
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	29.03%	9
TOTAL		31

<u>Question 9b</u>: Our agency consistently uses standardized tool(s) to screen/assess for: b) Suicide Risk



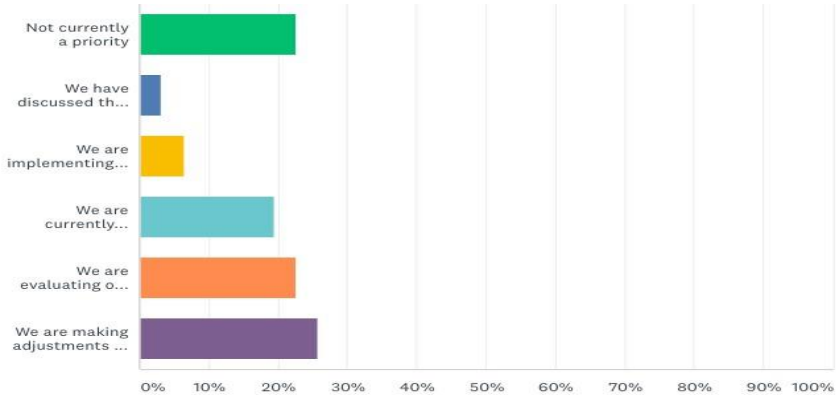
ANSWER CHOICES	RESPONSES	
Not currently a priority	3.23%	1
We have discussed this issue	9.68%	3
We are implementing a plan to address this issue	16.13%	5
We are currently implementing a process to address this issue	29.03%	9
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	25.81%	8
TOTAL		31

<u>Question 9c</u>: Our agency consistently uses standardized tool(s) to screen/assess for: c) Problem Substance Use



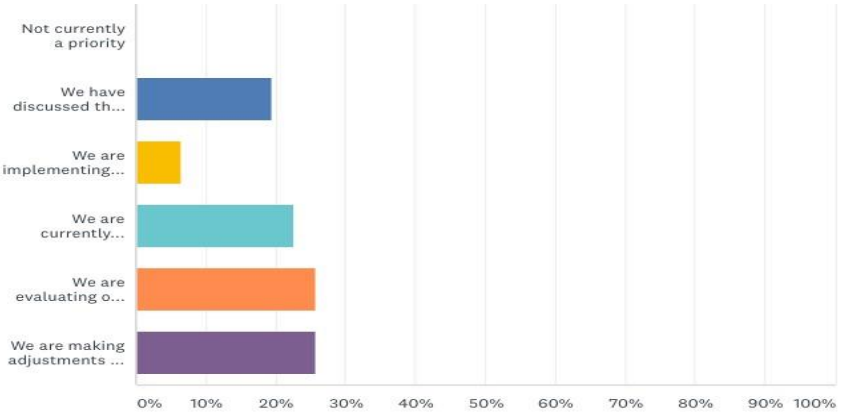
ANSWER CHOICES	RESPONSES	
Not currently a priority	19.35%	6
We have discussed this issue	9.68%	3
We are implementing a plan to address this issue	22.58%	7
We are currently implementing a process to address this issue	16.13%	5
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	16.13%	5
TOTAL		31

<u>Question 10</u>: Our agency uses tools to measure client progress (e.g. repeated PHQ 9, Therapeutic Alliance, etc.)



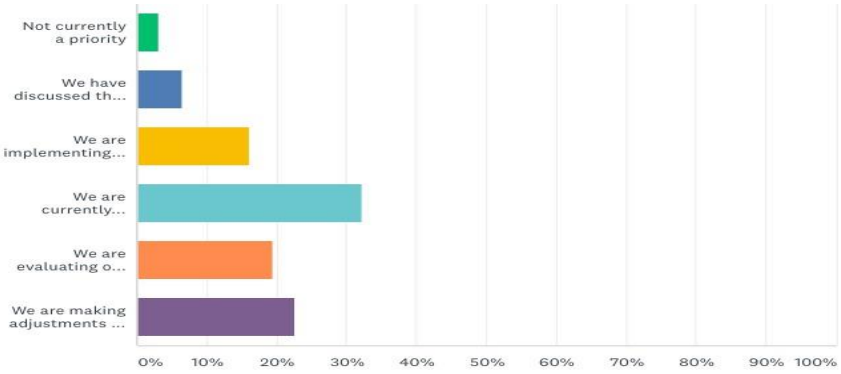
ANSWER CHOICES	RESPONSES	
Not currently a priority	22.58%	7
We have discussed this issue	3.23%	1
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	19.35%	6
We are evaluating our implemented plan to address this issue	22.58%	7
We are making adjustments to our plan to better address this issue	25.81%	8
TOTAL		31

<u>Question 11</u>: Our agency has clear processes in place for responding to patients with identified behavioral health issues



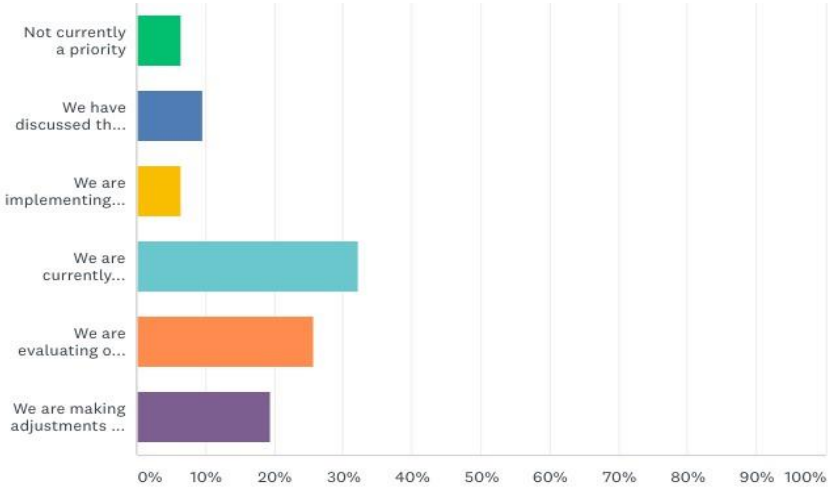
ANSWER CHOICES	RESPONSES	
Not currently a priority	0.00%	0
We have discussed this issue	19.35%	6
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	25.81%	8
We are making adjustments to our plan to better address this issue	25.81%	8
TOTAL		31

<u>Question 12</u>: Our agency is effective in responding when a patient has had a crisis event



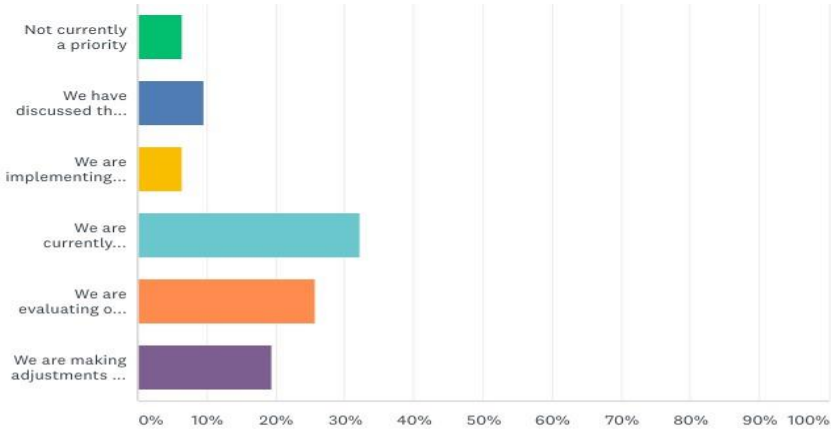
ANSWER CHOICES	RESPONSES	
Not currently a priority	3.23%	1
We have discussed this issue	6.45%	2
We are implementing a plan to address this issue	16.13%	5
We are currently implementing a process to address this issue	32.26%	10
We are evaluating our implemented plan to address this issue	19.35%	6
We are making adjustments to our plan to better address this issue	22.58%	7
TOTAL		31

<u>Question 13</u>: Our agency has same day/next day access for someone who has had a crisis event



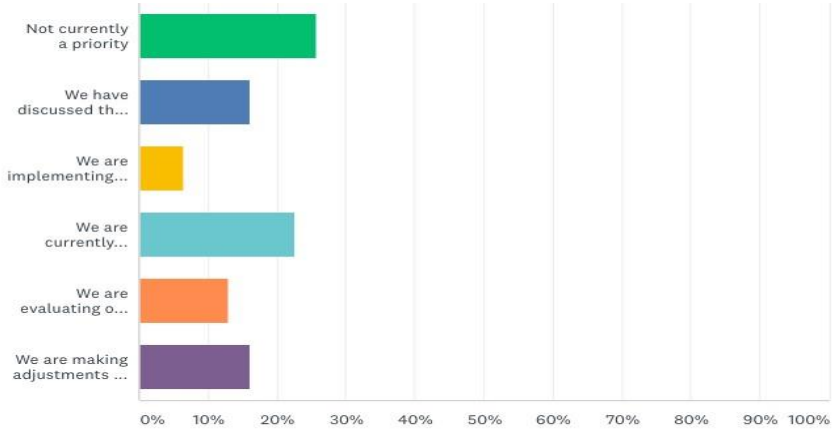
ANSWER CHOICES	RESPONSES	
Not currently a priority	6.45%	2
We have discussed this issue	9.68%	3
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	32.26%	10
We are evaluating our implemented plan to address this issue	25.81%	8
We are making adjustments to our plan to better address this issue	19.35%	6
TOTAL		31

<u>Question 14</u>: Our agency effectively coordinates with other service providers to address the needs of individual in crisis and/or post-crisis



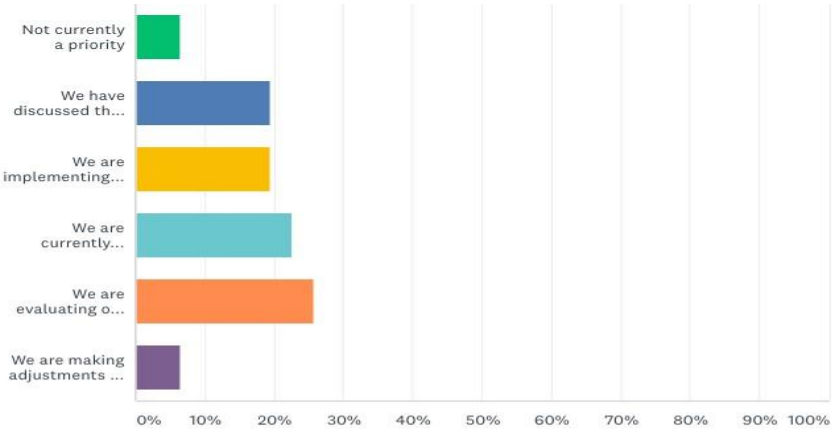
ANSWER CHOICES	RESPONSES	
Not currently a priority	6.45%	2
We have discussed this issue	9.68%	3
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	32.26%	10
We are evaluating our implemented plan to address this issue	25.81%	8
We are making adjustments to our plan to better address this issue	19.35%	6
TOTAL		31

<u>Question 15</u>: Our agency has access to peer coaches and/or other community-based supports



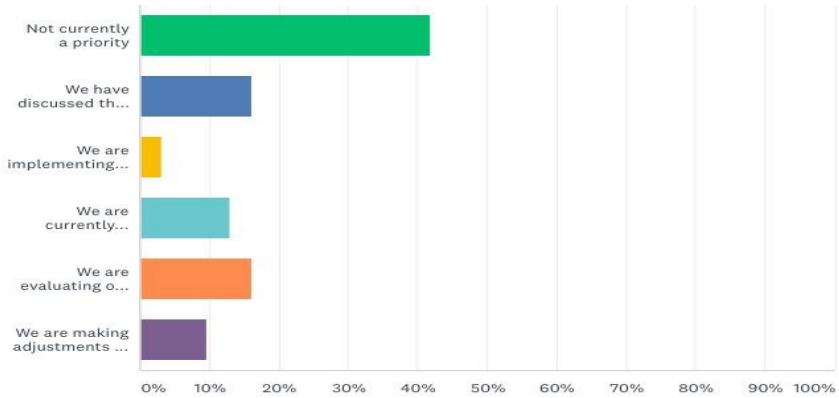
ANSWER CHOICES	RESPONSES	
Not currently a priority	25.81%	8
We have discussed this issue	16.13%	5
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	16.13%	5
TOTAL		31

<u>Question 16</u>: Agency staff have received specialized training on responding to crisis and/or post-crisis events



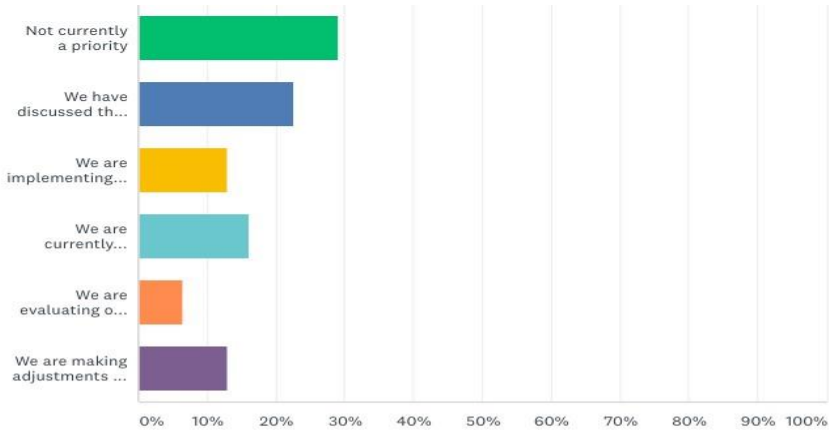
ANSWER CHOICES	RESPONSES	
Not currently a priority	6.45%	2
We have discussed this issue	19.35%	6
We are implementing a plan to address this issue	19.35%	6
We are currently implementing a process to address this issue	22.58%	7
We are evaluating our implemented plan to address this issue	25.81%	8
We are making adjustments to our plan to better address this issue	6.45%	2
TOTAL		31

<u>Question 17</u>: Our agency uses technology, such as telehealth, to expand access to behavioral health services



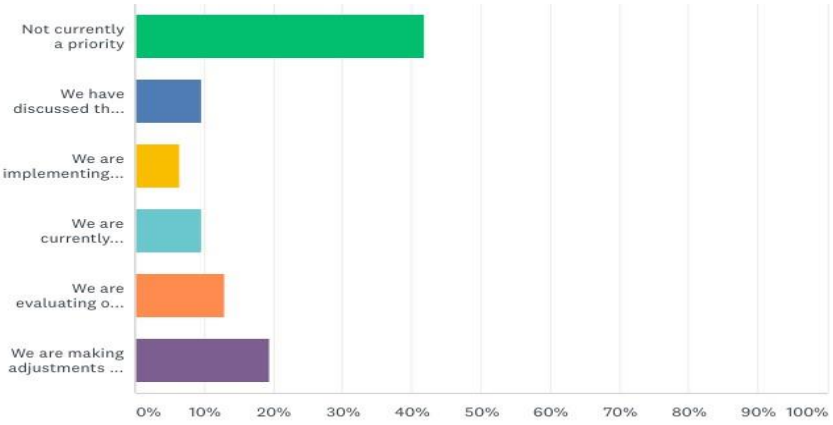
ANSWER CHOICES	RESPONSES	
Not currently a priority	41.94%	13
We have discussed this issue	16.13%	5
We are implementing a plan to address this issue	3.23%	1
We are currently implementing a process to address this issue	12.90%	4
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	9.68%	3
TOTAL		31

Question 18: Now is the right time to commit agency time and resources to behavioral health system change



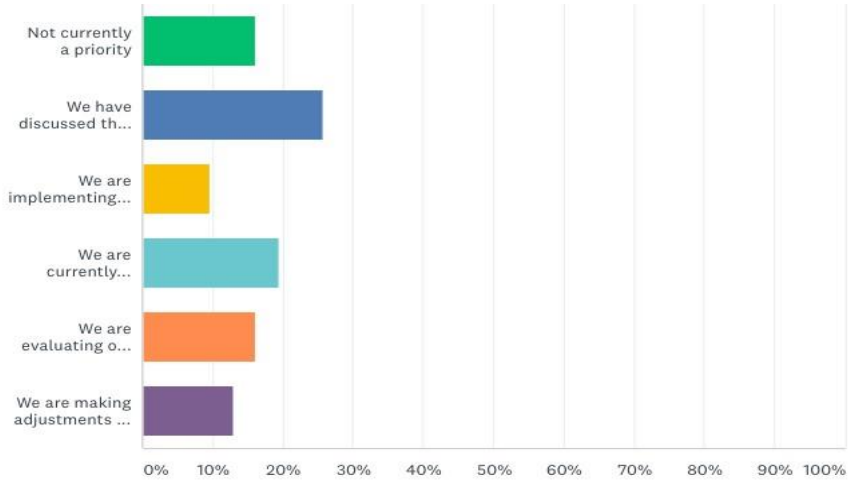
ANSWER CHOICES	RESPONSES	
Not currently a priority	29.03%	9
We have discussed this issue	22.58%	7
We are implementing a plan to address this issue	12.90%	4
We are currently implementing a process to address this issue	16.13%	5
We are evaluating our implemented plan to address this issue	6.45%	2
We are making adjustments to our plan to better address this issue	12.90%	4
TOTAL		31

Question 19: Our agency has integrated behavioral health and medical services on site



ANSWER CHOICES	RESPONSES	
Not currently a priority	41.94%	13
We have discussed this issue	9.68%	3
We are implementing a plan to address this issue	6.45%	2
We are currently implementing a process to address this issue	9.68%	3
We are evaluating our implemented plan to address this issue	12.90%	4
We are making adjustments to our plan to better address this issue	19.35%	6
TOTAL		31

<u>Question 20</u>: Our agency is able to effectively bill for crisis and post-crisis services



ANSWER CHOICES	RESPONSES	
Not currently a priority	16.13%	5
We have discussed this issue	25.81%	8
We are implementing a plan to address this issue	9.68%	3
We are currently implementing a process to address this issue	19.35%	6
We are evaluating our implemented plan to address this issue	16.13%	5
We are making adjustments to our plan to better address this issue	12.90%	4
TOTAL		31

Net Promoter Score (NPS)

How likely is it that you would recommend the crisis center to a friend or colleague?

DETRACTORS (0-6)	PASSIVES (7-8)	PROMOTERS (9-10)	NET PROMOTER® SCORE
35% 11	29% 9	35% 11	0

The **Net Promoter Score (NPS)** is commonly used as a management tool, with a range from -100 to +100 and it measures the willingness of customers to recommend a company's products or services to others. NPS was used to measure providers' overall satisfaction with the crisis center services. The NPS range is -100 to +100, a "positive" **score** or NPS above 0 is **considered** "**good**", +50 is "Excellent," and above 70 is **considered** "world class." A **NPS** that is below **0 would** be an indication that your business **has** a lot of issues to address. A **score** between **0** and 30 is a good range to be in, however, there is still room for progress.

- Providers had 29% **Passives** (score 7-8) were satisfied but unenthusiastic with the crisis center services.
- Providers had 35% **Detractors** (score 0-6) were unhappy with the crisis center services.
- Providers had 35% **Promoters** (score 9-10) were overall satisfied with the crisis center services.
- Providers had zero **(0) NPS** which is considered **"good"** and means that the majority of the providers would consider using the crisis center but there is still room for growth.

IV. PROVIDER GAPS ANALYSIS

We asked for the top three (3) gaps in current delivery system and modifications for the crisis system and areas of concentration was developed from the gaps identified. The areas of concentration should be considered for future state for the crisis center.

Provider Areas of Concentration for Gaps

- Improve access to behavioral health and crisis services
- Reduce wait time from referral to first appointment
- Improve access and affordability with transportation to services
- Improve communication and coordination with crisis center, behavioral health providers, & medical providers
- Improve communication and coordination with crisis center, law enforcement, and EMS
- Increase access to telehealth services
- Increase providers to service Medicaid and Medicare patients
- Improve marketing of crisis center
- Increase mental health training and education to law enforcement and EMS
- Improve the cost of care

1.) Current Gaps in Service Delivery

The top three (3) gaps in the current behavioral health delivery system that inhibit care coordination, access to care, availability of services, and ability to demonstrate value are:

Gap 1: Response	**Gap 2:** Response	**Gap 3:** Response
• Lack of beds for behavioral health crisis in our town and in the state	• Little or no children's mental health crisis support or services	• Expansion of behavioral services in rural areas

• Coordination between agencies – HIPAA always comes up • As EMS not enough training • Service Coordination • Regional communications with providers • ER doctors want to release our holds • None available locally • Poor response from some medical providers for care coordination, medication lists, etc. • Lack of collaboration/ leadership from BH service line in maintaining a value-based hybrid BHC model in our clinic • Lack of client follow through • Payment structure • Leadership buy in • Sharing information with primary care providers third party assessment without client integration/or coordination with ambulatory or community-based providers • Limited access to qualified staff hiring issues • Intensive outpatient services access options other than inpatient treatment or outpatient counseling • Communication between crisis center and providers. Need them to invite providers in • Not enough prescribers in the area to collaborate with • Timely communication response from insurance company • Emergency prescription/medicine evaluation • Most psychiatrists do not report client progress	• Lack of resources in our community • Lack of CHEMS program • Stigma reduction • Affordability • Delay in getting seen once referred • Services needed for people who cannot afford behavioral health services, and cannot qualify for Medicaid/Medicare • Lack of access to resources available to Boise-area clinics. • Lack of ongoing communication from the referral source • Social determinants support • Billing for all services provided • Informing primary care providers about psych inpatient treatment for their patients • Continual limitation/changes to "qualified provider" without reimbursement increases to allow private/non-hospital providers a reasonable wage • Fee Schedules - covering overhead expenses • Communication between inpatient facilities and outpatient care once patient is released • After care for patients admitted for inpatient care • Communication with ER • Not enough crisis services in the area to collaborate with • Lack of Provider compensation for many needed services.	• Payor sources or not having insurance • Usually drop off at ER with no follow ups • Patients barrier with access to care • Lack of communication between behavioral and medical health providers • Poor communication between providers • Lack of beds for crisis care at times • Lack of behavioral health availability after-hours/weekends. • Availability of staff • Access to care, hard to facilitate referrals to behavioral health system • Transportation availability, accountability and unrealistic requirements/risk to private providers even if willing to "provide transportation" • Gaps between services provided for those moving out of inpatient care • Available beds for ages 13-18 • More information to the community • Difficult to provide immediate access 24-7 for emergent crisis • Limited local resources that are free

	• No community-based supports for mentally ill • Cost of inpatient care is prohibitive	

2.) Current Gaps in Crisis System

The top three (3) gaps and modifications in the crisis system that are needed to address rural and vulnerable populations are:

Gap 1: Response	**Gap 2:** Response	**Gap 3:** Response
• Cost • Telehealth availability • Transportation • As EMS not enough training • Cooperation between medical and behavioral health providers • Access to care • Lack of beds for people in crisis at times • Lack of psychiatrists • Availability of BH resources - long appt scheduling wait times • Appropriate screening and referrals • Increasing the ability to use "support staff/provider extenders" that may live in the remote rural areas to partner with tele-providers, EMS, law enforcement, school staff, • Access to qualified staff • Access to ACT team in counties outside of Ada county • Transportation to services • No communication between crisis center and providers • Access to care • Service availability • 24-7 client access to telehealth, medical and counselor • Limited resources	• Insurance • Training and coordination with local law enforcement • Funding • Lack of CHEMS programs • Transportation • Communication between providers, first responders • Quicker response to referral • Inability to get services due to lack of insurance and inability to pay • Lack of Medicare/Medicaid affiliated providers • Availability of outside resources/coordination of care • Warm outreach and education to partner with "local, known, trusted and culturally acquainted" people, including "retired medical providers" etc. • Not enough inpatient beds (adolescent and adult) for increasing populations • Cost of care even with insurance • Transportation to care	• Beds available locally • Access • Usually drop off at ER with no follow ups • Providers are unavailable • Regional approach to the problem versus by county • Better communication • Distance to appropriate care, and lack of transport due to this problem • Roadblocks created by Medicare/Medicaid • Availability of staff • Delivery and monitoring of medication(s), and tools such as cell phones, laptops, electronics or such to access telehealth. • Need more telehealth providers and access to this service • Drug and alcohol services • Limited availability • Immediate access for counselor to reach medical evaluator and assist patient in accessing safety and services • Counselors willing to work through telehealth • Availability of staff

• Appropriate screening and referrals • Access to qualified staff • Access to services • Quality stinks • 24-7 client access to telehealth, medical and counselor	• Immediate safe house access for evaluation/diagnosis • Continuity of care • Availability of outside resources/coordination of care • Immediate safe house access for evaluation/diagnosis • Implement new programs	• Facility placement options for those also needing physical care. • Transportation • Immediate access for counselor to reach medical evaluator and assist patient in accessing safety and services • Publicize resources

Additional thoughts or comments about the system and/or how it might be improved:

- "Didn't give an option for plans already in place within agency"
- "We have no crisis center or access to one. Would be nice for patients with mental issues and behavioral issues"
- "Local leadership is fantastic, but BH service line leadership is inconsistent/out of touch with our clinic needs."
- "The crisis center is a great option, if people are able to get there. Most of the time when they are in crisis, they do not have a way to get 30 miles away."
- "I love that we have the service, but providers don't know enough about it. i.e. how to refer, follow up after a client has been there, etc."
- "Perhaps there could be a dispatch for these crises: trained call receivers, triage, mental health professionals sent to callers to location and assistance to getting them to immediate evaluation for medicine and safe housing until crisis is past.

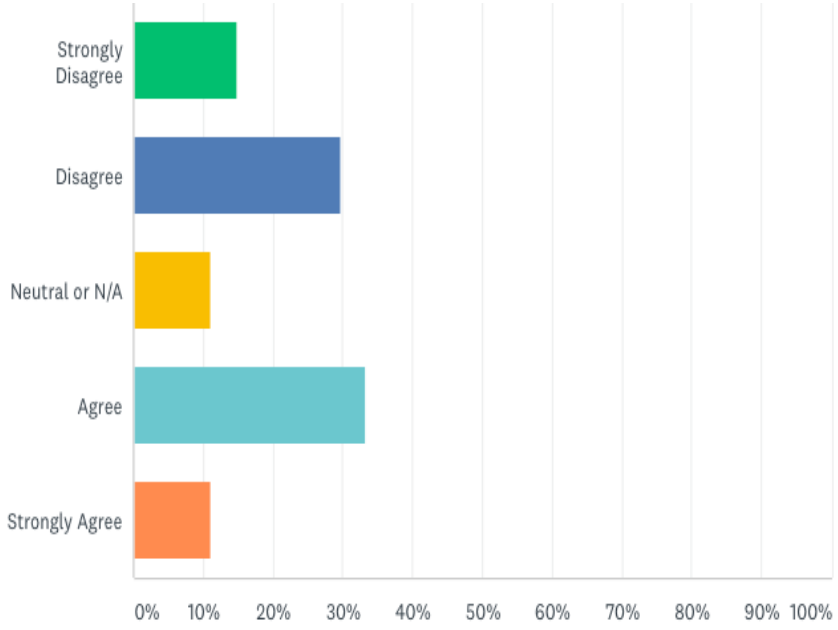
V. STAKEHOLDER SURVEY REPONSE SUMMARY

Fifteen (15) multiple-choice questions/sub-questions and three (3) open ended questions were included in the survey. For the multiple-choice questions, respondents had five (5) options:

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

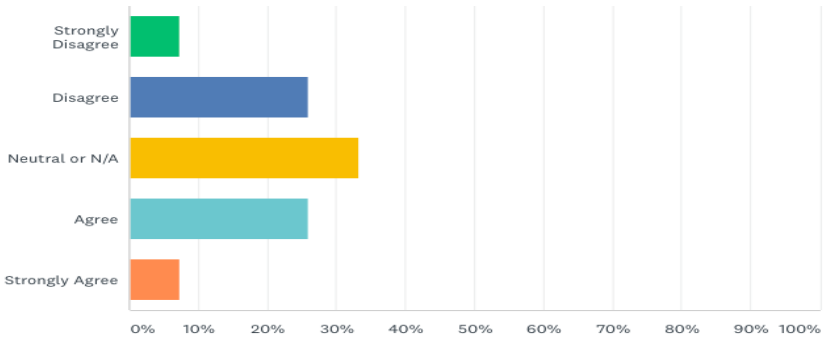
N=27 Respondents

Question 1: People know who to call when someone is in crisis



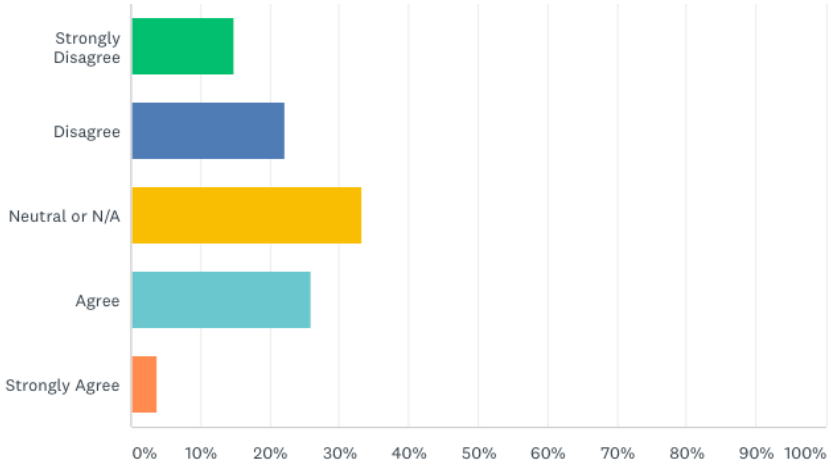
ANSWER CHOICES	RESPONSES	
Strongly Disagree	14.81%	4
Disagree	29.63%	8
Neutral or N/A	11.11%	3
Agree	33.33%	9
Strongly Agree	11.11%	3
TOTAL		27

<u>Question 2</u>: I trust that the behavioral health system will respond effectively when someone in crisis



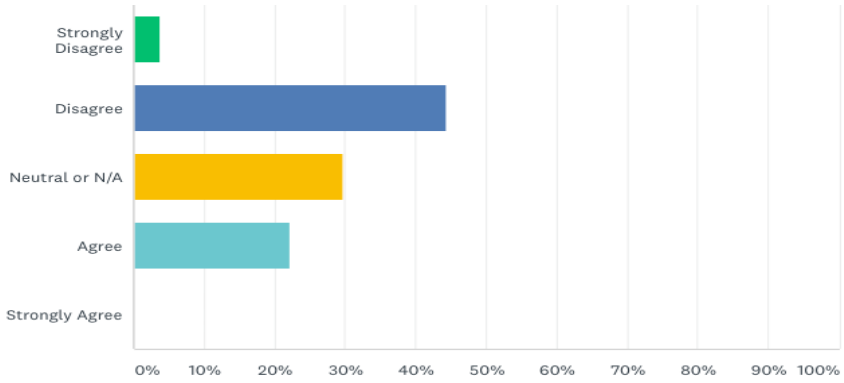
ANSWER CHOICES	RESPONSES	
Strongly Disagree	7.41%	2
Disagree	25.93%	7
Neutral or N/A	33.33%	9
Agree	25.93%	7
Strongly Agree	7.41%	2
TOTAL		27

<u>Question 3</u>: The current behavioral health system's resources would be adequate if reallocated more efficiently



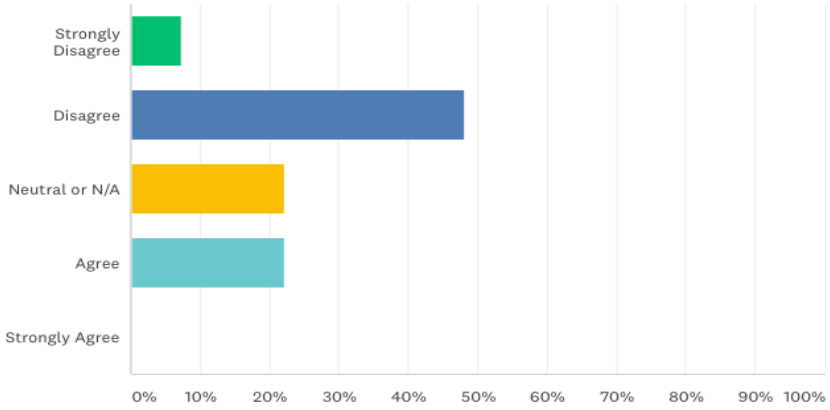
ANSWER CHOICES	RESPONSES	
Strongly Disagree	14.81%	4
Disagree	22.22%	6
Neutral or N/A	33.33%	9
Agree	25.93%	7
Strongly Agree	3.70%	1
TOTAL		27

<u>Question 4</u>: There is agreement among service providers and other stakeholders regarding what the problems are with the behavioral health system



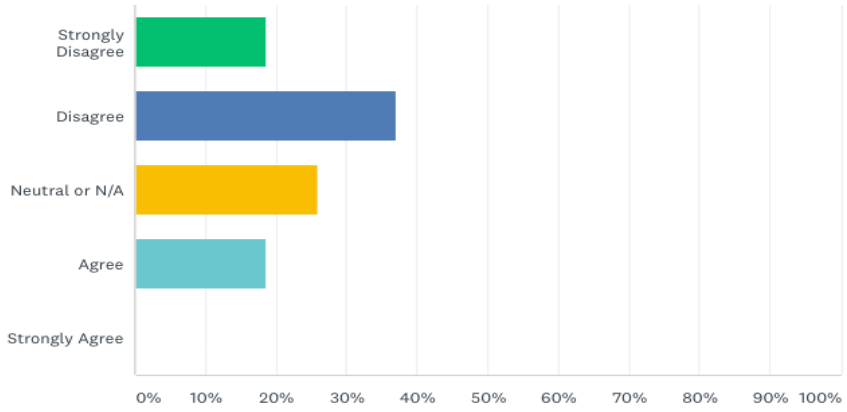
ANSWER CHOICES	RESPONSES	
Strongly Disagree	3.70%	1
Disagree	44.44%	12
Neutral or N/A	29.63%	8
Agree	22.22%	6
Strongly Agree	0.00%	0
TOTAL		27

<u>Question</u> 5a: There is agreement among service providers and other stakeholders regarding the current system's ability to: a) Respond to individuals experiencing a behavioral health crisis



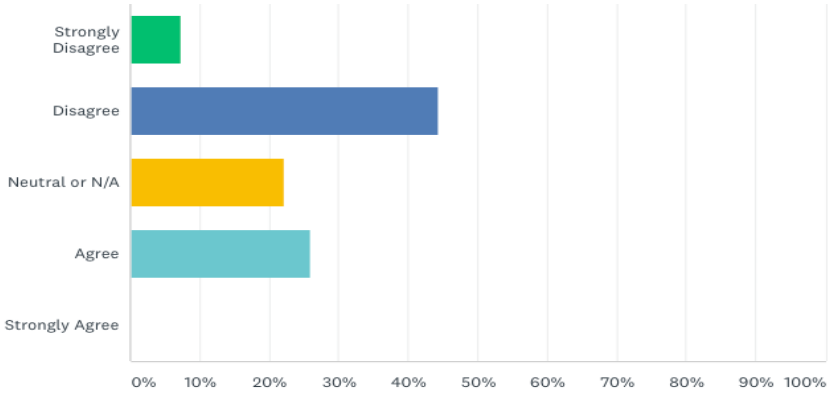
ANSWER CHOICES	RESPONSES	
Strongly Disagree	7.41%	2
Disagree	48.15%	13
Neutral or N/A	22.22%	6
Agree	22.22%	6
Strongly Agree	0.00%	0
TOTAL		27

<u>Question 5b</u>: There is agreement among service providers and other stakeholders regarding the current system's ability to: b) Prevent crisis events



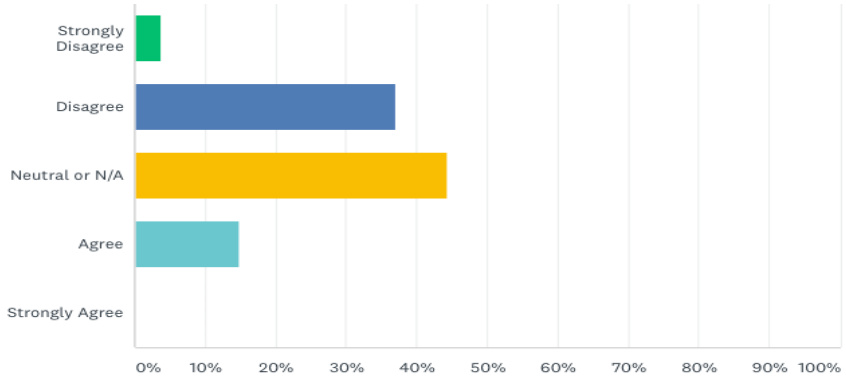
ANSWER CHOICES	RESPONSES	
Strongly Disagree	18.52%	5
Disagree	37.04%	10
Neutral or N/A	25.93%	7
Agree	18.52%	5
Strongly Agree	0.00%	0
TOTAL		27

<u>Question 5c</u>: There is agreement among service providers and other stakeholders regarding the current system's ability to: c) Provide services and supports to individuals after a crisis event



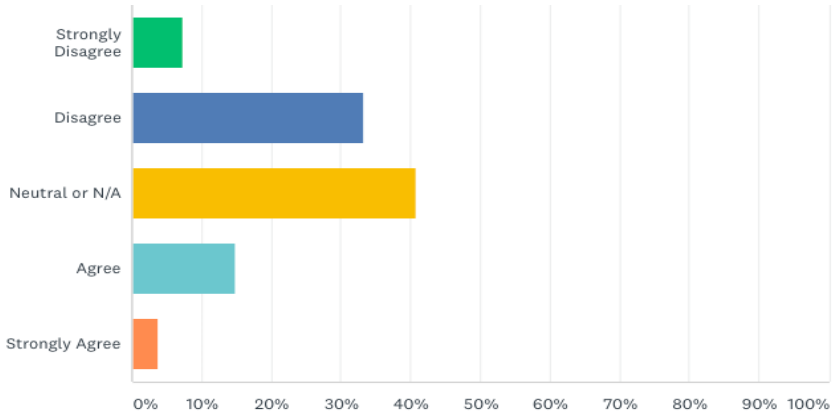
ANSWER CHOICES	RESPONSES	
Strongly Disagree	7.41%	2
Disagree	44.44%	12
Neutral or N/A	22.22%	6
Agree	25.93%	7
Strongly Agree	0.00%	0
TOTAL		27

<u>Question 6a</u>: There is agreement among service providers and other stakeholders regarding what should be done to improve the system's ability to: a) Respond to individuals experiencing a behavioral health crisis



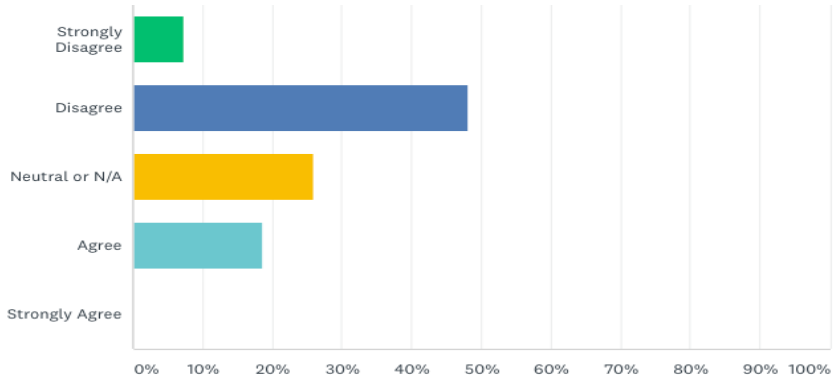
ANSWER CHOICES	RESPONSES	
Strongly Disagree	3.70%	1
Disagree	37.04%	10
Neutral or N/A	44.44%	12
Agree	14.81%	4
Strongly Agree	0.00%	0
TOTAL		27

<u>Question 6b</u>: There is agreement among service providers and other stakeholders regarding what should be done to improve the system's ability to: b) Prevent crisis events



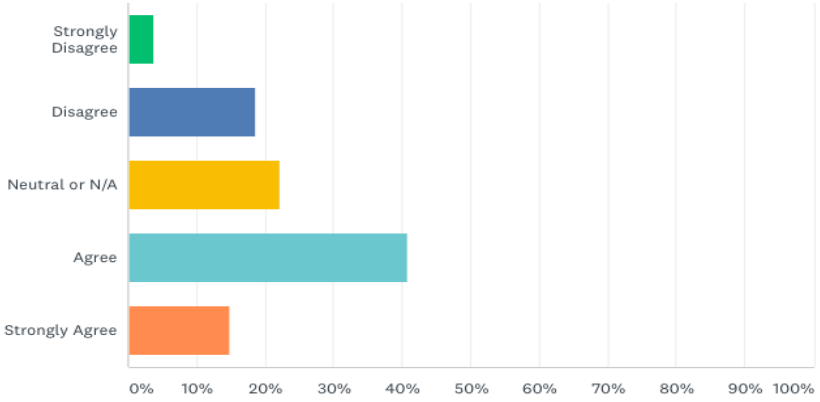
ANSWER CHOICES	RESPONSES	
Strongly Disagree	7.41%	2
Disagree	33.33%	9
Neutral or N/A	40.74%	11
Agree	14.81%	4
Strongly Agree	3.70%	1
TOTAL		27

<u>Question 6c</u>: There is agreement among service providers and other stakeholders regarding what should be done to improve the system's ability to: c) Provide services and supports to individuals after a crisis event



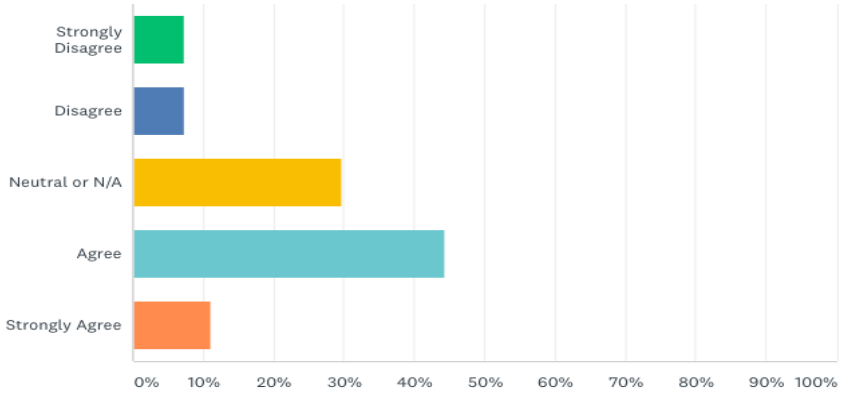
ANSWER CHOICES	RESPONSES	
Strongly Disagree	7.41%	2
Disagree	48.15%	13
Neutral or N/A	25.93%	7
Agree	18.52%	5
Strongly Agree	0.00%	0
TOTAL		27

<u>Question 7</u>: I believe that my organization will need to change in order to support behavioral health system change



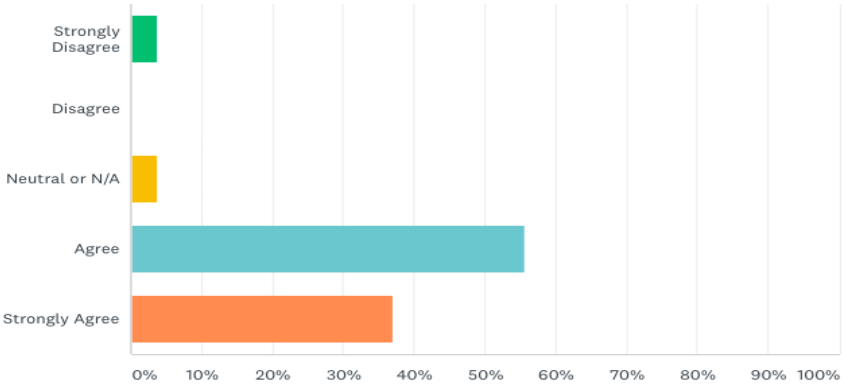
ANSWER CHOICES	RESPONSES	
Strongly Disagree	3.70%	1
Disagree	18.52%	5
Neutral or N/A	22.22%	6
Agree	40.74%	11
Strongly Agree	14.81%	4
TOTAL		27

<u>Question 8</u>: Within my organization, there is leadership buy-in to commit resource to improve how we interact with the behavioral health system



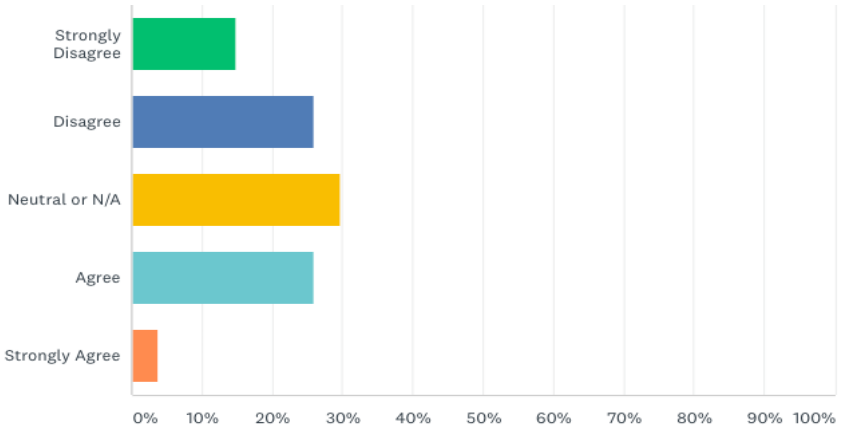
ANSWER CHOICES	RESPONSES	
Strongly Disagree	7.41%	2
Disagree	7.41%	2
Neutral or N/A	29.63%	8
Agree	44.44%	12
Strongly Agree	11.11%	3
TOTAL		27

<u>Question 9</u>: Now is the right time to commit time and resources to behavioral health system change



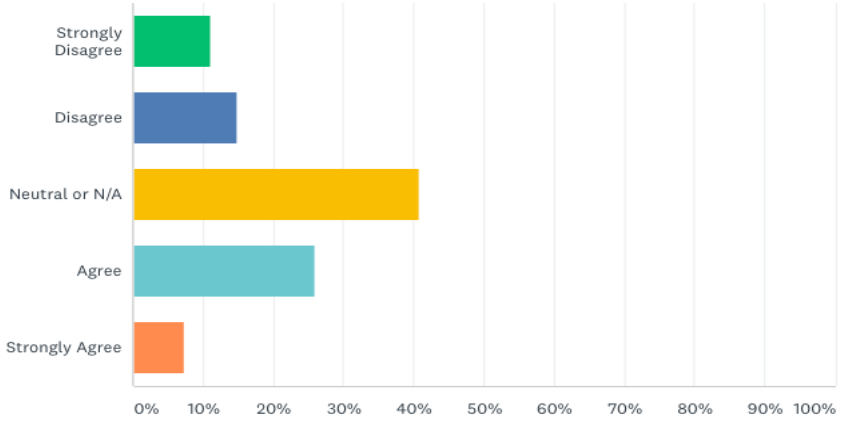
ANSWER CHOICES	RESPONSES	
Strongly Disagree	3.70%	1
Disagree	0.00%	0
Neutral or N/A	3.70%	1
Agree	55.56%	15
Strongly Agree	37.04%	10
TOTAL		27

Question 10: My organization has the necessary resources to support system change



ANSWER CHOICES	RESPONSES	
Strongly Disagree	14.81%	4
Disagree	25.93%	7
Neutral or N/A	29.63%	8
Agree	25.93%	7
Strongly Agree	3.70%	1
TOTAL		27

Question 11: Staff within my organization have the time available to support system change



ANSWER CHOICES	RESPONSES	
Strongly Disagree	11.11%	3
Disagree	14.81%	4
Neutral or N/A	40.74%	11
Agree	25.93%	7
Strongly Agree	7.41%	2
TOTAL		27

Net Promoter Score (NPS)

How likely is it that you would recommend the crisis center to a friend or colleague?

DETRACTORS (0-6)	PASSIVES (7-8)	PROMOTERS (9-10)	NET PROMOTER® SCORE
37% 10	19% 5	44% 12	7

The **Net Promoter Score (NPS)** is commonly used as a management tool, with a range from -100 to +100 and it measures the willingness of customers to recommend a company's products or services to others. NPS was used to measure providers' overall satisfaction with the crisis center services. The NPS range is -100 to +100, a "positive" **score** or NPS above 0 is **considered** "**good**", +50 is "Excellent," and above 70 is **considered** "world class." A **NPS** that is below **0 would** be an indication that your business **has** a lot of issues to address. A **score** between **0** and 30 is a good range to be in, however, there is still room for progress.

- Stakeholders had 37% **Passives** (score 7-8) were satisfied but unenthusiastic with the crisis center services.
- Stakeholders had 19% **Detractors** (score 0-6) were unhappy with the crisis center services.
- Stakeholders had 44% **Promoters** (score 9-10) were overall satisfied with the crisis center services.
- Stakeholders had **7 NPS** which is considered **"good"** and means that the majority of the stakeholders would consider using the crisis center.

VI. STAKEHOLDER GAPS ANALYSIS

We asked for the top three (3) gaps in current delivery system and areas of concentration was developed from the gaps identified. The areas of concentration should be considered for future state for the crisis center.

Stakeholder Areas of Concentration for Gaps

- Improve access to behavioral health and crisis services
- Reduce wait time from referral to first appointment

- Improve access and affordability with transportation to services
- Improve communication and coordination with crisis center, behavioral health providers, & medical providers
- Increase providers to service Medicaid and Medicare patients
- Improve marketing of crisis center
- Increase mental health training and education to law enforcement and EMS
- Improve the cost of care
- Improve behavioral health integration in primary care
- Increase medication management providers for the mental health population
- Improve data sharing
- Improve point of contact for crisis services
- Improve continuum of care or continuity of care
- Create value-based contracting
- Improve family involvement

1.) Current Gaps in Service Delivery

The top three (3) gaps in the current behavioral health delivery system that inhibit care coordination, access to care, availability of services, and ability to demonstrate value are:

Gap 1: Reponses	**Gap 2: Responses**	**Gap 3: Reponses**
• Insurance status of individuals who require care • Cost to families • Knowing who to contact regarding various situations • Transportation • Laws pertaining to rights, tie the hands of those trying to help • Access to psychiatrists • Quality and meaningful care • Availability • Sharing of data • Lack of behavioral health integration in primary care • No immediate access to medication evaluations	• Ultimate guarantor of care for every individual who require care • Availability • What training is available to inform staff • Resources • No place to put those persons deemed at risk, long term • Ability to correct identify need • Not knowing what the resources are • Lack of service providers • Time • Certified staff to meet the need • People outside of the field do not know how to deal with mental health • Identify behavioral health problems • Lack of continuum of care • Insurance rates • Access to inpatient treatment • The system is not user friendly • Access • Fractured delivery system • Lack of value-based care within behavioral health	• Communication between government and privately run agencies who provide care to the same individual • Family buy in • Are there more than one behavioral health service delivery systems • Inactivity or inappropriate activity of Adult Protective Services, they seem to go after the wrong cases • Funding • Training of staff • Inability to collaborate with other agencies • Information • Not enough mental health facilities in our area • Same service processes in assessing the needs • Lack of workforce • Lack of support and communication between providers • Access to crisis care • Care is not strictly based on need but availability of funding • Value • Facilities/resources

	• No safe housing for unstable clients in crisis	• Lack of behavioral healthcare providers • No coordinated aftercare

What type of agency or community partner are you representing?

- Behavioral health advocacy for adults
- School District
- Greenleaf Friends Academy
- Community Action Partnership
- City Government
- Ambulance or EMS
- Library
- Reverse integrated behavioral health agency
- Education
- We are an agency that does developmental, vocational and employment services for the disabled
- Council Valley Library, where information can be found to help people
- Public library out of town
- Physician practice
- Optometry office
- Juvenile Justice System
- Ability Community Resources
- Private audiology practice that deals with patients who have depression due to their conditions. We also service Veterans who are at risk for multiple mental health issues
- Medicaid MCO or Provider Network
- I am an individual retired mental health counselor
- Limited liability private practice

On average, how many hours a week do you or your agency/organization spend coordinating and/or interacting with:

Behavioral health service providers and/or organizations:	**Individuals with behavioral health issues:**	**Individuals experiencing behavioral health crises:**
• 35 • Once or twice a month • Very little • 0 or none • An hour or two • About of third of staff time • 40 – 60 • 1 or less • 50% • 5 • 3	• Less than 4 • Once or twice a month • Every day • 1 hour • 2, 3, 8, or 10 • 0 or none • 40 plus • Occasionally • About half the time • 10 – 25 or 45 – 50 • Unsure or unknown • 10% or 20%	• Less than 1 • Once or twice a month • Everyday • 1, 2, 3 or 10 • 0 or None • Occasionally or sporadically • 1 hour • 10% • Approximately 20% • Unsure or unknown • 5%

Additional thoughts or comments about the system and/or how it might be improved:

- "I didn't know there was a crisis center locally. If we had information about it, we would be happy to display it in the office. I don't feel like a very informed person to answer these survey question that I received via email."
- "The need for quality mental health services for youth and non-secured placements are needed in our Region."
- "You might want to consider restructuring question 20"
- "Greater community involvement"

VII. 2017 MENTAL HEALTH & SUBSTANCE USE DISORDER PROVIDER CAPACITY SURVEY

This Mental Health/Substance Use Disorder (MH/SUD) provider survey was developed by YNot Innovators, LLC in February 2017. YNot Innovators created and deployed the survey to assess and identify Behavioral Health (BH) Provider location, staffing, service types, electronic health records (EHR), and capacity.

The categories in the survey were:

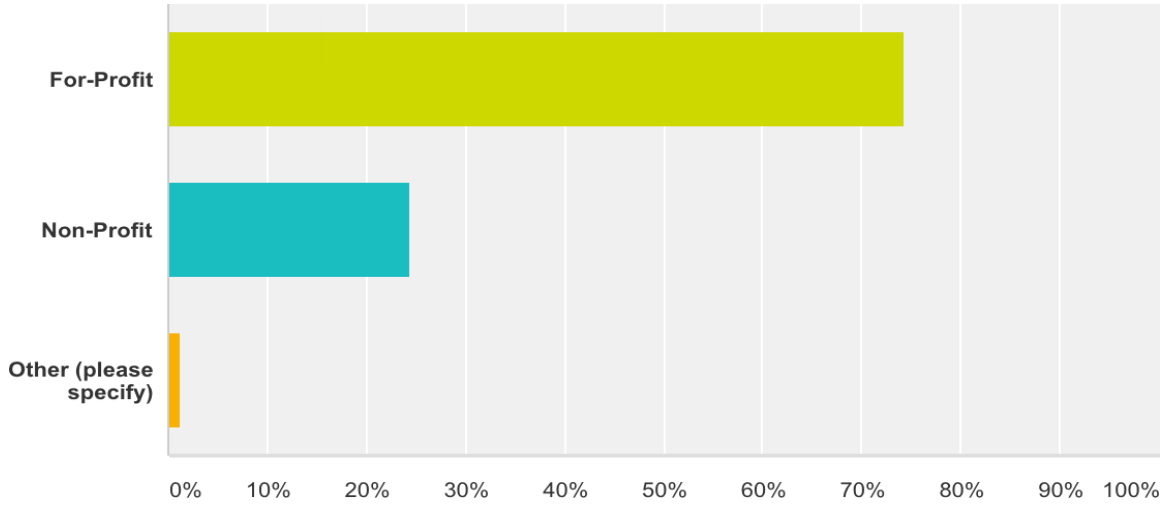
- ***Gaps***
  - Providers in the network
  - Resources in different geographic locations
  - Diagnostic & Workforce issues
- ***Continuum of Care***
- ***Identification of Population*** (High Risk and Rising Risk)
- ***EMR & Inter/Intra-agency*** communication issues (Interoperability, MOUs, etc.)
- ***Parity*** (Capture high Risk Population) Utilization Review & Management
- ***Differences in Population Health Management vs Service Delivery***
- ***Level of Care*** for continuum of care services

N = 75 Respondents completed the surveys out of 500 facilities or single provider. There was a broad range of Masters and Doctorate Level Providers surveyed.

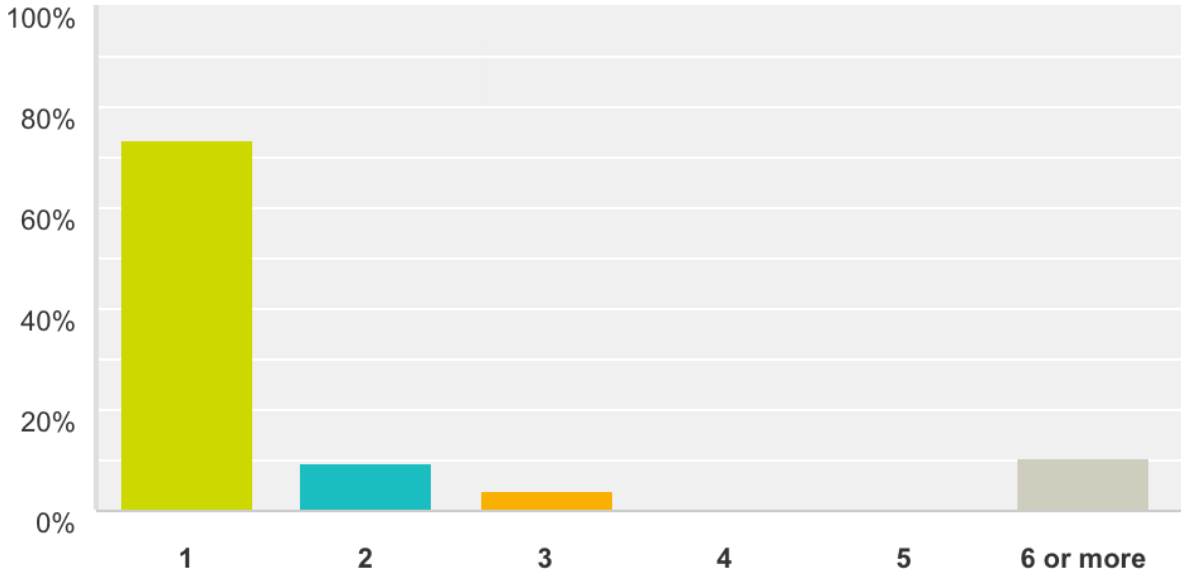
- Licensed: PhDs, PsyDs, LCSW, LMFT, & LCPC
- Non-Licensed: LPC, LMSW, & Psychologist
- Broad Range of Care Coordination and Case Management services and staff

1.) 2017 Survey Results

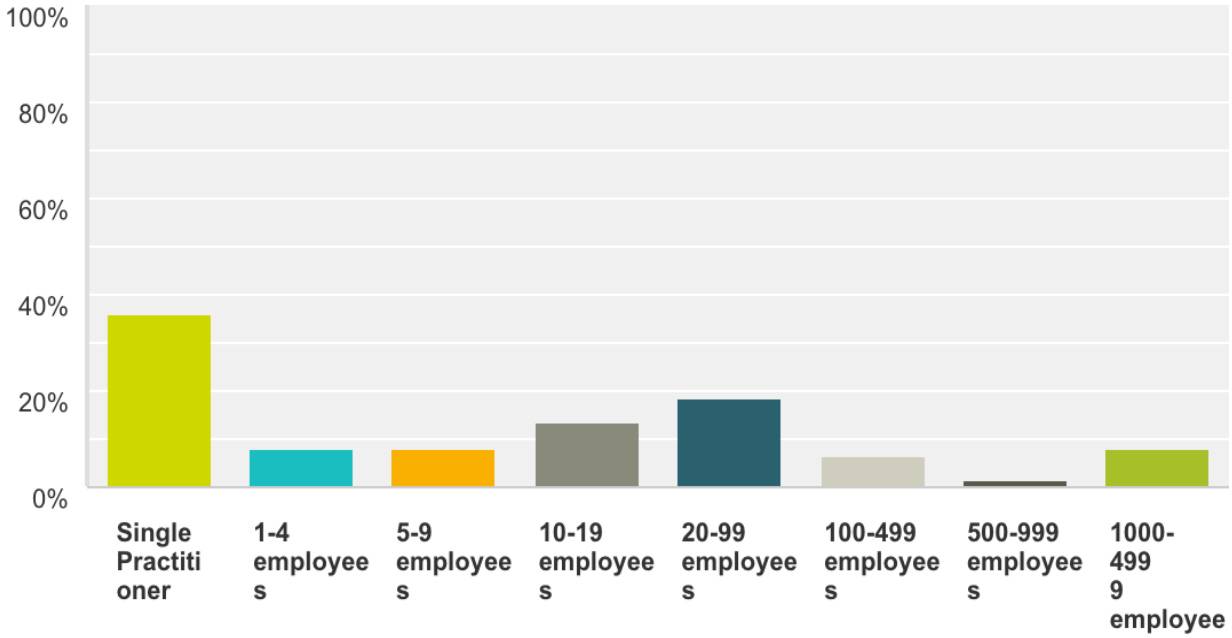
For Profit vs Non-Profit: Significantly higher number of For-Profit versus Non-Profit organizations.



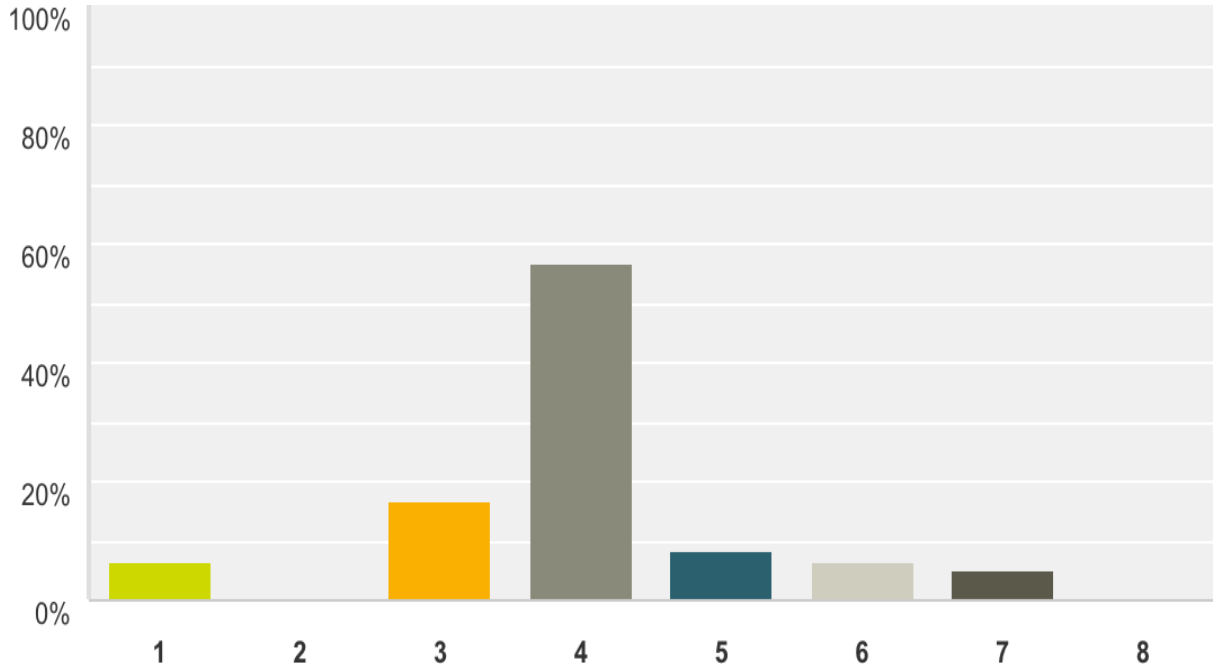
Number of Locations: Most organizations have only one location.



Number of Employees: High percentage have single practice but good diversity of organizations with multiple employees.



Health and Welfare Region: High percentage of providers are located in Region 4 (Ada, Valley, Elmore, & Boise Counties)



Provider or Organization Payor Mix: Providers have a good diverse payor mix but percentage for BPA/SUDs was the lowest.

Medicaid	61.33%	46
Optum for MH	70.67%	53
BPA for SUDs	36.00%	27
Medicare	46.67%	35
Medicare and Medicaid	40.00%	30
VA or TriWest	53.33%	40
EAP	65.33%	49
Workman's Compensation	32.00%	24
Blue Cross of Idaho	97.33%	73
Regence Blue Shield	90.67%	68
Aetna	88.00%	66
United Health	80.00%	60
PacificSource	93.33%	70
SelectHealth	97.33%	73
Self Pay	97.33%	73

Electronic Health Records: High percentage of providers with no electronic health record.

Cerner PowerChart	0.00%	0
EpicCare	12.86%	9
NextGen	0.00%	0
Allscripts	0.00%	0
NextGen	0.00%	0
athenahealth	1.43%	1
Centricity	7.14%	5
eClinicalWorks	1.43%	1
CPSI System	0.00%	0
Optum Physician	0.00%	0
Valant Behavioral Health EHR	2.86%	2
TherapyNotes	7.14%	5
BestNotes	11.43%	8
Credible	1.43%	1
Idaho WITS	7.14%	5
Profiler	0.00%	0
Organization does not have EHR	24.29%	17

Organizational Credentials: Most providers or organizations are credentialed for Outpatient Mental Health.

Outpatient Mental Health (MH)		82.67%	62
Outpatient Substance Use Disorders (SUD)		16.00%	12
Outpatient Integrated Behavioral Health (IBH) in primary care		10.67%	8
Outpatient Reverse Integration		1.33%	1
Inpatient Psychiatric		2.67%	2
Inpatient SUDs		2.67%	2
Residential MH		1.33%	1
Residential SUDs		2.67%	2
Social Detox for SUDs		0.00%	0
Medical Detox for SUDs		4.00%	3
State Crisis Center		0.00%	0
Tele-health		6.67%	5
Other (please specify)	Responses	22.67%	17

Types of Mental Health Services: Highest percentage of service is Individual Therapy with Family Therapy coming in second. Medication management, case management, and community based supports, such as care coordination, all scored at 31% or lower.

Individual Therapy		87.84%	65
Group Therapy		35.14%	26
Family Therapy		74.32%	55
Family Support Services		18.92%	14
Community-Based Rehabilitation Services (CBRS)		22.97%	17
Medication Management		31.08%	23
Crisis Management		45.95%	34
Civil Commitment		2.70%	2
Comprehensive Psychological Evaluation		32.43%	24
Comprehensive Neuropsychological Evaluation		13.51%	10
Case Management		31.08%	23
Community Health Workers		4.05%	3
Peer Support Specialist		20.27%	15
Care Coordination		24.32%	18
Skills Trainers		10.81%	8
Interns Bachelor's Level		8.11%	6
Interns Master's Level		29.73%	22
Interns Doctorate Level		2.70%	2
EAP		52.70%	39
Organization does not provide mental health services		4.05%	3
Other (please specify)	Responses	13.51%	10

Types of SUD Services: Highest percentage of service is Individual Therapy with Family Therapy coming in second.

Individual Therapy		45.16%	28
Group Therapy		17.74%	11
Family Therapy		22.58%	14
Recovery Coaches		4.84%	3
Community-Based Rehabilitation Services (CBRS)		8.06%	5
Medication Management		9.68%	6
Crisis Management		19.35%	12
Case Management		17.74%	11
Community Health Workers		3.23%	2
Peer Support Specialist		9.68%	6
Care Coordination		9.68%	6
Skills Trainers		6.45%	4
Interns Bachelor's Level		6.45%	4
Interns Master's Level		9.68%	6
Interns Doctorate Level		0.00%	0
EAP		25.81%	16
Organization does not provide SUDs services		45.16%	28
Other (please specify)	Responses	6.45%	4

Types of Screening Instruments: Highest percentage is the Suicide Screenings with PHQ9 for depression screening coming in second and CAFAS/PECFAS for children in close third.

PHQ2	12.50%	8
PHQ9	37.50%	24
PHQA (Adolescent)	10.94%	7
GAD7	21.88%	14
GADA (Adolescent)	9.38%	6
AUDIT	10.94%	7
DAST	10.94%	7
GAIN	23.44%	15
CRAFFT	6.25%	4
TWEAK (SUDs for Pregnancy)	0.00%	0
CAFAS/PECFAS	31.25%	20
ECSII/CASII/LOCUS	0.00%	0
4 Quadrant Model	3.13%	2
Suicide Screenings	60.94%	39
Organization does not use screening instruments	9.38%	6
Other (please specify) Responses	35.94%	23

Care Coordination Activities: Highest percentage of care coordination activities reported by providers or organizations is "Communicate and coordinate treatment progress with patient's PCP or their team regularly" with "Coordinate treatment planning with patient's PCP or their team regularly" in close second.

Coordinate treatment planning with patient's PCP or their team regularly	59.02%	36
Communicate and coordiante treatment progress with patient's PCP or their team regularly	65.57%	40
Communicate and/or coordinate if patient disengages or no shows appointments with PCP or their team regularly	40.98%	25
Provide updated medication list to patient's PCP or their team regularly	31.15%	19
Provide information to patient's PCP or their team when patient is admitted or discharged from ED	22.95%	14
Provide information to patient's PCP or their team when patient is admitted or discharged from Inpatient Psychiatric Hospital	27.87%	17
Provide information to patient's PCP or their team when patient is admitted or discharged from Inpatient SUDs	18.03%	11
Other (please specify) Responses	31.15%	19

Access Standards: Highest percentage of access is Routine Appointments with Urgent Appointments coming second.

Same Day Access	40.28%	29
Routine Appointment (Within 10 days)	87.50%	63
Urgent Appointment (Within 48 hours)	79.17%	57
Crisis - Non-Life Threatening Emergencies Appointment (Within 6 hours)	48.61%	35
After Hours Appointment (Assistance provided 24 hours a day/7 days a week with instructions to the patient regarding what to do in an emergency situation.)	43.06%	31
Appointment within 7 days after discharge from inpatient psychiatric hospitalization	66.67%	48
Appointment within 30 days after discharge from inpatient psychiatric hospitalization	34.72%	25
Other (please specify) Responses	9.72%	7

Organizations with MD/DO Prescribers: Highest percentage have no MD/DO prescribers and coming in second having only one (1) provider.

None	71.83%	51
1	21.13%	15
2	4.23%	3
3	0.00%	0
4	1.41%	1
5	0.00%	0
6 or more	1.41%	1

Organizations with Midlevel Prescribers: Highest percentage have no Midlevel prescribers and coming in second having only (one) 1 provider.

None	63.01%	46
1	15.07%	11
2	12.33%	9
3	2.74%	2
4	2.74%	2
5	1.37%	1
6 or more	2.74%	2

RECOMMENDATIONS FOR DATA COLLECTION

Mental health, substance use, crisis, and integrated behavioral health data is difficult to capture across the service delivery and multiple payer systems. Currently, at a state level and nationally there are minimal data collection capabilities due to lack of resources, minimal consensus on data platform, and HIPAA issues. The following recommendations are meant to develop a data management and structure to collect, aggregate, and analyze the mental health, substance use, crisis, or integrated behavioral health population for patient outcomes and value-based payments.

Data collection is a critical component for a variety of reasons including:

- Mapping trends in utilization of the program
- Identifying gaps
- Monitoring outcomes
- Reporting to funding and regulatory sources
- Providing evidence of benefit to the community and/or potential funding sources

Key recommendation for the challenging task data collection include:

- Maintain commitment. When faced with increasing demands on staff time commitment to data collection can easily fall by the wayside.
- Over time and with changes in staff, consistency of data collection can decrease. Mapping out data collection processes and training new staff can assist with this.
- It is important to approach data collection in an intentional manner as it is far too easy to fall into the trap of collecting data for the sake of collecting data.
- Know what question the data needs to answer and ensure that the data has a true relationship to the answer.
- Avoid the pitfall of good intentions which often result in adding another data point and another data point. Avoid chasing every shiny new data point that comes along.

One recommendation of this report is the use of the *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide* manual produced by the Substance Use and Mental Health Services Administration (SAMHSA, Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice, 2018) as a guide for implementation of data collection. The guide "provides information about building necessary partnerships, documenting program activities, identifying key metrics, establishing data collection processes, analyzing and reporting data, using data to improve programs, and expanding capacity to collect and use data". The guide is a companion to *Practice Guidelines: Core Elements in Responding to Mental Health Crises*.

While the guide outlines methods that focus on CIT programing, the overall structure translates well to crisis and behavioral health systems. The model includes focus on strong community partnerships and the importance of a "continuum of crisis services available to citizens prior to police involvement". The model assumes that CIT is "just one part of a robust continuum of behavioral health services".

The model's core elements include ongoing elements, operational elements, and sustaining elements.

The guide recommends that partnerships "expand their data collection efforts in a way that makes sense for their local program" and breaks data types down into three tiers: 1) Mission Critical Data, 2) Intermediate Data, and 3) Advanced Data. The guide further outlines a seven (7) step process:

- Step 1: Ensure the right partnerships are in place
- Step 2: Document your local program
- Step 3: Identify key metrics
- Step 4: Establish a consistent, routine data collection process
- Step 5: Establish regular data analysis and reporting to the field
- Step 6: Incorporate what is learned into program improvement
- Step 7: Expand program data collection as capacity and skills grow

Some suggestions for crisis center data collection include:

- Recidivism rates: What percent of clients served by the crisis center have an additional crisis episode in the following 30, 60, and 90 days.

- Higher levels of care: What percent of clients served by the crisis center are admitted to a psychiatric hospital during the crisis event, within 7 or 30 days of a crisis event? Of these is there any patterns associated with community service provider access and engagement patterns?

- Emergency Department utilization: What percent of client served by the crisis center had an emergency department visit for any reason within 30 days prior to and/or following the crisis event? What was the reason (primary diagnosis) for the ED visit?

- Police system involvement: What percent of clients served by the crisis center had police contact within 30 days pre/post crisis and if so, how many contacts and for what?

- Access and engagement/retention: What percent of client served by the crisis center received post-crisis services from a community behavioral health provider within 48 hours, seven (7) or 14 days. What percent of client served by the crisis center received four (4) services from the same community behavioral health provider within 30 days? Include whether the individual had an established behavioral health provider prior to the crisis event as one of the data elements.

    - Use of NIATx Four Aims or a similar target configuration could be helpful in ongoing larger crisis response systems improvement. The NIATx Four Aims are:

        - Reduce waiting time between first request for service and first treatment session
        - Reduce no-shows by reducing the number of patients who do not keep an appointment
        - Increase admissions to inpatient and outpatient treatment
        - Increase continuation from the first through the fourth treatment session

- Crisis prevention: What percent of client served by the crisis center, who had an established behavioral health provider, received at least one service within three (3) days of the crisis event? What services and how many were provided to the individual in the 30 days prior to the crisis event?

- Role of primary care: What percent of client served by the crisis center received one or more services from their primary care provider within seven (7) and 30 days of the crisis event? What percent of the services were from a behavioral health consultant?

Including demographics such as age, gender, county of origin, diagnoses, referral sources (including whether brought in by law enforcement), and type and quantity of services provided by WICCC when querying data will allow for deeper dives into service and outcome patterns. Other data points such as insurance provider, homeless status and annual income can also be helpful.

The ability to track data for all individual served will be impacted by the ability to compare crisis center data and data from community behavioral health and primary care providers as well as hospital emergency departments. It may be necessary to begin with a subsection of individuals served base on insurance type, assuming that the associate insurance partner is willing/able to provide data. Information from insurance providers allows for the use of claims data from any type of health service for which a claim was submitted. By utilizing insurance information one can observe:

- Were there any emergency department visits pre and/or post crisis event and if so for what diagnoses
- What and how many services were delivered by community providers pre and/or post crisis event (implications regarding the system's ability to avoid crises and/or support individuals post crisis in order to avoid future crises)
- How much time elapsed between the crisis event and the next behavioral health services post crisis (implications regarding system's ability to respond quickly to an individual post crisis and to engage/retain the individual in ongoing treatment)

FINAL CONCLUSIONS & RECOMMENDATIONS

The following discussion of information gathered and the implications for system improvement and sustainability will take a slightly larger system focus rather than focus more exclusively on crisis services. This is, in part, driven by the critical role played by multiple system stakeholders in pre and post crisis services and supports. An additional consideration is that the original timeline for Western Idaho Community Crisis Center (WICCC) to begin providing services was October 2018. As with many new projects, the WICCC experienced complications which resulted in an April 23, 2019 start date. This later start date has not allowed for the anticipated data collection to occur or for more longitudinal patterns of strengths and challenges to emerge. The 2019 data collection should be considered a "baseline" period and subsequent annual data collection would provide a longitudinal comparison for quality improvement. Ideally, more time is needed for the new crisis services to the health ecosystem to settle into its place, for other parts of the system to readjust, and for natural fluctuations in patterns to solidify.

I. Potential Implications

Census data provided an overview that reflects five out of six counties having increasing populations, Canyon County having the largest increase at 18.3%. Washington County was stable overall with a decrease of 37 residents. While the region is showing growth, only Canyon County had a growth rate at or above Idaho's overall growth rate.

> Potential Implication: Competition for scarce State resources could be impacted by regions with greater growth rates than Region 3.

All counties in Region 3, with the exception of Canyon County, exceed Idaho's 65 years old and older percentage of 15.9% of their population.

> Potential Implication: The older adult population requires specialty services, including crisis response, tailored to the needs associated with older adults. This will impact the type and amount of services as well as the need for specialized training for behavioral health providers. It is important to remember that suicide attempts are more likely to result in death among the older adult population. Additionally, depression, related to issues such as sense of loss of role in society and chronic pain, social isolation and medical problems can increase the probability of an attempt. Education and income levels are lower than the state median percentages and disability under the age of 65 is higher than the state median percent. This in combination with a larger older adult population can result in a population with higher levels of need and less financial ability to meet those needs.

In 2007, Senate Concurrent Resolution No. 108 directed engagement of an independent contractor. Their areas of focus were to include assessment of treatment capacity, cost, eligibility standards, and areas of

responsibility, as well as making recommendations for improving the system. Twelve years later, while changes have occurred, the areas of challenge remain largely the same. The chosen contractor, WICHE, conducted a subsequent evaluation in 2018. The report noted some significant changes had occurred since the 2008 report and one of the changes sited was the transition to a managed care model for Medicaid utilizing Optum as the managed care organization.

> Potential Implication: While the transition to a Medicaid managed care model was a significant change, it did not include psychiatric hospitalization costs. This inhibits the system's ability to shift high cost hospitalization funding, currently located at the State level, to lower cost community-based care which can serve to divert individuals from needing hospitalization. It is acknowledged that this is easier said than done and there is significant risk associated with taking on responsibility for the cost of psychiatric hospitalization. Shared risk between the managed care entity and the state in addition to targeted system transformation and funding would likely be necessary in order to re-align resource utilization.

WICHE's 2018 report concluded that the "overall system remains fragmented". A fragmented system serves to exacerbate services delivery challenges. It is likely to decrease efficient use of funding and inhibit outcomes. It can cause the loss of staff working in the system and/or deter new professionals from entering the system. Individuals in need of services can find it difficult to navigate and may not be able to access needed services. Data collection is an area of challenge for many systems. Having consistent access to useful data points across populations and/or insurance types can be difficult. The ability to access data that allows for tracking of the impact of interventions across both medical and behavioral health is generally only available through insurances who cover both. Data is critical to being able to show value added and to inform decisions regarding resource allocation.

Service provider survey response of 31 is very small based on the total population of SWDH six counties. The service provider survey responses were mixed showing varying levels of readiness for system transformation and for participation in transformation. To calculate a score for service provider overall readiness for change, feedback regarding leadership commitment, having identified champions, believing that their organization will need to be part of the change, and believing that now is the right time to commit time and resources was used. The more neutral responses of "not currently a priority" and "have discussed this issue" but no action taken accounted for 39% of the responses. The question regarding "Staff believe that our agency will need to change in order to support behavioral health system change" elicited 74% for the same more neutral responses. When providers were asked "How likely is it that you would recommend the crisis center to a friend or colleague?" the net promoter score was shockingly a zero (0).

> Potential Implications: It appears that service providers are interested in system improvement but competing demands for time/funding and varying levels of understanding regarding the larger behavioral health ecosystem impacts providers' current ability to be part of effecting change. Additional coordinating supports will be needed to harness and improve confidence in the change resources offered by system service providers.

Stakeholder survey response of 27 is very small based on the total population of SWDH six counties. The stakeholder survey responses were also mixed showing varying levels of agreement or understanding of the crisis service systems and transformation readiness. To calculate a score for

stakeholder overall agreement or understanding of the crisis system and systems transformation readiness was used. The responses of "strongly disagree" and "disagree accounted for 34% of the responses. The neutral response of "neutral or N/A" constituted 27% of the responses. When stakeholders were asked "How likely is it that you would recommend the crisis center to a friend or colleague?" the net promoter score was only a seven (7).

Potential Implications: Feedback from stakeholders and also service providers reflected a wide array of gaps in quality and availability of care, the wish for increased use of technology, a desire to find alternant ways to meet communities' needs, improve communication, repair the fractured system, and address limited resources. One of the most glaring comments were ones where the community or stake holders were unaware of the crisis center existed. Other comments included issues with the distance individuals must travel to get to the crisis center and challenges with post crisis referrals.

II. Crisis Center Recommendations

There are a wide variety of opportunities for system transformation, many of which would require significant transformation of the state system. A significant number of these recommendations can be found in the WICHE report. While it is important that efforts continue to improve the effectiveness of the larger system, the following recommendations focus on efforts that do not require statewide change. This will allow Region 3 to strengthen its system and outcomes while efforts to address state level transformation continue.

1. **Communication and Coordination: Utilize a structure similar to the one used for Sequential Intercept Mapping (SIM)** for crisis and pre/post crisis systems mapping after the WICCC has been in operation for at least nine months. Conducting this process and having a broad array of service providers and stakeholders participating in this process will serve at least three functions: 1) document system change as a result of WICCC services, 2)increase participants' understanding of the intricacies of the service delivery ecosystem, and 3) allow for broader participation in creating the local plan for improving pre/post crisis response and communication among providers/stakeholders.

2. **Community Outreach: WICCC outreach** to the SWDH 6 counties to provide marketing materials and education to improve awareness of the crisis center services.

3. **Organization and Provider Accountability**: Detailed **Letters of Agreement** between system partners including rapid post crisis access for treatment, psychiatric access (medications), and communication between WICCC and established/new service providers. Commitment to upholding the agreements by all involved will be critical.

4. **Upskilling Communities: Community education** regarding crisis and other behavioral health resources including when to seek services, how to access, and what to expect out of treatment.

5. **Evidence Based Practice and Method: Use of Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step by Step Guide** to inform data collection and utilization as well as establishing the necessary relationships to support the process.

6. **Sustainability: Engaging multiple insurance companies as sources of data**. This will allow for tracking of multiple types of service delivery, medical and behavioral health, in order to determine positive outcomes including medical costs associated with behavioral health interventions, e.g. emergency department utilization. It will also allow for tracking of pre and post crisis service delivery patterns.

7. **Payment Method**: Work with insurance companies to establish **Value Based Contracting** with service providers that includes pre and post crisis response requirements.

8. **Going Beyond Needs Assessments**: There have been a wide variety of system assessments including WICHE 2008 and 2018 reports which are quite comprehensive. The next steps need to be financial and structural change investments to operationalize what has already been identified in these reports.

9. **Improving Stakeholder and Provider Surveys**: Repeat baseline surveys for Provider and Stakeholder Readiness Survey and the 2017 BH/SUDs Provider to compare progress.

10. **Future Model for Crisis System Recommendations**: Please refer to page 103 or Appendix 1 for recommendation regarding a **Regional Hub and Spoke Care Network.**

Appendix 1: Future Model Recommendation

I. Regional Hub and Spoke Care Network

Based on the information from the system assessment, the recommendation is to achieve a clinical practice and financial redesign in health care delivery systems. Without central accountability, a fragmented delivery system, and the resources to coordinate care, there is only so much that rural providers in the state can do to manage behavioral health. The goal is to target the specific needs of rural health systems in the application of integrated care and value-based approaches. The redesign will address the behavioral health crisis system to create a behavioral health accountable strategy. The strategy would execute an accountable inter-professional team-based care model that services the rural or low resource communities to incorporate practice models and protocols that guide. This would incentivize improved coordination and collaboration among community health professionals, alternative health workers, patients, and families.

The future outcome would be a sustainable regional crisis center infrastructure to develop the SWDH Region 3 Crisis Center Health Improvement Team (CC-HIT) hub and spoke model for the behavioral health population using the initial development of the SWDH 3 Crisis Center. SWDH would be well-positioned to develop the Region 3 CC-HIT infrastructure and to establish a sustainable value-based accountable crisis center model for rural communities. SWDH would become the primary hub, and the spokes would be Adams, Canyon, Gem, Payette, Owyhee, and Washington counties. The hub and spoke structures and new care delivery model will hold the crisis center contractor and the patient's care team (e.g., primary care providers, behavioral health providers, emergency room, inpatient facilities, etc.) accountable in managing and coordinating care across the patient's healthcare continuum. The result would be to improve patient outcomes, reduce utilization, and improve provider performance outcomes. Please refer to Figures 1 & 2 for a graphic description of the CC-HIT hub and spoke model.
It should be noted that while the crisis center fills a gap for adult mental health services in SWDH counties and provides the opportunity for alternative treatment for preventable incarceration or admission to the emergency room, services must include children as part of the service delivery.

CC-HIT aims to address lack of access to clinical care, crisis services, care management and care coordination for the rural populations of the Southwest Region of Idaho related to mental health (MH), behavioral health (BH), substance use disorders (SUD), and opioid use disorders (OUDs) while simultaneously developing a management support system to provide technical assistance and share resources amongst rural community based partners to support the service delivery. This will be accomplished through the creation of a robust care network and accountable health neighborhood infrastructure including care providers and supportive evaluation and coordination resources. In partnership with Southwest District Health, county level indigent fund managers, public/private payers, provider networks, and other private and non-profit organizations will create a regional care coordination and care management process for treating and supporting patients retrospectively identified through county indigent registries, and a prospective data management and care management tool for tracking individual patients through various levels of care as well as the associated spend. This new system would reduce the total cost of care for payers and state general funds as MH/SUD/OUD patients are more actively managed and tracked through community-clinical linkages.

Recommended Strategies for CC-HIT

1. Strategies.
    a. Create a review and sorting protocol for county indigent rosters
    b. Retrospectively review rosters for eligible patients
    c. Create a prospective screening process for new indigent patients
    d. Create a financial model that incorporates indigent, Medicare, Medicaid, & Commercial payors using primary care utilization data and a capitation model

2. Strategies.
    a. Perform environmental scan for support agencies in the six-county region
    b. Recruit support agencies to participate in care activities and mapping via a care compact
    c. Refer patients to Southwest District Health for assessment and referral
    d. Deploy a utilization and care management tool to track patient encounters with SWDH and community partner organizations
    e. Manage evaluation through data tracking software and linked data management tools.

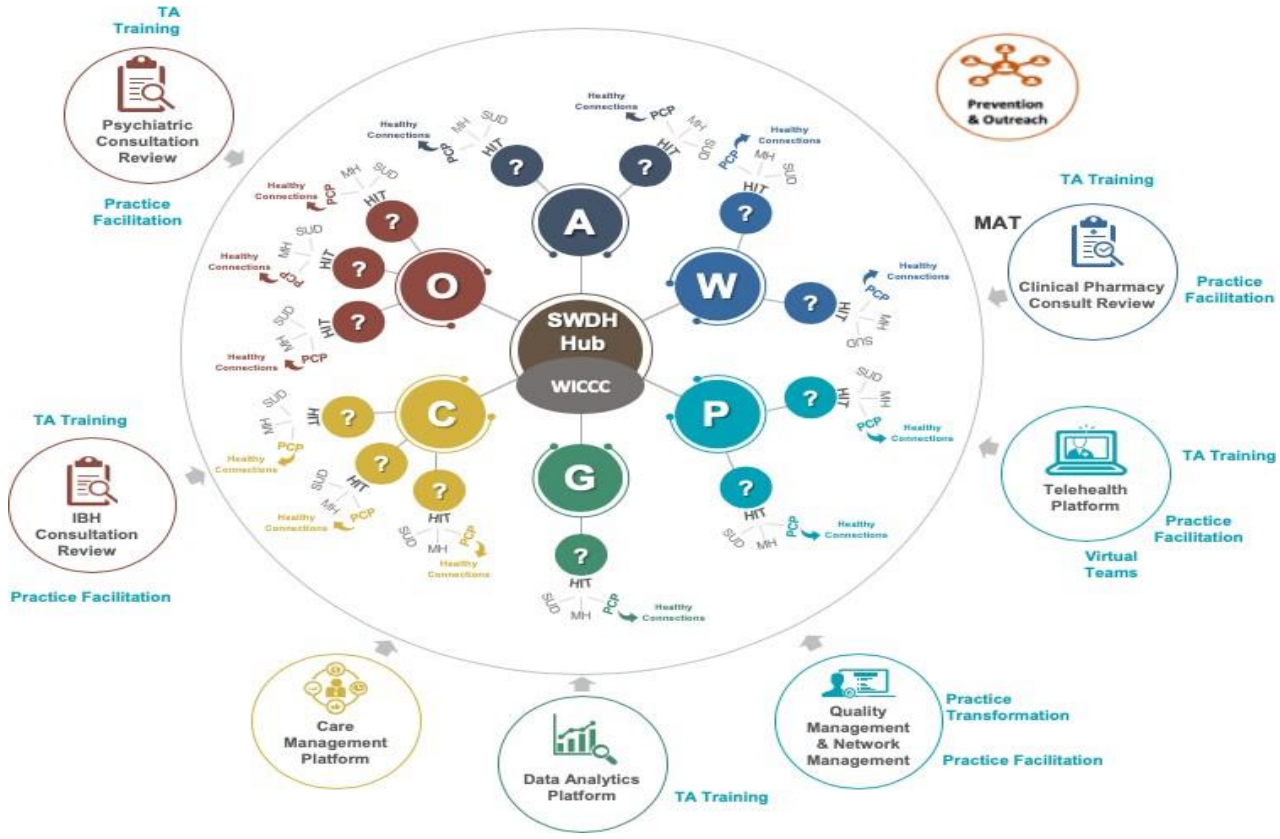
3. Strategies.
    a. Utilize a retrospective analysis to determine pre-care management total cost of care for regional indigent patients.
    b. Track total cost of care for patients managed through program for one year.
    c. Utilize an established comparative algorithm to project cost savings in fee for service vs. value-based setting.

4. Strategies.
    a. Convene a meeting of state payers (organized through the multi-payor workgroup) to share cost of care outcomes.
    b. Develop a public roadmap for payers to develop their own programs

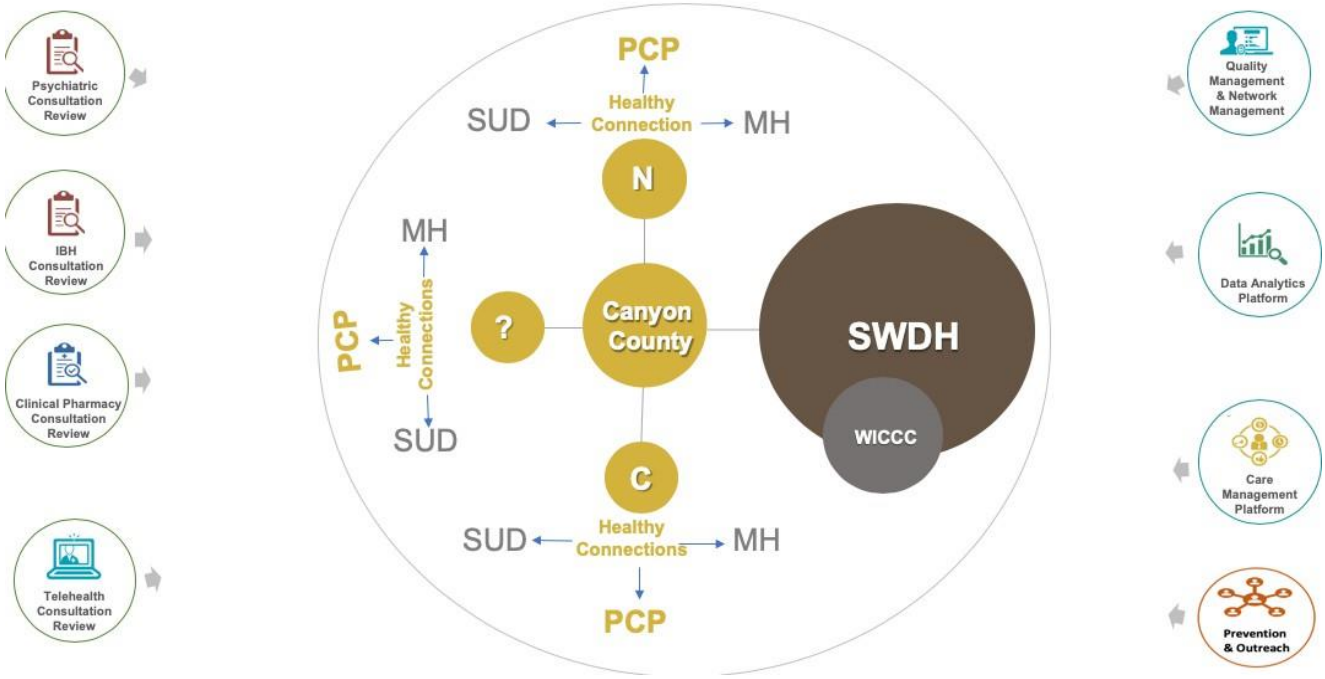
Significance and Impact of CC-HIT

The care network would create a regional infrastructure for all BH/MH/SUD/OUD patients to provide high quality and coordinated care while simultaneously providing justification for durable/cost-effective funding regarding community-clinical linkages for the population served. Currently, there is limited incentive for agencies across sectors to utilize a common care management strategy for patients resulting in a fragmented system of care that is challenging to navigate at best and losing patients through the cracks at worst. The impact of this fragmentation is especially profound for the low income and rural communities of Idaho. By creating the tools to better coordinate and manage patients, the care networks will not only create a portfolio of tools that will better serve patients and their families but also evaluate this resource with the goal of changing the relationship between payors and providers allowing future scaling to other regions across the state and country, with an emphasis on rural and low income populations. Through the management support system and shared resources, agencies could better partner while reducing the cost of care and patients would receive high quality and coordinated treatment. Lastly, the system could be mapped onto any patient or payer target group after successful demonstration of cost savings through the indigent fund beneficiaries. As a result, CC-HIT has the opportunity to create a structure that would have a much larger regional benefit to patients, providers, and communities.

Figure 1. Region 3 Crisis Center Health Improvement Team (HIT) Hub and Spoke Model



Example of Regional System for Canyon County



Definitions from the Hub and Spoke Model

- PCP = Primary Care
- BH = Behavioral Health
- SUD = Substance Use Disorder
- MH = Mental Health
- A = Adams County
- W = Washington County
- P = Payette County
- G = Gem County
- C = Canyon County (N=Nampa and C=Caldwell)
- O = Owyhee County
- HIT = Health Improvement Teams
- WICCC = Western Idaho Community Crisis Center

Roles and Responsibilities

CC-HIT

- Identify primary care providers or organizations as anchor points to the County Spokes to the SWDH Hub for referral and coordination of care.
- Develop participation agreements, with SWDH with WICCC, Inc to define expectations and provide accountability standards for CC-HIT to manage and coordinate patients throughout the care continuum and to ensure patients are in the least restrictive treatment setting.
- Each Hub, Spoke, & HIT will be required to demonstrate a strong working relationship with Primary Care associated with Healthy Connections, Mental Health, and Substance Use Disorder services and be accountable to identified patients attributed to the CC-HIT.
    - Hub: SWDH with WICCC, Inc as the regional crisis center
    - Spokes: SWDH Region 3 Counties (Adams, Canyon, Gem, Payette, Owyhee, and Washington)
    - HIT: MOU or care compact partners

Role of the project management team

- Recommend internal staffing or contractor to provide project management support to facilitate the development, implementation, and continuous quality improvement of CC-HIT. The project management team will assist the CC-HIT team in identifying the best practices, standard practices, and barriers and the opportunities for change from the other crisis centers. The project management team will work with SWDH and WICCC to address those barriers and provide innovative solutions where possible. Additionally, the following are services that will be available to Hub, spoke, & HIT teams to optimize their ability to meet participation agreements.

- Recommend content expert to provide technical assistance to CC-HIT, as available if needed, to leverage resources for the CC-HIT Hub and spoke organizations to offer clinical and operational resources. The content expert and additional supports may be unavailable or unaffordable, to support without the efforts of the CC-HIT work. The team will provide:
    - Psychiatric Consultation and Practice Facilitation
    - Clinical Pharmacy Consultation and Practice Facilitation
    - Integrated Behavioral Health Consultation and Practice Facilitation

- Telehealth Consultation and Practice Facilitation
- Clinical and Operational Support and Trainings
- Prevention and Outreach Consultation
- Paraprofessional Services Consultation: intensive case management, peer support specialist, family support specialist, community health worker, etc.

- Recommend contracting for care management & data management and data analytic tools to assist CC-HIT organizations in collecting uniform clinical and claims data, to analyze data to provide patient outcomes, and to provide meaningful reports and actionable data to CC-HIT to provide:
    - Quality and Network Management Systems
    - Data Analytics Platform
    - Care Management Platform

- TA will assist and facilitate committees to leverage information and obtain feedback about the CC-HIT from different stakeholders like Regional Crisis Centers, CC-HIT organizations, providers, consumers, caregivers, and payers. The committees and learning collaboratives with other regional crisis centers will be used to disseminate their experience in developing standards, protocols, and metrics but also the lessons learned from their implementation and maintenance of their crisis centers.
    - Regional Crisis Centers Committee
    - HIT Steering Committee
    - Quality Performance & Outcome Committee
    - Patient/Family/Care Giver Advisory Committee
    - Payer Contracting Committee

Role of Crisis Centers and HUB will be to collaborate with the CC-HIT Hub. The project will be centered around supporting Hub and the crisis center to successfully manage and operate the crisis center to improve outcomes for mental health patients in crisis. SWDH will be the epicenter coordinating care with the CC-HIT spokes in SWDH Region 3 counties. The close collaboration with WICCC, Inc will ensure CC-HIT design is feasible, scalable, and sustainable in:

- developing and implementing the CC-HIT Hub
- developing the CC-HIT spoke organizations process
- identifying the CC-HIT spoke organization in each county
- developing the care coordination process between CC-HIT Hub and spoke
- developing and implementing patient outreach between CC-HIT Hub and spoke
- developing clinical and patient outcome metrics for the crisis center and the CC-HIT organizations
- supporting and facilitating CC-HIT steering, patient and caregiver, regional crisis center, quality & outcome, and payer contracting committees

Role of the Southwest District Health Administration

- Oversee the CC-HIT activates and the Crisis Center Contract and progress
- Collaborate with TA contractor and WICCC, Inc to ensure CC-HIT project is meeting expectations and outcomes
- Provide feedback to project management team of potential issues or barriers

II. Certified Community Behavioral Health Clinics (CCBHC)

Another recommendation is to utilize the Certified Community Behavioral Health Clinics (CCBHCs) model in regard to infrastructure, coordinating care, service delivery, and payment method. The information below describes the history and components CCBHC program.

In order to develop a framework for a regional system with quality and reporting standards Idaho should consider modeling after the federal **Certified Community Behavioral Health Clinics (CCBHC)** demonstration project. A potential demonstration project could involve a multi-payer group such as foundations, Medicaid, and commercial payors who would invest to create a regional hub and spoke model based on CCBHC framework where Southwest Health District (provider neutrality) is the regional central hub for Region 3.

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (hereinafter "PAMA" or "the statute") was signed into law. Among other things, PAMA requires the establishment of demonstration programs to improve community behavioral health services, to be funded as part of Medicaid (PAMA, § 223). PAMA specifies criteria for certified community behavioral health clinics to participate in demonstration programs. These criteria fall into six areas: (1) staffing, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and other reporting, and (6) organizational authority. The criteria within this document address each of the areas. The behavioral health clinics participating in this demonstration program and meeting criteria will be known as Certified Community Behavioral Health Clinics (CCBHCs)[i].

The CCBHCs represent an opportunity for states[1] to improve the behavioral health of their citizens by; providing community-based mental and substance use disorder services; advancing integration of behavioral health with physical health care; assimilating and utilizing evidence-based practices on a more consistent basis; and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, and improvement over existing services. Enhanced federal matching funds made available through this demonstration for services delivered to Medicaid beneficiaries offer states the opportunity to expand access to care and improve the quality of behavioral health services.

PAMA is clear that, regardless of condition, CCBHCs are to provide services to all who seek help, but it is anticipated the CCBHCs will prove particularly valuable for individuals with serious mental illness (SMI), those with severe substance use disorders, children and adolescents with serious emotional disturbance (SED), and those with co-occurring mental, substance use or physical health disorders. Those who are most in need of coordinated, integrated quality care will receive it from CCBHCs. The statute directs the care provided by CCBHCs be "patient-centered." It is expected CCBHCs will offer care that is person-centered and family-centered in accordance with the requirements of section 2402(a) of the Affordable Care Act (ACA), trauma-informed, and recovery-oriented, and that the integration of physical and behavioral health care will serve the "whole person" rather than simply one disconnected aspect of the individual. The criteria are infused with these expectations and states are encouraged to certify clinics providing care consistent with these principles.

[1] The term "State" is defined in the statute (PAMA § 233(e)(4)) as having "the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)

Although the CCBHC demonstration program and Prospective Payment System (PPS) are designed to work within the scope of state Medicaid Plans and to apply specifically to individuals who are Medicaid enrollees, the statute also requires the CCBHCs not to refuse service to any individual on the basis of either ability to pay or place of residence. In addition to these requirements for inclusive service, CCBHCs will serve persons for whom services are court ordered.[2] These conditions, together with the fact that improving access to and the quality of health care for the Medicaid population also may positively affect the health of others through changes in overall methods of care delivery, means the CCBHC demonstration program may have long lasting and beneficial effects beyond the realm of Medicaid enrollees.

These criteria were developed based on a review of selected state Medicaid Plans, standards for Federally Qualified Health Centers and Medicaid Health Homes, and quality measures currently in use by states. The criteria were refined and finalized through a public participatory process that occurred between November 2014 and March 2015, and included a National Listening Session, consultation with tribal leaders, written public comments, and solicitation for public response on the Substance Abuse and Mental Health Services Administration (SAMHSA) website.[3]

The criteria are intended to extend quality and to improve outcomes of the behavioral health care system within the authorities of state regulations, statutes and state Medicaid Plans. These criteria establish a basic level of services at which the CCBHCs should, at a minimum, operate. They allow the states flexibility in determining how to implement the criteria in a manner best addressing the needs of the population being served. The criteria are designed to encourage states and CCBHCs to further develop their abilities to offer behavioral health services that comport with current best practices.

CCBHCs must offer the following services either directly or through a formal contract with a Designated Collaborating Organization (DCO). These services must be offered and will be paid for even if they are not included in a state's Medicaid plan:

1. Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization*
2. Screening, assessment and diagnosis including risk assessment*
3. Patient-Centered treatment planning or similar processes, including risk assessment and crisis planning*
4. Outpatient mental health and substance use services*
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk**
6. Targeted case management**
7. Psychiatric rehabilitation services**
8. Peer support and counselor services and family supports**
9. Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration**

*CCBHC must directly provide

[2] This program does not extend Medicaid coverage or payment to inmates of correctional institutions.

[3] Also see guidance issued by CMS regarding the state PPS to be used as part of the demonstration program (PAMA, § 223(b))

**May be provided by CCBHC and/or DCO

The service array is deliberate. CCBHCs provide the comprehensive array of services that are necessary to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and addictions. CCBHCs also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma informed care, and physical-behavioral health integration. Highlights regarding this comprehensive array include:

- Easy and welcoming access to services regardless of ability to pay or location of residence to ensure those who need services are able to receive them.
- Immediate screening, assessment, and risk assessment for mental health, addictions, and basic primary care needs to ameliorate the chronic co-morbidities that drive poor health outcomes and high costs for those with behavioral health disorders.
- 24/7/365 crisis services to help people stabilize in the most clinically appropriate, least restrictive, least traumatizing, and most cost-effective settings.
- Full clinical, operational, and financial commitment to peer and family support, recognizing these elements as essential for recovery.
- Tailored emphasis on active and veteran military, who have served our country with honor, to ensure they receive the unique health care support they need.
- Expanded coordination with other health care and social service providers, with a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.

The requirements are based on the measurement landscape as of the time the CCBHC criteria were drafted (March 2015) and, given the rapid change occurring in the measurement field, might change, particularly if altering these quality measures enables better alignment with other reporting requirements. The measures should align to all payers (Medicaid, Commercial, & Medicare) even though the description below references Medicaid).

For the same reason, Quality Bonus Measures (QBMs) are not specified in these criteria, rather they are established by CMS as part of the PPS. The table below is divided into data/measures required to be reported by the CCBHCs and those required to be reported by the states. Reporting is annual and data are required to be reported for all CCBHC consumers, or where data constraints exist, for all Medicaid enrollees in the CCBHCs. In addition to these reporting requirements, the demonstration program evaluator will require the reporting of additional data to be used as part of the project evaluation. Those additional data are not specified in these criteria. All data collected and reported by the state must be flagged to distinguish the individual CCBHCs and consumers served by CCBHCs, as well as a comparison group of clinics and consumers. In addition, the consumer's unique Medicaid identifier must be attached.

1. Standardized data elements modeled on the FQHC Uniform Data System:
    - Encounter data
2. Consumer demographics
3. Staffing
4. Service usage
5. Service access
6. Care coordination

- Clinical outcomes data
- Quality data
- Other data as requested

2.) Quality Measures Required Measures for Quality Bonus Payments

1. Follow-Up after Hospitalization for Mental Illness (adult age groups)
2. Follow-Up after Hospitalization for Mental Illness (child/adolescents)
3. Adherence to Antipsychotics for Individuals with Schizophrenia
4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
5. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
6. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
7. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
8. Screening for Clinical Depression and Follow Up Plan
9. Antidepressant Medication Management
10. Plan All-Cause Readmission Rate
11. Depression Remission at Twelve Months Adults

3.) CCBHC Quality Metrics

Potential Source of Data	Measures or Other Reporting Requirements	NQF Endorsed	CCBHC Required
EHR, Patient records, Electronic scheduler	Time to Comprehensive Person- and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)	A SAMHSA-Developed Metric (Standard Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients)	Y
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0421, PQRS #128)	Y
EHR, Encounter data	Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)	Based on a measure stewarded by the National Committee for Quality Assurance (NQF #0024, HEDIS 2016, Medicaid Child and Adolescent Core Set)	Y
EHR, Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	Based on a measure stewarded by the American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #0028, PQRS #226)	Y
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)	Based on a measure stewarded by the American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #2152, PQRS #431)	Y
EHR, Patient records	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-BH-C)	Based on a measure stewarded by the American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #1365, Medicaid Child and Adolescent Core Set)	Y

EHR, Patient records	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	Based on a measure stewarded by the American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #0104)	Y
EHR, Patient records	Screening for Clinical Depression and Follow-up Plan (CDF-BH)	Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0418, Medicaid Adult Core Set)	Y
EHR, Patient records Consumer follow-up with standardize d measure (PHQ-9)	Depression Remission at Twelve Months (DEP-REM-12)	Based on a measure stewarded by Minnesota Community Measurement (NQF #0710)	Y
	Routine Care Needs (ROUT)	A SAMHSA-Developed Metric (Number/Percent of clients requesting services who were determined to need routine care)	N
EHR, Patient records	Deaths by Suicide (SUIC)	A SAMHSA-Developed Metric (Number of Suicide Deaths by Patients Engaged in Behavioral Health (CCBHC) Treatment)	N
EHR, Patient records	Documentation of Current Medications in the Medical Record (DOC)	Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0419, PQRS #130)	N
EHR, Patient records	Controlling High Blood Pressure (CBP-BH)	Based on a measure stewarded by the National Committee for Quality Assurance (NQF #0018, HEDIS 2016, Medicaid Adult Core Set)	N
	Housing Status (HOU)	A SAMHSA-Developed Metric	Y
MHSIP surveys	Patient Experience of Care Survey (PEC)	A SAMHSA-Developed Metric	Y
MHSIP surveys	Youth & Family Experience of Care Survey (YFEC)	A SAMHSA-Developed Metric	Y
	Follow up After Emergency Department Visits for Mental Illness (FUM)	Based on a measure stewarded by the NCQA (drafted HEDIS 2017)	Y
	Follow up After Emergency Department Visits for Alcohol and Other Drug Dependence (FUA)	Based on a measure stewarded by the NCQA (drafted HEDIS 2017)	Y
	Plan All-Cause Readmission Rate (PCR-BH)	Based on a measure stewarded by the NCQA (NQF# 1768, HEDIS 2016, Medicaid Adult Core Set)	Y
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	Based on a measure stewarded by the NCQA (NQF# 1832, HEDIS 2016)	Y
	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	Based on a measure stewarded by the CMS (HEDIS 2016, Medicaid Adult Core Set)	Y
	Follow up After Hospitalization for Mental Illness (FUH-BH-A)	Based on a measure stewarded by the NCQA (NQF# 0576, HEDIS 2016, Medicaid Adult Core Set)	Y
	Follow up After Hospitalization for Mental Illness (FUH-BH-A)	Based on a measure stewarded by the NCQA (NQF# 0576, HEDIS 2016, Medicaid Child and Adolescent Core Set)	Y

	Follow up Care for Children Prescribed ADHD Medication (ADD-BH)	Based on a measure stewarded by the NCQA (NQF# 0108, Medicaid Child and Adolescent Core Set)	Y
	Antidepressant Medication Management (AMM-BH)	Based on a measure stewarded by the NCQA (NQF# 0105, HEDIS 2016, Medicaid Adult Core Set)	Y
EHR, Patient Record	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	Based on a measure stewarded by the NCQA (NQF# 0004, HEDIS 2016)	Y
	Suicide Attempts (SU-A)	A SAMHSA Developed Metric	N
	Diabetes Care for People with SMI: Hba1c poor control (9.0%) (SMI-PC)	Based on a measure stewarded by the NCQA (NQF# 2607)	N
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Based on a measure stewarded by the NCQA (HEDIS 2016)	N
	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	Based on a measure stewarded by the NCQA (NQF# 1933, HEDIS 2016)	N
	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)	Based on a measure stewarded by the CMS (NQF# 1880)	N
EHR, Patient records, Electronic scheduler	Reporting	Mean number of days before the comprehensive person-centered and family centered diagnostic and treatment planning evaluation is performed for new clients	N

4.) Organizational Authority Governance and Accreditation

It is envisioned the organizations meeting the CCBHC standards will be able to provide comprehensive and high-quality services in a manner reflecting evidence based and best practices in the field. Combined with the other program requirements of Section 223, the criteria within this section are meant to bolster states' ability to identify and support organizations with demonstrated capacity and capability to meet the CCBHC criteria. CCBHCs must be:

- Nonprofits
- Part of local government behavioral health authority
- Under the authority of Indian Health Service, Indian Tribe or Tribal organization
    - Governing board members "reasonably represent" those served
    - States are encouraged to require national accreditation (e.g. CARF, COA, JCAHO)

Appendix 2: System & Geo Map

The current system has no connection or coordination point because there are no one or system accountable to manage a patient's continuum of care. Providers are not incentivized or held accountable to ensure patients are in the right level of care or in the least restrict treatment setting. Currently, we can identify providers through internet search engines, various media marketing, telephone directories, and payer provider networks. However, all the providers work in silos and there is no organization holding providers accountable for standards of access, follow up care, patient outcomes, care management, care coordination, crisis services, or quality of care. We are able to identify service providers and their information, but our list doesn't constitute an exhaustive list due to a lack of updated provider database. Additionally, we could not measure functional connections with relevant partner services due to the nature of the dysfunctional systems as described above.

Refer to the following link for SWDH Service Map: https://www.c-who.org/swdh-resource-map/

Appendix 3: Project Definitions

ALICE Gap: A phrase coined by United Way to describe individuals and families whose income is above the Federal poverty line but who are "Asset Limited, Income Constrained, Employed".

Behavioral Health (AHRQ Definition): is an umbrella term for care that addresses any behavioral problems impacting health, including mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors. The job in all kinds of care settings and done by clinicians and health coaches of various disciplines or training.

Behavioral Health Integration: SAMHSA notes that primary care settings have become a gateway for many individuals with behavioral health and primary care needs. To address these needs, many primary care providers are bringing behavioral health care services into their setting. Models have emerged that include the use of care managers, behavioral health consultants, behavioralists, or consultation models within the primary care setting.

Health Professional Shortage Area (HPSA): Health Professional Shortage Areas (HPSAs) are designations that indicate health care provider shortages in primary care, dental health; or mental health. These shortages may be geographic-, population-, or facility-based.

Integrated Behavioral Health Care (AHRQ Definition): is the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Mental Disorder (DSM 5 Definition): is a behavioral or psychological syndrome or pattern that occurs in an individual the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals) that reflects an underlying psychobiological dysfunction that is not solely a result of social deviance or conflicts with society.

Social Determinants of Heath (SDOH): Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH) (https://www.cdc.gov/socialdeterminants/index.htm).

Substance Use Disorder (DSM 5 Definition): occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Per DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Appendix 4: Definitions from CCBHC

Important terms used in these criteria are defined below. SAMHSA recognizes states may have existing definitions of the terms included here and these definitions are not intended to supplant state definitions to the extent a state definition is more specific or encompasses more than the definition used here.

Agreement: As used in the context of care coordination, an agreement is an arrangement between the CCBHC and external entities with which care is coordinated. Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity. The agreement describes the parties' mutual expectations and responsibilities related to care coordination.

Behavioral Health: Behavioral health is a general term "used to refer to both mental health and substance use" (SAMHSA-HRSA [2015]).

Care Coordination: The Agency for Healthcare Research and Quality (2014) defines care coordination as "deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, 4 and effective care to the patient." As used here, the term applies to activities by CCBHCs that have the purpose of coordinating and managing the care and services furnished to each consumer as required by PAMA (including both behavioral and physical health care), regardless of whether the care and services are provided directly by the CCBHC or through referral or other affiliation with care providers and facilities outside the CCBHC. Care coordination is regarded as an activity rather than a service.

Case Management: Case management may be defined in many ways and can encompass services ranging from basic to intensive. The National Association of State Mental Health Program Directors (NASMHPD) defines case management as "a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery" (NASMHPD [2014]). See also the definition of "targeted case management."

CCBHC or Clinic: CCBHC and Clinic are used interchangeably to refer to Certified Community Behavioral Health Clinics as certified by states in accordance with these criteria and with the requirements of PAMA. A CCBHC may offer services in different locations. For multi-site organizations, however, only clinics eligible pursuant to these criteria and PAMA may be certified as CCBHCs.

CCBHC Directly Provides: When the term, "CCBHC directly provides" is used within these criteria it means employees or contract employees within the management structure and under the direct supervision of the CCBHC deliver the service.

Consumer: Within this document, the term "consumer" refers to clients, persons being treated for or in recovery from mental and/or substance use disorders, persons with lived experience, service recipients and patients, all used interchangeably to refer to persons of all ages (i.e., children, adolescents, transition aged youth, adults, and geriatric populations) for whom health care services, including behavioral health services, are provided by CCBHCs. Use of the term "patient" is restricted to areas where the statutory or other language is being quoted. Elsewhere, the word "consumer" is used.

Cultural and Linguistic Competence: Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse consumers (Office of Minority Health [2014]).

Designated Collaborating Organization (DCO): A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for care coordination including services to which it refers consumers. Payment for those referred services is not through the PPS but is made through traditional mechanisms within Medicaid.

Engagement: Engagement includes a set of activities connecting consumers with needed services. This involves the process of making sure consumers and families are informed about and initiate access with available services and, once services are offered or received, individuals and families make active decisions to continue receipt of the services provided. Activities such as outreach and education can serve the objective of engagement. Conditions such as accessibility, provider responsiveness, availability of culturally and linguistically competent care, and the provision of quality care, also promote consumer engagement.

Family: Families of both adult and child consumers are important components of treatment planning, treatment and recovery. Families come in different forms and, to the extent possible, the CCBHC should respect the individual consumer's view of what constitutes their family. Families can be organized in a wide variety of configurations regardless of social or economic status. Families can include biological parents and their partners, adoptive parents and their partners, foster parents and their partners, grandparents and their partners, siblings and their partners, care givers, friends, and others as defined by the family.

Family-Centered: The Health Resources and Services Administration defines family centered care, sometimes referred to as "family-focused care," as "an approach to the planning, delivery, and evaluation of health care whose cornerstone is active participation between families and professionals. Family-centered care recognizes families are the ultimate decision-makers for their children, with children gradually taking on more and more of this decision-making themselves. When care is family-centered, services not only meet the physical, emotional, developmental, and social needs of children, but also support the family's relationship with the child's health care providers and recognize the family's 6 customs and values" (Health Resources and Services Administration [2004]). More recently, this concept was broadened to explicitly recognize family-centered services are both developmentally

appropriate and youth guided (American Academy of Child & Adolescent Psychiatry [2009]). Family-centered care is family-driven and youth-driven.

Formal Relationships: As used in the context of scope of services and the relationships between the CCBHC and DCOs, a formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. This formal relationship does not extend to referrals for services outside either the CCBHC or DCO, which are not encompassed within the reimbursement provided by the PPS.

Limited English Proficiency (LEP): LEP includes individuals who do not speak English as their primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

Peer Support Services: Peer support services are services designed and delivered by individuals who have experienced a mental or substance use disorder and are in recovery. This also includes services designed and delivered by family members of those in recovery.

Peer Support Specialist: A peer provider (e.g., peer support specialist, recovery coach) is a person who uses their lived experience of recovery from mental or substance use disorders or as a family member of such a person, plus skills learned in formal training, to deliver services in behavioral health settings to promote recovery and resiliency. In states where Peer Support Services are covered through the state Medicaid Plans, the title of "certified peer specialist" often is used. SAMHSA recognizes states use different terminology for these providers.

Person-Centered Care: Person-centered care is aligned with the requirements of Section 2402(a) of the Patient Protection and Affordable Care Act, as implemented by the Department of Health & Human Services Guidance to HHS Agencies for Implementing Principles of Section 2403(a) of the Affordable Care Act: Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs (Department of Health & Human Services [June 6, 2014]). That guidance defines "person-centered planning" as a process directed by the person with service needs which identifies recovery goals, 7 objectives and strategies. If the consumer wishes, this process may include a representative whom the person has freely chosen, or who is otherwise authorized to make personal or health decisions for the person. Person-centered planning also includes family members, legal guardians, friends, caregivers, and others whom the person wishes to include. Person-centered planning involves the consumer to the maximum extent possible. Person-centered planning also involves self- direction, which means the consumer has control over selecting and using services and supports, including control over the amount, duration, and scope of services and supports, as well as choice of providers (Department of Health & Human Services [June 6, 2014]).

Practitioner or Provider: Any individual (practitioner) or entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services (42 CFR § 400.203).

Recovery: Recovery is defined 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." The 10 guiding principles of recovery are: hope; person driven; many pathways; holistic; peer support; relational; culture; addresses trauma; strengths/responsibility; and respect. Recovery includes: Health (abstinence, "making informed healthy choices that support physical and emotional wellbeing"); Home (safe, stable housing); Purpose ("meaningful daily activities … and the independence, income and resources to participate in society"); and Community ("relationships and social networks that provide support, friendship, love, and hope") (Substance Abuse and Mental Health Services Administration [2012]).

Recovery-Oriented Care: Recovery-oriented care is oriented toward promoting and sustaining a person's recovery from a behavioral health condition. Care providers identify and build upon each individual's assets, strengths, and areas of health and competence to support the person in managing their condition while regaining a meaningful, constructive sense of membership in the broader community (Substance Abuse and Mental Health Services Administration [2015]).

Shared Decision-Making (SDM): SDM is an approach to care through which providers and consumers of health care come together as collaborators in determining the course of care. Key characteristics include having the health care provider, consumer, and sometimes family members and friends acting together, including taking steps in sharing a treatment decision, sharing 8 information about treatment options, and arriving at consensus regarding preferred treatment options (Schauer, Everett, delVecchio, & Anderson [2007]).

Targeted Case Management: Targeted case management is case management, as defined above, directed at specific groups, which may vary by state. CMS defines targeted case management as case management furnished without regard to requirements of statewide provision of service or comparability that typically apply for Medicaid reimbursement. 42 CFR § 440.169(b). Examples of groups that might be targeted for case management are children with serious emotional disturbance, adults with serious mental and/or substance use disorders, pregnant women who meet risk criteria, individuals with HIV, and such other groups as a state might identify as in need of targeted case management. See also the definition of "case management."

Trauma-Informed: A trauma-informed approach to care "realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration [2014]).

Appendix 5 – BSU Ethnography Summary

Boise State University (BSU) performed a targeted ethnography of behavioral health (TEBH) in Emmett, Idaho and Grand View, Idaho for Southwest District Health Department in 2019 as a supporting assessment for behavioral health services specifically related to the Crisis Center. The primary research method utilized was contextual, in-depth interviews targeting key organizational and community contacts. Interviews were typically at least 30 minutes in duration and conducted in an interview subject's home, place of work, or community where they could feel most comfortable. The BSU TEBH team conducted 48 interviews in total for the project, 39 of which could be considered contextual, in-depth. Interviewees included clinical providers, community members managing mental illness and/or substance use, agency administrators, law enforcement, and general community members. Both assessed locations were analyzed for general community ethnographic features, non-patient/provider experience ("outer-circle of care"), and patient experience. The results of these interviews were then analyzed for key themes and findings as reported below.

1.) Emmett

Community Ethnographic Findings

The following central themes were identified by the TEBH team:

1.) Emmett has a strong identity as a distinct and autonomous local community.
2.) Residents spoke frequently of the need to travel "over-the-hill" to the Boise metropolitan core.
3.) On average, residents in Emmett have greater needs, and fewer resources to meet their needs, than residents who live "over-the-hill" in the Boise metropolitan core.
4.) The necessity of traveling "over-the-hill" is unlikely to go away, and current modes of transportation are felt to be inadequate.

A significant theme in the interviews with Emmett residents and professionals was the comparison and contrast with the neighboring Boise metropolitan area. While Boise is approximately 40 minutes from Emmett, residents of Emmett identify as a very distinct community. However, many residents have economic and service ties within Boise, necessitating traveling "over the hill". This is in part due to stagnation in economic growth within Emmett. The implications for the Crisis Center include a view that the location is "over the hill" and external to the community. Participant proposed solutions included delivering services in Emmett and enhancing transportation to external services including the Crisis Center. Finally, there was a noted concern with lack of access in Emmett to regular therapy and crisis care. While there may be opportunities to improve access to crisis care through the Crisis Center, this will not solve the issue of access to regular therapy.

The Outer Circle

The "outer circle" includes non-healthcare supports and services for behavioral health patients including law enforcements, EMTs, and peer support volunteers. The TEBH team was unable to interview clinical providers for the purposes of this report.

1.) Critical elements of behavioral health care are lacking locally, making travel beyond Emmett necessary.

2.) Existing transportation for many behavioral health patients is problematic and insufficient.
3.) The components of the outer circle of care are not well-coordinated.
4.) Drug court programs, and the local peer support center are bright spots for an important segment of patients.
5.) Caregivers and patients alike lacked detailed procedural knowledge on using the Western Idaho Crisis Center.

The TEBH assessment noted that law enforcement plays a central role in behavioral health crises in Emmett while EMS is more removed. Law enforcement can then become a connection to the services offered through drug courts for recovery. The drug courts emerged as a reported success in assisting community members with substance use disorders. Another positive supportive element within Emmett are peer resources. Peer support includes groups for those in recovery, job and educational training, and reentry programs. Despite these assets, the assessment noted significant challenges in meeting patients' medical needs regarding crisis care. The local Emergency Room does not have the capability to actively manage a behavioral health crisis and patients are often routed out of the community to larger hospitals with psychiatric services. Access to routine care may be increasing as the local hospital develops an integrated behavioral health program. Further evaluation of these findings suggest that the Crisis Center will meet the needs of many patients who are transported "over the hill" to hospital services. However, access to the Crisis Center and understanding of procedural elements is still lacking. In order to respond to these barriers to utilization, a transportation system could be developed with additional education for "the outer circle" on how to utilize the Crisis Center.

The Patients

As the TEBH team interviewed local patients, the following key themes were identified:
1.) Patients articulated a need for low cost or free professional behavioral health services.
2.) Patients desired a combination of peer support and professional therapy.
3.) Local law enforcement loomed large in patient narratives.
4.) Patients do not view the local E.R. as a place to turn when they are experiencing a behavioral health crisis.
5.) The intimacy of the local community was viewed as both an asset and a challenge.
6.) Most patients had not heard about the Western Idaho Crisis Center in Caldwell.

Through ethnographic interviews, the TEBH team noted the needs, experiences, and values of local patients. These participants indicated additional resource needs regarding behavioral health services at a low or reduced cost and a combined approach between peer support and professional therapy. Many patients reported encounters with law enforcement as a gateway to receiving treatment for substance use and co-occurring disorders. This pathway leads to drug court which was also described as an excellent resource for recovery. Regarding routine care, patients noted challenges in maintaining the same treatment provider and scheduling. Patients also indicated that crisis care was not sufficient in Emmett with transportation outside of the community required. Despite these challenges, patients were very positive in reports of peer support services. Repeatedly, peer support was described as an essential asset. There was little knowledge of the Crisis Center and patients suggested that a local resource be developed in Emmett. The report does indicate that the Crisis Center has the potential to help patients who would historically be transported to in-patient psychiatric units. Utilization will likely increase if there is more information available in the community regarding the Crisis Center and if a transportation solution is

developed. Additional opportunities to enhance patient experience include the creation of crisis services at a low-cost as a partnership between the peer support center and professional therapists and the establishment of a "crisis room" locally.

2.) Grand View

Community Ethnographic Findings

The following central themes were identified by the TEBH team:

1.) Grand View is a very small community, but it provides services to a vast geographic area.
2.) The services available in Grand View are quite minimal, and insufficient to meet community needs.
3.) To meet local needs, Grand View residents must regularly travel to larger cities that are some distance away.
4.) Grand View is not growing, but neither does it appear to be shrinking.
5.) Residents in the area express a philosophy that combines self-reliance with taking care of their community, and critical services rely on volunteers.

The TEBH team noted that a central feature of Grand View is its size. The city has a population of around 450 residents but is a catchment for an area of approximately 2,900 square miles that contains only an addition 700 community members. Despite the large area that the city serves, community resources are lacking with many residents traveling to Mountain Home or Boise for healthcare. The local economy largely employs unskilled, physical labor. Distinct from many frontier communities with similar economic dependencies, Grand View has not lost significant population in recent years. The population has remained relatively stable and community members expressed a strong ethos of self-reliance, internal to those that live in Grand View. An evaluation of these findings indicates that local control over access and development is critical as residents determine if they will use the Crisis Center. Respecting local values of autonomy will likely include positive reception and utilization of the Crisis Center.

The Outer Circle

In Grand View, the outer circle consisted of local volunteers who provide support to behavioral health clients. In interviews with these individuals, the following themes were identified:

1.) There is no local inner circle of care in Grand View.
2.) Alcoholics Anonymous (AA) is the only source of regular therapy in the community.
3.) EMTs play a pivotal role in crisis care.
4.) Other components of the outer circle of care are missing.
5.) The outer circle is staffed by volunteers.

Across the themes identified, it is clear that there are extremely limited treatment resources in Grand View. There is no formal therapy resource for residents but other assets are available. Alcoholics Anonymous is popular and regularly attended as a peer support tool. In addition, EMTs are very active in behavioral health crises in Grand View and typically take the lead in emergency calls with voluntary transport to Boise or Mountain Home. This response often takes volunteer staff away from other emergency response duties. Both of these resources are staffed by volunteers and other support options appear to be lacking including drug courts and clinical services. The Crisis Center has the opportunity to

meet a need within the community and aligns with the EMT, voluntary transport model already established. However, the Crisis Center is close to 90 miles from Grand View. An alternative may be to route patients to the crisis center in Boise. The TBEH team also identified the following opportunities to provide supportive behavioral health resources to the community: regular professional therapist access, a peer support center, and improved drug court relationships.

The Patients

Reports on the patients in Grand View included the following themes:

1.) Local residents want to help and do help those that are struggling because there are no other resources.
2.) Alcohol misuse is very common.
3.) There is a perception that some people move to Grand View because of the low rents and lack of law enforcement.

The TEBH team reported a strong sense of community in attempting to assist neighbors who were struggling with mental health and substance use issues. This is in part due to local values and in part due to the lack of supportive resources. Interviewees noted the very real need for care options for residents and the preponderance of alcohol misuse. Finally, some residents reported increasing issues with substance use due to an authorizing environment that allows drug abuse. Assessment of the interview findings suggests that there is good alignment between the needs in Grand View and the Crisis Center services. However, distance and travel pose significant barriers to utilization. The provision of free or low-cost transportation would help address this need.

Appendix 6 – Atlas Market Research Summary

Atlas Communications performed a market research report for Southwest District Health in order to assess opportunities to increase utilization of the Crisis Center. The report indicates a significant lack of resources related to behavioral health in the state of Idaho despite a high need for services. This is likely related to lack of funding for behavioral health services. Insufficient funding results in high cost to the counties for indigent/crisis care and a heavy reliance on volunteers. Another barrier to care includes stigma regarding mental health and substance use. A perception of stigma may prevent patients from seeking more information regarding their behavioral health needs. The report suggests several established strategies in order to manage the aforementioned challenges in increasing appropriate utilization of the Crisis Center. These include public awareness outreach efforts to reduce stigma and educate individuals about behavioral health, relationship development with referral partners, follow-up with patients after an event and patient education/word of mouth. The conclusion of this report suggests that the optimal opportunity to build patient contact is through relationship development with local providers to increase referrals. In addition, a community relations campaign to increase pre-crisis event awareness of the Crisis Center and self-referrals is advised.

Bibliography

(2019). Retrieved from Motor Vehicle Safety: https://www.cdc.gov/motorvehiclesafety/impaired_driving/index.html

2019 Point-In-Time Homeless Count (Region 3): Idaho, Housing & Finance Association. (2019). Retrieved from https://www.idahohousing.com/homelessness-services-programs/hmis/

(2016). *Addressing the Social Determinants of Health: The Role of Health Professions Education.* Committee on Training in Primary Care Medicine and Dentistry Advisory.

AETC. (2015). *Mental Health/Substance Use Care: Clinic/Health Center Readiness Assessment.* Retrieved from https://aidsetc.org/resource/mental-healthsubstance-use-care-clinichealth-center-readiness-assessment-tool

Akosa, A. (2018). *The Impact of Social Determinant of Health (SDH) on Population Health Outcomes.* Franciscan Alliance.

(2009). *ALICE: Asset Limited, Income Constrained, Employed.* United Way.

Artiga, S., & Hinton, E. (2018). *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. Retrieved from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

Bleich, S., Jones-Smith, J., Wolfson, J., Ziaozhou, Z., & Story, M. (2015). The Complex Relationship Between Diet and Health. *Health Affairs*, Vol. 34, No. 11.

Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Rep.*, Jan-Feb (Suppl 2): 19 - 31.

Braveman, P., Dekker, M., Egerter, S., Sadegh-Nobari, T., & Pollack, C. (2011). *How Does Housing Affect Health.* Robert Wood Johnson Foundation.

CDC. (n.d.). *National Center For Chronic Disease Prevention and Health Promotion.* Office on Smoking and Health.

CIVHC. (2013). *Paying for Integrated Primary Care and Behavioral Health.* Center for Improving Value in Health Care.

Cobb, H. (2016). *The National Council Magazine: Crisis to Recovery.*

Collaborators, U. B. (2013). The State of US Health 1990 - 2010. *JAMA*, 310 (6): 591 - 608.

(2013). *Community Integration Self-Assessment Tool Draft Final Report.* JBS INTERNATIONAL, INC.; ADVOCATES FOR HUMAN POTENTIAL, INC.; NASMHPD RESEARCH INSTITUTE, INC.

County Health Rankings By University of Wisconsin. (2012). Retrieved from www.countyhealthrankings.org

CSDH. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* World Health Organization.

Cycle of Crisis: Idaho Behavioral Health Alliance. (2019). Retrieved from idahovoices.org/behavioralhealth

Drapeau, C., & McIntosh, J. (2017). *U.S.A. Suicide: 2017 Official Final Data.* American Association of Suicidology.

Elving, W. J. (2005). The role of communication in organisational change. *Corporate Communications:*, Vol. 10 Issue: 2, pp.129-138.

(2017 - 2018). *Facts, Figures, and Trends.* Idaho Department of Health and Welfare.

Foundation., W. H. (2014). *Social Determinants of Mental Health.* World Health Organization.

Gilchrist, E., Brou, L., Kirchner,, S., Gold, S., Muther, J., & Wong, S. (2018). *Aligning and Advancing Integrated Behavioral Health Across Idaho: A Stakeholder's Report.*

Harris, A. A. (2002). Crafting a change message to create transformational. *Journal of Organizational Change Management*, Vol. 15 Iss 2 pp. 169 - 183.

Heath, S. (2017). *What Are the Top Common Social Determinants of Health*. Retrieved from https://patientengagementhit.com/news/what-are-the-top-common-social-determinants-of-health

Hernandez, D., & Suglia, S. (2016). *Leveraging the Soaical Determinants to Build a Culture of Health.* Robert Wood Johnson Foundation.

HRSA Data. (n.d.). Retrieved from https://data.hrsa.gov/#table

HSRA. (n.d.). *Data Warehouse, Mental Health Care*. Retrieved from http://datawarehouse.hrsa.gov/hpsadetail.aspx#table

Hutchings, G., & King, K. (2009). *Ensuring US Health Reform Includes Prevention and Treatment of Mental Health and Substance Use Disorders - A Framework for Discussion: Core Consensus Principles for Reform from the Mental Health and Substance Use Community.* SAMHSA.

ICER. (2015). Enhancing Patient Outcomes and Health System Values Through Integration of Behavioral Health Into Primary Care. *Institute for Clinical adn Economic Review*, 1 - 6.

Idaho Behavioral Health Standards: Idaho Division of Behavioral Health. (n.d.). Retrieved from http://healthandwelfare.idaho.gov/Portals/_Rainbow/Manuals/Mental%20Health/BHStandardseManual/NetHelp/index.html

Idaho Department of Health and Welfare, D. o. (2018). *Get Healthy Idaho: Measuring and Improving Population Health.*

(2016). *Idaho Health Behaviors: Results from the Behavioral Risk Factor Surveillance System.* Division of Public Health; Bureau, Idaho Department of Health and Welfare Statistics.

IDPH. (2016). *Idaho Resident Suicide Deaths 2010 - 2014.* Division of Public Health: Bureau of Vital Records and Health Statistics.

Jackson, E. (2005). *A Community-Based Comprehensive Psychiatric Crisis Response Service.* Technical Assistance Collaborative.

Jarvis, D. (2011). *Mental Health and Substance Use Provider Readiness Assessment.* Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2013/01/Provider-Readiness-Assessment.pdf

Jarvis, D. (2011). *Mental Health, Substance Use Disorder Provider Organization Readiness Assessment.* The National Council.

McGlynn, E., Asch, S., Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., & Kerr, E. (2003). The Quality of Health Care Delivered to Adults in the United States. *The New England Journal of Medicine*, 348:2635-2645.

(2009). *Mental Health Report: Idaho State Planning Council on Mental Health.*

Ng M, Fleming, T., Roberson, M., Thomson, B., & et al. (2014). Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study. *Lancet*, 384(9945):766-81.

Nguyen, T., Hellebuyck, M., Halpern, M., & Fritze, D. (2018). *The State of Mental Health in America 2018.* Mental Health America.

Older Adults. (2019). Retrieved from Suicide Prevention Resource Center: https://www.sprc.org/populations/older-adults

Physical Activity. (2017). Retrieved from https://www.cdc.gov/physicalactivity/index.html

Physical Activity and Health: The Link Between Physical Activity and Morbidity and Mortality. (1996). Retrieved from https://www.cdc.gov/nccdphp/sgr/pdf/sgrfull.pdf

(2017). *Practice/Financial Redesign Initiative: Behavioral Health Crisis Intervention Network System Design for Rural Communities.* Blue Cross of Idaho.
Reed, J. (2012). *Primary Care: A Crucial Setting for Suicide Prevention*. Retrieved from https://www.integration.samhsa.gov/about-us/esolutions-newsletter/suicide-prevention-in-primary-care
Reed, J. (2012). *Primary Care: A Crucial Setting for Suicide Prevention.* SAMHSA.
Reiss, B., Brunisholz, K., Dredge, C., Bricot, P., Grazier, K., Wilcox, A., & Reiss, B. (2016). Association of Integrated Team-Based Care with Health Care Quality, Utilization, and Cost. *JAMA*, 316(8) 826 - 834.
SAMHSA. (2010). *Mental Health 2010 Report*. Retrieved from www.samhsa.gov
SAMHSA. (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.* HHS Publication.
SAMHSA. (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.* Rockville, MD: SAMHSA.
SAMHSA. (2018). *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice.* HHS Publication.
Saxon, V., Dhrubodhi, M., & Thomas, D. (2018). Behavioral Health Crisis Stabilization Centers: A New Normal. *Journal of Mental Health and Clinical Psychology*, 2(3): 23-26.
Simmons, T., & Idaho Press. (2019). *Boise Crisis Center*. Retrieved from https://www.idahopress.com/news/local/boise-has-had-a-crisis-center-for-months-here-s/article_b53d94ab-796a-584c-b011-cb716974f1c8.html
Suicide Facts & Figures: American Foundation for Suicide Prevention (Idaho). (2018). Retrieved from https://afsp.org/about-suicide/state-fact-sheets/#Idaho
SWHC. (2016). *The Southwest Region Community Health Assessment.* Southwest Health Collaborative.
System, S. U. (2015). *Idaho 2015 Mental Health National Outcomes Measures (NOMS).*
Tupa, L., & Koch, H. (2018). *System Redesign Status Update and Mental Health Service Array Assessment.* Western Interstate Commission For Higher Education.
United Way of Treasure Valley: Community Assessment. (2017). Retrieved from https://www.unitedwaytv.org/sites/unitedwaytv.org/files/2017_UW_CommunityAssessment.pdf
US Census Quick Facts. (n.d.). Retrieved from https://www.census.gov/quickfacts/fact/table/ID,US/PST045218
Weiner, B. (2009). A theory of organizational readiness for change. *Implementation Science*, 4:67.
What's different About Rural Health Care? (n.d.). Retrieved from http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care.
WHO. (2003). *Global Strategy on Diet, Physical Activity, adn Health*. Retrieved from http://www.who.int/dietphysicalactivity/publicatios/facts/chronic/en/index.html
WHO. (2014). *Social Determinants of Mental Heath report* . World Health Organization.
WICHE. (2008). *Idaho Behavioral Health System Redesign: Findings and Recommendations for the Idaho Legislature.*

[i] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf