

Regional 4 Behavioral Health Board

Gaps and Needs Analysis

2015

(Prepared and submitted March 2016)

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

Identified Regional Service Needs and Gaps <i>Relating to Prevention, Treatment and Rehabilitation Services</i>	Short Falls and Challenges	Recommendations <i>Including those related to Family Support Services and Recovery Support Services</i>	Improvement and Strategy Measures
HOUSING -Some housing options exist in Ada County, but there are no options in Valley, Elmore or Boise counties.	-Affordable and accessible housing including for offenders, and releases from hospitals	-Address housing policies that support eviction due to lack of compliance; support alternative policies that do not threaten housing but support accountability.	-Decrease risk for homelessness in our vulnerable populations.
	-Supported housing for chronic mentally ill	-Establish a supported housing entity that supports independent living through medication management and life skills checks, internal access to MH service and community planned support groups. -Increase in SUDS daily rates for housing to allow agencies the ability to open additional houses.	

	-Supported housing for youth unable to return home after state care (or other residential)	-Establish an Emancipation Home type program.	
	-Additionally: lack of housing and treatment options for youth unable to remain at home -Lack of mid level care for youth/adults	-Develop temporary residential housing and treatment for youth with mental illness who are unable to remain in homes. -Invest in home based therapies and family support services	-Support funding for provision of Medicaid mid level services (IOP/ Partial Care)
Sober/Transitional Housing	-Process to get into sober/transitional housing takes 1-4 weeks	-More housing options available -2 week grace period for GAINS assessment (if engaged in Recovery Support Services) -Provide more support while accessing programs and services	
Mother/child Housing for individuals with Behavioral Health challenges	-There are no supported family housing options available. -There are no detox/in-patient facilities for pregnant women	-Develop family/parenting programs with supported housing -Expand existing detox and treatment to include pregnant women	
		-Transitional housing for individuals moving between levels of care.	
TRANSPORTATION	-Bus system supports minimal needs of the region as a whole.	-Bus system expansion. -Lines and available hours -Explore and develop transportation regarding treatment appointments for children and adults. -More direct ride options for SUD/MH clients	-Improve access to care/services/supports and decrease no show rates.

	- Bus pass availability for MH/SUD treatment needs	-Establish a state supported bus pass program for MH/SUD individuals to attend treatment, medical, probation and other related appointments in areas with transportation.	
	-Lack of transportation options in rural areas for adults and youth	-Develop transportation options in rural areas and/or increase tele-medicine.	
		-Utilize Trained Peer Transport services from rural areas for access to treatment. Utilize and fund peer transport options to reduce law enforcement transports when unnecessary	
		-Expand Village Van and Access transit services	
SERVICES FOR NON-CRIMINAL JUSTICE AT-RISK YOUTH	-Schools in more rural areas do not have the resources to provide services needed for children/families with mental illness. -Lack of training and resources to hire within. These services are currently contracted out which limits response	-Research funding sources such as the Juvenile Justice Commission, develop a model for schools/communities to refer at-risk youth, engage parents/caregivers in family supports (family therapy/groups), work with DHW for crisis services (law enforcement, schools, parents, caregivers). Engage in community trainings such as trauma informed care, suicide prevention, at-risk youth behavior education. -Provide for funding streams to allow for training school staff on mental illness and behavioral	-Decrease in referrals to juvenile probation, outcomes/data from successful model implementation and crisis calls deferred, and increase in parental /caregiver involvement in family supports.

	and resources for the school.	health. Funding stream to hire these positions in-house. -Develop Peer Support programs for public high schools	
	-Minimal trauma informed care and strengthening families training opportunities	-Establish and/or continue to support training opportunities.	
	-Support for children of incarcerated parents	-Establish a state-wide system, at the court level, to identify children of parents being incarcerated; provide professionals to engage them in prevention interventions immediately. -Develop and facilitate peer support groups for children and families of incarcerated individuals.	
RESILIENCY, RECOVERY AND WELLNESS SUPPORT	-Support for community mental health crisis centers in all regions	-Further support for community Recovery Centers, Peer Wellness Centers, and Crisis Centers -Expand Recovery Wellness programs for SUD/MH clients (Mindfulness, Meditation, etc...)	
	-Additional resources for community supervision	-Provide for additional probation officers based on per capita population. -Support- IDOC in Mentoring Program	
	-Lack of available respite care workforce for families with kids diagnosed as mentally ill	-Maintain respite care programs. -Establish subsidized respite care programs.	-Continue education/funding for respite program to increase training and workforce.

	-Lack of support/education/training for Crisis Intervention Teams (CIT) to respond to families	-Provide training for first responders on mentally ill children and their families. -Add Peer Supports to (PET) Psychiatric Evaluation Team and emergency rooms	
-Stigma which creates barriers to accessing resources, treatment, and appropriate utilization of available services		-Provide trainings and empowerment workshops to raise awareness and recovery support from the community	
SYSTEM ISSUES -Lack of clarity around desired outcomes from authorities	- Policy and legislation requirements are often redundant and in conflict with current licensing standards	-Establish and communicate measureable goals for state mental health/SUD system, in a fashion that incorporates input from all levels. -Break down barriers regarding state licensing conflict with crisis shelters and respite care and increase training, including access to supervision for Recovery Coaches, Peer Support, and Family Support Services.	-Follow and gain feedback from DHW regarding outcomes project for SUD services for 2016
-Lack of coordination of care between behavioral health care and primary health care providers	-Need for better communication and consistency across division lines -Health data exchange does not accept records from BH providers because of real and perceived barriers relate to privacy (ie 42 CFR & protections for psychotherapy notes) -People with serious mental illness die on average between ages 53-56.	-Establish working relationship with licensing boards so that policy and legislation is written with current licensing standards in mind. -Remove payment barriers to BH providers by reinstating collateral contact and telephonic case management codes under fee for service.	

	<p>2/3 of premature deaths are due to preventable/treatable medical conditions. 70% of individuals with significant MH/SUD have a least 1 chronic health condition, 30% have 3 or more.</p>		
	<p>-Need for better communication with contract managers</p>	<p>-Create and fund treatment teams (Med-Psycho-Social) and a program that facilitates collaboration and communication between providers.</p> <p>-Continue to invest in integrated health care such as medical homes, SHIP and Community Health Centers. Idaho needs to continue to seek ways to “close the gap” in health insurance.</p>	
	<p>-Need to create funding stream for gaps in care -Offender re-entry -Patients released from IDOC/SHS -Medicaid expansion population</p>	<p>-Division lines (Behavioral Health and Medicaid) collaborate, measure goals/outcomes of both populations concurrently, drill down with contract managers and into provider network.</p> <p>Increase coordination across agencies (schools, Juvenile Corrections, Correction, Courts, Medicaid and Regional mental health services).</p>	<p>Encourage the State to apply for available CCBHC funding to create MH FQHC’s in state.</p> <p>Encourage partners to collaborate with BHB’s, providing information regarding funds that may be available for both offender re-entry and State hospital clients for housing and treatment</p>

	-Establish a culture of collaboration with Medicaid provider and contractor. Increase oversight of Medicaid contractor, increase communication across lines.	-Reestablish town hall meetings with Optum-Medicaid.	
	-Legislative support of program needs	-Support of legislation related to proposed mental and behavioral health services and programs. -Support the belief that the lack of health care coverage is a significant problem for people receiving MH services and ask that the legislature seriously consider health care provision options.	
TREATMENT SERVICES AND INTERVENTION			
-Reduction in Community Based Rehabilitation Services (CBRS)	-Limited other treatment and/or support options -Lack of mid level services (IOP/Partial Care) -Lack of Family engagement for preventative services	Continued supportive provider trainings. -Creation of additional services to support the void of CBRS -Trainings needed for providers to engage families Increase available FFT, address shortage of LMFT providers	-Coordinate with stakeholders to support addition of Medicaid funding for mid-level services) -Continue to look at trainings state wide.
-Optum Idaho SUD Referrals	-Lack of SUD diagnosis and internal referral process	-Engage Optum to provide data reports, monitoring/enforcing that providers are operating within their scope of practice, using evidence based practices, appropriate referral of co-occurring clients. Progress: Have requested data and measures to ensure SUD referrals.	-Increase diagnosis and treatment of SUD and co-occurring.

<p>-Lack of integration between Substance Use Disorder and Mental Health treatment</p> <p>- Lack of integration and collaboration between mental health, SUD's, and health treatment</p>	<p>-Policy barriers to quality care and accessibility.</p>	<p>-Improve communication between Medicaid/Behavioral Health division lines</p> <p>-Support policy changes that allow for assessments to be conducted based on licenses not facility approval,</p> <p>-Improve oversight by Medicaid contractor to identify clients with SUD needs and conversely push toward Drug Dependent Epidemiology (DDE) programs for all SUD providers</p> <p>-Incorporate American Society of Addiction Medicine (ASAM) in Medicaid paperwork, allowances In Idaho Behavioral Health plan the billing matrix to bill for communication.</p>	<p>-Improved service provision and patient outcomes. Maintain capacity (provider networks).</p>
<p>-Insufficient access to SUD services</p>	<p>-Lack of SUD residential treatment options longer than 30 days. Lack of services for non-intravenous drug users (non-IVDU), Pregnant Women and Women with Children (PWWC), non-felony individuals with addictions</p>	<p>-Provide support for treatment of adults with addictions (non-criminal justice).</p> <p>-Address budget constraints with regard to residential services</p>	
<p>ACCESS TO SERVICES</p> <p>-Half of all mental illness emerges by age 14 and three quarters by age 24. In the US, there is an average lag of 8 to 10 years between onset of mental health conditions and the</p>	<p>-Mental health services for families in rural areas</p> <p>-2/55 agencies in Region IV have appropriate Infant mental health (0-3) service availability</p>	<p>-Increase Tele-health utilization; provide state-subsidies for professionals willing to work in outlying areas. Load re-payment options.</p> <p>-Support Aim Early Idaho program</p>	<p>-Provide education to follow Rule on Tele-health services.</p>

start of treatment. While nearly 1 and 5 American youth live with a mental health conditions, less than half receive any services.	-Idaho lacks any significant early intervention programs, treatment and support programs for its youth.	and state endorsement training -Open tele-health with Medicaid up to mid level clinicians.	
	-Inability to access reimbursement for prevention or treatment Lack of supportive funding to assist with medications (adult and children)	-Support Medicaid expansion or Healthy Plan Idaho.	
	-SOAR needs faster accessibility to Medicaid approval. -Lack of urban and rural transitional services and support (youth and adult) -Address culture and flow of services within schools to avoid needing to press legal charges prior to achieving needed services -4th District Court has no current Juvenile drug court	-Increase SOAR trained professionals in the area. -Diversify potential workforce to community health or Peer Support staff . -Decrease time frame for those in need to access services. -Increase groups and other supports for transitional aged youth. -Support continued awareness/ education of available programs within schools	
-Lacking ability for case managers under Optum Idaho to effectively coordinate care due to face to face limitations of service	-Lack of clarity regarding CM eligibility guidelines, contradictions between Optum definition, IDAPA, and case managers.	-Seek clarification and transparency of service delivery that compensates providers for expected service function and outcomes	
ACCESS TO SERVICES WITHOUT CRIMINAL JUSTICE INVOLVEMENT	-Increased need for diversion programs	-Establish diversion programs in lieu of incarceration.	

		-Allow-access to services to individuals w/out CJ involvement.	
	-Legislation to de-criminalize substance use disorders	-Work toward addressing recommendation outlined in Justice Reinvestment Initiative (JRI).	
<p>PROGRESS AND ACCOMPLISHMENTS:</p> <p>1) Systems expanding/ attending to Infant Mental Health Issues. Coordination with Progress Stakeholders occurring</p> <p>2) Adolescent track added to state-wide ICADD conference</p> <p>3) Increased funding for Access to Respite care and programs developed</p> <p>4) Optum reports 100% access to MH services in what was a once struggling area (Idaho City) Included coordination with police, schools and providers</p> <p>5) Nearly 50% of Boise Police Officers are now trained in CIT to support appropriate diversion and non-criminalization of MH issues.</p> <p>6) MH coordinator position added in BPD to support community efforts.</p> <p>7) Telehealth now approved under SUD funding.</p> <p>8) Grant Application submitted for a Community Safety Center (Safety/justice Grant) by law enforcement stakeholders in Ada County.</p> <p>9) Peer Wellness Center opened in Boise.</p>	-Limit incarceration terms, reassess risk levels	<p>-Establish diversion programs that include treatment and community supervision in lieu of incarceration for low risk offenders.</p> <p>-Gather data from IDOC regarding response Matrix, geared toward reducing re-incarceration for those on probation or parole.</p>	

