BEHAVIORAL HEALTH TRANSFORMATION WORK GROUP

RESPONSE TO PUBLIC COMMENT ORGANIZED BY THEMES

OCTOBER 29, 2010

Table of Contents

Introduction

From May 2009 through October 2010 the Behavioral Health Transformation Work Group (BHTWG) has worked to generate a Plan for the Transformation of Idaho's Behavioral Health System that commits the State of Idaho to the process of developing an efficient and effective client-centered behavioral health system (as required by Executive Order 2009-14 and 2010-01). Rather than starting over, BHTWG specifically opted to use the results and recommendations of previous work in this area to inform their proposed action. BHTWG's Plan pursues the vision and goals that reflect the collective recommendations from that body of work. BHTWG's effort differs from previous efforts in that it proposes a specific transformation structure and action, rather than, once again, studying the need for transformation itself.

BHTWG reviewed and used as a foundation for their effort recommendations generated by other studies and outreach efforts. Specifically, their efforts were informed by a Western Interstate Commission for Higher Education study commissioned by the Idaho State Legislature and conducted in 2009. This report provided the basis of the vision, goal and direction the BHTWG pursued. The WICHE process included a statewide public survey process, to which WICHE received the input and response of more than 550 individuals from around the state. The input of approximately 160 individuals through in-person interviews also informed the study. WICHE's outreach process is described in their report on page 43. The WICHE report can be found in its entirety at http://www.legislature.idaho.gov/sessioninfo/2008/interim/mentalhealth_WICHE.pdf. WICHE's findings and recommendations helped guide the BHTWG's work.

BHTWG also reviewed and reflected on the work of other inputs and recommendations generated through previous processes. These include the 2006 Final Report of the Legislative Council Interim Committee on Mental Health and Substance Abuse; the December 15, 2006 Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps; annual reports of the State Mental Health Planning Council; and initiatives of the Interagency Committee on Substance Abuse and Prevention. Furthermore, BHTWG submitted an earlier version of their proposal to a technical panel of experts who have experienced transformation, and whose advice and guidance substantively enhanced the focus and direction of BHTWG's draft. That report can be found at http://www.marshabracke.com/BHTWG_docs.htm.

The BHTWG also considered a proposal by Division of Financial Management Administrator Wayne Hammon, who responded to the Governor's request to conduct an objective assessment about how to best manage the 2011 sunset of the Interagency Committee on Substance Abuse Prevention and Treatment and the role of the Office of Drug Policy. Hammon conducted that study and generated a recommendation to the Governor, which proposes that the Director of Transformation direct the work of a Behavioral Health Transformation Office.[1] The BHTWG recommendations are consistent with many elements of Hammon's proposal.

A special session was convened to gather the observations and insights of the judiciary. The judiciary articulated the unique characteristics of juvenile and criminal justice populations with behavioral health

[1] Next Steps in Behavioral Health / Drug Policy: Draft Discussion Paper. Wayne Hammon, Administrator, Division of Financial Management. August 11, 2010.

needs, requiring the specialized competence of providers and communication, transition and planning across behavioral health, criminal justice and juvenile justice systems.

BHTWG meetings included the participation by a range of stakeholders who provided input inside and outside the meeting setting, formally and informally.

BHTWG secured the support of Red Sky Public Relations to conduct a public outreach process for the purpose of sharing information about the draft product and soliciting help and suggestions to improve it. The public outreach process featured the presentation of the BHTWG recommended structure directly to approximately 400 people, whose concerns, suggestions and sentiments have been documented in a BHTWG Stakeholder, Consumer and Family Outreach report produced by Red Sky Public Relations. A copy of this document can be downloaded at http://www.marshabracke.com/BHTWG_docs.htm.

In addition, Red Sky Public Relations staff conducted an analysis of those comments, categorizing them into the ten themes. BHTWG following their review of the outreach inputs and the thematic summaries produced by Red Sky, considered how to best use that input in the development of their draft Plan. BHTWG also generated a written response to each theme.

This document is the BHTWG's Response to Public Comment, Organized by Themes.

1. Level of Detail [100 respondents]:

Summary:

While some respondents felt the BHTWG was on the correct path with the structure as proposed, many were concerned that the proposal, as presented, did not provide enough detail.

BHTWG explained the process and reiterated that the goal of the proposal was to provide a framework for transformation and present it to stakeholders and the family and consumer groups. BHTWG did not want to reach out with so much detail that those participating in the outreach would feel their inputs would not influence the outcome; their input is important to the transformation effort.

Concerns included that there isn't enough detail: 1) on which to comment; 2) to understand how this is different from the existing system of services provided; 3) to understand the funding structure, and 4) to understand how the plan will be implemented.

Representative Comments:

- *"From what was just presented there was no actual 'plan'. The information was presented as 'this is just an idea, there's nothing to say that this will go anywhere'. There were also no statistics or any information to show that this was evidence based and no formal plan for how these changes will be funded."*
- *"Would need to see a better/more clear definition of how, who will be doing what to make a determination."*
- *"The wording of the enabling legislation and H&W rules will tell more. This proposal doesn't present enough day-to-day detail at this point; it's just a dream on paper right now, but a good start. It presents a general overview of how the system might work. To say it offers 'clear responsibilities and actions' at this stage is a fallacy. Baby steps."*

BHTWG's response:

It is true that the BHTWG is proposing structural change and only conceptualizing many of the details. The structure is intended to commit the state to transformation and the development of a truly integrated behavioral health system. Many entities involved in the new structure - consumers and families, local and regional stakeholders and leadership, and the structural entities who will be focusing collectively on behavioral health - will do more concrete thinking regarding the details associated with the transformed system as the process evolves. BHTWG considers the change from the current structure to the structure proposed to be the a significant action steps required in order to make the integration of the behavioral health system and the transformation to a client-focused regionally driven system a reality.

The proposed structure integrates and streamlines what currently exists (see table below). This structure is suggested to be established as appropriate by Executive Order (in 2010) and legislative action (in 2011). While components of the transformed system are conceptually presented, participants in the new structure will guide the development of the system in more detail.

The new governance structure and all the individuals involved on a local, regional and state level will continue to work to flesh out the next phases of transformation, capitalizing on their collective

experience, environmental context, workforce capacity and best practices. For example, regions will develop location-specific strategies to pursue on behalf of consumer and families in their regions; the State Behavioral Health Authority will work on establishing statewide standards of care; and the Director of Transformation will facilitate the development of a braided funding system which make the best use of the taxpayers dollar.

Features of the new structure include:

Element	Existing	Recommended	Action Steps
Systems	▪ Substance Abuse ▪ Mental Health	▪ Behavioral Health	Generate an integrated structure which can then pursue behavioral health work
Funding	▪ Siloed	▪ Braided	Integrate the structure and begin to position funders to pay the same amount for the same service with consistent standards.
Regional Leadership	▪ Regional Advisory Councils (substance abuse only) ▪ Regional Mental Health Boards (mental health only)	▪ Regional Behavioral Health Community Development Boards ▪ Robust Subcommittee involvement (specifically including Consumers and Families)	Pursue legislation in 2011 to develop Regional Behavioral Health Community Development Boards.
State Level Coordination	▪ State Mental Health Planning Council (mental health only) ▪ Interagency Community on Substance Abuse Prevention and Treatment (substance abuse only) ▪ Department of Health and Welfare ▪ Idaho Department of Juvenile Corrections ▪ Idaho Department of Correction ▪ State Department of Education ▪ Office of Drug Policy ▪ Courts ▪ Counties	▪ State Behavioral Health Planning Council ▪ Statewide Behavioral Health Interagency Cooperative	Pursue legislation in 2011 to develop the Statewide Behavioral Health Planning Council.. With the delivery of this plan (October 2010, issue an Executive Order to establish the Statewide Behavioral Health Interagency Cooperative to coordinate the operational elements of transformation. To be followed by legislation in 2011.
Director of Transformation	▪ None	▪ Director of Transformation	Pursue legislation in 2011 to establish the position of the Director of Transformation per the BHTWG Director of Transformation Job Description.

This Plan guides the development of a "coordinated, efficient state behavioral health infrastructure with clear responsibilities, leadership authority and action." It establishes a specific structure for generating the transformed system it describes, and puts in motion the process for developing that system over time.

2. Funding [86 respondents]:

Summary:

Given the current economic crisis and the recent closure of Department of Health and Welfare [DHW] offices throughout the state of Idaho, many are concerned about the financial viability of making any changes to the system at this time given shrinking resources. Further, it is anticipated that DHW will be forced again to do more with even less funding during this next fiscal year.

BHTWG pointed out that how to fund the system at this point is unknown. They reiterated BHTWG was formed by the Governor as a state priority. They discussed the potential impact of healthcare reform and how Medicaid will play a larger funding role in the future. BHTWG said that this new structure allows regions to pursue cost-savings through partnerships that are not currently available to the

system; it would allow all to band together with one clear vision and voice which would provide more meaning to the legislature during budget discussions.

Concerns regarding funding included: questioning how regions, especially the more rural regions, will compete for funding; asking for hard data or specific case studies demonstrating how this approach will save the taxpayers' money overall; and asking how the indigent population would be supported through the braided funding concept and that much more discussion will be needed to ensure their care. Participants discussed the need to incentivize early interventions and prevention services versus responding to crisis scenarios, as this is a much more effective utilization of scarce resources. Some mental health providers and drug and alcohol treatment providers were each concerned with the combining of services as they each feared they would lose their needed share of funding. Some suggested the state establish a "sin tax" for alcoholic beverages in order to assist with the funding of behavioral health initiatives was prevalent throughout some of the outreach meetings.

Representative Comments:

- *"A regional array of services makes intuitive sense but is not practical given the costs related to implementing a full range of services for each community."*
- *"I feel this transformation concept is just a veiled attempt to reduce services and centralize. I suggest providing proper funding to quality providers."*
- *"The only funding discussed was the fact that there would be NO new money. 'Braided funding' is not an increase in funds it just uses the existing funds in a different way – not necessarily more efficiently."*

BHTWG Response:

Clearly resources are tight and in this current economic crisis, shrinking. With DHW offices closing and severe cuts in local and state governments, BHTWG recognize that the viability of pursuing transformation at this time will be questioned.

The reality is that the impetus for transforming the behavioral health system has been underway for years. Many groups have proposed a transformed system (see response to Section 3 - Outreach below). The fact that BHTWG has been asked to develop a plan to achieve it at a time when DHW has had to close some of its offices is coincidental, unfortunate, and unrelated. However, DHW and other entities who fund behavioral health services intend to be deliberate about making economic adjustments now that line up with an effective behavioral health system in a transformed environment.

By using the lack of resources as a reason to make no change, the existing situation will get predictably worse - and higher cost crisis services will become the stop gap for escalating issues avoided by the availability of early intervention and prevention services.

BHTWG has spent time collecting and discussing the dollars spent on mental health and substance abuse services and systems across the state. This effort has generated an understanding of what is collectively spent; but what is spent on behavioral health does not answer important questions about the actual need and the cost of that need.

To answer these questions, and to use what funding the state does have most effectively, there is much more work to do. It will be incumbent upon the Behavioral Health Interagency Cooperative to continue

to explore how to best leverage the taxpayer dollar to get the most appropriate services to consumers and families at the most appropriate time, location and cost.

There is local experience which informs this opportunity. For example:

Detention Clinician Project

The Detention Clinician Project authorized by the Idaho Legislature in 2008 continues as a partnership among DHW, counties and the Idaho Department of Juvenile Corrections (IDJC), using state funds to place a clinician in each of the twelve juvenile detention centers around the state. Some of the findings from a research study completed by Dr. Ted McDonald of Boise State University reveal the following:

- Three out of four juveniles (75%) entering detention facilities have a mental health and/or substance abuse issue;
- Over half of the juveniles who are recommended for community-based mental health and/or substance abuse services after an evaluation by a detention clinician accessed those services within 15-30 days post release;
- Eighty-five percent (85%) of probation officers and judges reported that information from the clinician had an impact on case disposition and service planning;
- One hundred percent (100%) of judges and probation officers indicated a strong desire to see the clinician program continue; and
- Nearly seventy-five percent (75%) of parents reported that their child had received at least one of the services recommended by the clinician.

Data collected by IDJC during juvenile detention facility inspections reveals a drop in critical incidents as well as admissions. During a presentation of this report on February 2, 2010, Juvenile Detention Administrators credited the drop in incidents and admissions to the presence of clinicians in the facilities. They also reported increased morale, confidence, and competence of facility staff due to the training and support provided by clinicians.

Contracting Initiatives

IDJC funds a program to support the community based treatment of juveniles at risk of commitment and for those leaving a period of commitment. One of the evidence-based services offered within this program is Functional Family Therapy (FFT). Rates of reimbursement for FFT services varied depending upon the overall level of service indicated in the service plan and were in many cases different. IDJC was able to achieve the same cost of FFT services to the common rate paid by IDHW.

Reductions in Community Hospitalization Costs

Home Recovery Team (HRT) is an innovative public-private partnership that was formed in DHW Region 4 in February 2009. This team focused on the provision of community supports as an alternative to hospitalization for those in crisis, with services provided by a combined HRT staff mix of two professionals and two Certified Peer Specialists. At a cost of approximately $200,000 per year, the Home Recovery Team (HRT) provided short-term (i.e., 7-14 days) intervention, daily in-home support and treatment for at risk individuals. The savings from diverted hospitalizations in the first year of HRT operation was approximately $600,000. Despite the success of the HRT pilot, this project was discontinued in May 2010 because of budget cuts.

In addition to the reduction in hospitalization realized through the HRT, the Division of Behavioral Health also implemented a new process for admissions and discharges to the state hospitals. The new process established a protocol to identify the coordination of regional and hospital responsibilities for the admission and discharge processes. Through the creation of the new policy, the Department saved an estimated 1.2 million dollars in Community Hospitalization funds over the previous fiscal year.

Through transformation, Idaho positions itself to create efficiencies and cost savings, avoid cost-shifting to higher crisis services or correctional facilities, leverage the collective dollars available to support consumers and families through a braided funding approach, and intentionally and deliberately put more emphasis on early intervention and prevention and community supports in a regionally based client-focused system.

Any cost savings or efficiencies achieved through interagency cooperation is specifically intended to be *reinvested* in the system and support consumers and families.

BHTWG also recognizes that Medicaid is a primary funder of this system. It is not the only funder, but the biggest funder. With Health Care Reform there will be an increased number of individuals on insurance and individuals who qualify for Medicaid. This will put even more demands on the system. BHTWG's plan intends to help the state position itself to support those service needs in the most efficient and effective manner that is consumer and family based and regionally driven. It will take time; it will take work; and it will depend on an efficient, integrated and coordinated structure to bring all of these important elements together.

3. Outreach [85 respondents]:

Summary:

Survey results reflect mixed opinions about the appropriate level of outreach. Many said they were unaware of the WICHE recommendations, the establishment of the Behavioral Health Transformation Work Group in 2009 by the Governor and the BHTWG's efforts to-date. This lack of knowledge and understanding created the appearance of a process being rushed.

BHTWG explained that it did not feel comfortable moving forward with the outreach meetings until they as a group, felt comfortable with the overall proposed framework for the system. They also described the challenge of trying to provide enough information to gain meaningful input, but not provide so much that people felt that their input would not be influential. BHTWG described its reliance on the WICHE Report recommendations, and how input from these meetings and survey responses would shape the recommendations from the BHTWG to the Governor in the October 2010 report. This is a phased transformation and stakeholder and consumer group input will help guide its implementation.

Concerns included: the fact that the BHTWG asked for feedback from the public within months of the report being due to the Governor; whether or not enough notice had been provided; whether or not all of those who should have participated in the process actually did so. Some were also concerned that, given the proximity to the Governor's deadline, whether the respondents would really be heard in a meaningful way. Further, because many participants had not heard of the work group efforts to-date, they expressed frustration that the plan appeared to being pushed through.

Representative Comments:

- *"My concern is that stakeholder input will be sought out then the powers that be will end up doing what they are planning anyway. The listening through this is just going through the motions. I have seen it before."*
- *"There needs to be more input than 30 days before going to the governor. Stakeholders and consumers need to be consulted more. More town meetings. How can the work group make recommendations in this manner? Only give until September 18 to provide the survey? Why is it pushing the plan this way? What is the agenda?"*
- *"Rather than actively seeking out input from those who work in the field, the emphasis placed on governmental entities to shape and design systems who are not current on issues facing practitioners. ICSA is a good example, this is a long-standing issue with little improvement in many years."*

BHTWG Response:

From May 2009 through October 2010 the BHTWG has worked to generate a plan that commits the State of Idaho to the process of developing an efficient and effective client-centered system. Rather than starting over, BHTWG specifically opted to use the results and recommendations of previous work in this area to inform their proposed action. Based on that existing body of work, the BHTWG generated an action plan to pursue the vision and goals that reflect that work. BHTWG's effort differs from previous efforts in that it focuses on generating action steps to achieve transformation, rather than, once again, studying the need for transformation itself.

BHTWG reviewed and used as a foundation for their effort recommendations generated by other studies and outreach efforts. Specifically, the group's efforts were informed by a Western Interstate Commission for Higher Education study commissioned by the Idaho State Legislature and conducted in 2009. This report provided the basis of the vision, goal and direction the BHTWG pursued. The WICHE process included a statewide public survey process, which generated input from more than 550 individuals from around the state. Approximately 160 individuals also provided input through in-person interviews. WICHE's outreach process is described in their report on page 43. The WICHE report can be found in its entirety at http://www.legislature.idaho.gov/sessioninfo/2008/interim/mentalhealth_WICHE.pdf. WICHE's findings and recommendations informed the BHTWG's work.

BHTWG also reviewed and reflected on the work of other inputs and recommendations generated through previous processes. These include the 2006 Final Report of the Legislative Council Interim Committee on Mental Health and Substance Abuse, the December 15, 2006 Comprehensive Statewide Mental Health Transformation Action Plan 2007: The First Steps, annual reports of the State Mental Health Planning Council, and initiatives of the Interagency Committee on Substance Abuse Prevention and Treatment.

Furthermore, BHTWG considered a proposal by Division of Financial Management Administrator Wayne Hammon, who responded to the Governor's request to conduct an objective assessment about how to best manage the 2011 sunset of the Interagency Committee on Substance Abuse Prevention and Treatment and the role of the Office of Drug Policy. Hammon conducted that study and generated a recommendation to the Governor, which proposes that the Director of Transformation direct the work of a Behavioral Health Transformation Office. The BHTWG recommendations are consistent with many elements of Hammon's proposal.

A special session was convened to gather the observations and insights of the judiciary. The judiciary articulated the unique characteristics of juvenile and criminal justice populations with behavioral health needs, requiring the specialized competence of providers and communication, transition and planning across behavioral health, criminal justice and juvenile justice systems.

BHTWG conducted a statewide stakeholder, public and consumer-specific outreach process. This process featured the participation of a range of stakeholders, consumers and families at seven regional stakeholder meetings and four family and consumer-specific meetings. At each meeting BHTWG presented the recommended structure. Ultimately, BHTWG discussed this structure with approximately 400 people, whose concerns, suggestions and sentiments were collected and reviewed. The Stakeholder, Family and Consumer Outreach Report contains all of this input. These materials can all be found at http://www.marshabracke.com/BHTWG.docs.htm.

All of this input influenced the development of BHTWG's Plan for the Transformation of Idaho's Behavioral Health System. The BHTWG will deliver the input to the Director of Transformation and the State Behavioral Health Interagency Cooperative, as they will want to continue to examine and utilize the information provided in this process to incorporate in transformation implementation.

BHTWG's plan is a phased project. Phase 1 changes the structure of government to focus on behavioral health, streamline the structure, and enable transformation. Phase 2 empowers the regions to work within and build their regional systems, fosters the increasingly focused coordination of the state payers of those services, and provides for the leadership of a Director of Transformation to facilitate the effort. The new structure integrates involvement by stakeholders, consumers and families to help shape the system and inform the specific details.

4. Access to Care and Resources [66 respondents]:

Summary:

In general, access to care and resources was discussed in conjunction with funding. There appeared to be a shared understanding that priorities, availability and access to services differs in every region, and that regions being able to determine what their priorities should be is a step in the right direction.

BHTWG reiterated that access to care for all within the state is the work group's top priority. Access to care is the reason for the creation of the BHTWG, the BHTWG's proposed structure and the envisioned system. Discussion around this topic included a request to not eliminate providers, to have regional boards determine how to best provide access, and that a lack of a qualified workforce statewide is problematic and needs to be examined.

One significant concern was about access to care and resources, particularly in rural areas. Concerns were raised over how regions will provide services and if said services were to be provided by private providers, would the rural areas lose out. People were concerned that with limited providers, and even more limitations given the lack of providers who take Medicaid patients, that access would be even more limited. Some felt that the elimination of DHW's role in actual service delivery would drastically decrease services to patients. Statistics in the rise of the statewide hospitalization and suicide rates over the past year were cited several times. People sought more specificity to the regional detail. Generally, people are fearful that their needs will not be met.

Representative Comments:

- *"As part of fleshing out the existing plan, work to guarantee that needed services are provided effectively and efficiently on a local basis wherever possible so people can receive needed services close to home."*
- *"Identify specific steps to identify and establish a collaborative relationship between the department and providers in rural areas."*
- *"Services are always the first to be cut during budget crisis. We need to shift our focus on less 'administration' and more on building communities and focusing on meeting the needs of the people.*

BHTWG's Response:

The WICHE Report, Department of Labor data, BHTWG, regional stakeholders and consumers know that access to services - including rural access and workforce availability - is a problem. This is an issue that the state is going to have to work on, and one on which the structure – at the regional and state level - will need to focus specific attention. Access to care is the number one transformation goal. The impetus behind the notion of transformation is about increasing access. BHTWG has sought and the proposed structure must continue to seek opportunities that arise through the process conducted in Idaho and capitalize on learning from successes achieved in other states.

In the BHTWG Technical Panel Summary Document, March 24-25, 2010, the results of a technical expert review of an early version of the BHTWG's work are available at http://www.marshabracke.com/BHTWG.docs.htm. Access is one of several issues about which the presenters spoke. Bill Hogan, Commissioner of Alaska Department of Health and Social Services, and Dr. Steve Holsenbeck, Chief Medical Officer for ValueOptions Colorado Partnerships, both spoke specifically about the challenge - and necessity - of securing access in remote areas and building workforce. Their examples, as well as others yet to be secured, can inform the regional and state effort.

5. Measurement and Outcomes [47 respondents]:

Summary:

Another focus of discussion during the outreach focused on measuring outcomes and performance. Two regions specifically felt that they had good methodologies to measure their results. BHTWG acknowledged that in moving forward it will be helpful to look at these regions' best practices and see what methods may be applicable statewide.

Some suggested options by survey respondents for measurement of outcomes included the monitoring of the following:

- Utilization of standardized surveys
- Reduction in overall costs
- Track service outcomes
- Suicide rates
- Cost-benefit analysis
- Assessments
- Decrease in cases

- Tracking days in inpatient facilities/jails/homeless shelters
- Recidivism

Given that not all regions have a clear measurement system, BHTWG discussed the need for a consistent system of measurement throughout the state. Without the consistency of measuring performance outcomes, it is difficult to meaningfully and effectively address issues associated with mental health and substance use disorder treatment and delivery in a statewide context. At this point in time, DHW does not have the internal infrastructure to pursue a statewide monitoring process. In the new system, DHW will focus on developing a consistent statewide model to enable increasingly informed decision-making and open the door to pursuing funding mechanisms not currently available.

Representative Comments:

- *"Provide data on specific outcomes that relate to recovery in the community of choice for project participants. The service costs to outcomes."*
- *"I think the main way to increase funding is to improve outcomes and show solid data to the Feds to prove that what we are doing is working and shows the needs of the state for these services, but the Legislature and Executive offices have made it very clear that behavioral health services are not top priority."*
- *"I think this will be difficult to measure because I expect continuing rise in the number of patients as a direct result of the current state of our economy."*

BHTWG's response:

BHTWG seeks a transformed system that is client-focused and outcome-based, and which is adaptable to continuous improvement based on data and measurements that inform it.

Collecting data regarding the use and effectiveness of Idaho's Behavioral Health System includes three (3) distinct components: measures of utilization, financial/cost data, and measures of outcome. Utilization data measures the number of individuals served and the number of services delivered. Financial/cost data measures expenditures at the system, organization, program, and individual level. Outcome measures tell system stakeholders how effective services are at individual and aggregate levels.

While utilization, financial, and outcome data are often viewed as mutually exclusive, the most useful indicators of success marry the measures together. For example, looking at how many adult consumers received services from one agency is helpful, a better measure is to identify the cost of a particular program, how many consumers utilize that program, and how effective it was at keeping them out of jail, out of the hospital, and in their own community maintaining a residence and a job.

All of the measures collected through public comment are already being collected at the agency and program levels. The Division of Behavioral Health has data on how many assessments were completed, overall costs of services, days in inpatient facilities, etc. Medicaid performs targeted research on outcomes as relates to specific policy directives that come from the legislature or the governor's office. Additionally, quality assurance studies are conducted on an on-going basis. IDOC, IDJC and others also collect these measures. The barrier that we identify is looking across the entire system to inform the development of the behavioral health system as a whole, and how to best help those individuals who transition through many or all of them.

A transformed behavioral health system will include a data system that includes utilization, financial/cost, and outcome measures from all agencies, programs and sources that are involved in assisting consumers achieve their goals.

6. Structure [33 respondents]:

Summary:

Concerns regarding a lack of information of the overall structure were reflected under a portion of Theme #1 "Lack of Information." Respondents cited a lack of knowledge as to how this will function, a lack of understanding as to who are the best people for the roles, fear that the new structure will drive up costs, and whether the new system is different from that that is in place now.

At each outreach meeting, BHTWG discussed the new proposed structure, respective roles and responsibilities, and reporting and accountability.

Thoughts expressed by the respondents range from who should be the Transformation Champion [as there are mixed opinions if it should be from within or outside of the state structure or if this should be a singular or shared position]; clearly delineating the responsibilities of each board, etc.; and addressing how each component can be efficient and effective when so much of the participation is the voluntary contribution of busy professionals.

Representative Comments:

- *"Clarification needs to be made on who/how regional board members are chosen and will those members be paid? It seems irresponsible to hand this level of responsibility to regions that are already lacking leadership already."*
- *"This seems like we are re-inventing the wheel. There needs to be more participation and involvement in the cooperative from community partners not just department heads. If we are going to be successful in transforming behavioral health throughout the state we need input from all areas of behavioral health not just state run agencies."*
- *"The plan does not create the service delivery system – it merely charges regional boards with the job."*

BHTWG Response:

More information about the proposed structure is included in the BHTWG's Plan for the Transformation of Idaho's Behavioral Health System, October 28, 2010 (Plan) at http://www.marshabracke.com/BHTWG.docs.htm. The Plan provides a more detailed description of each of the structural elements and their function, and responds to some of the specific questions and suggestions collected during the outreach process. Also note that at the October 5, 2010 meeting, the BHTWG proposed two name changes to ensure greater clarification. What was called the Transformation Champion in public outreach process is now called the Director of Transformation; and what was called the Guarantor of Care is now called the State Behavioral Health Authority.

The Plan also describes the intent to have a physician/psychiatrist representative from the Regional Provider Network on the Regional Board as part of the Regional Provider Network requirement, and another health care professional, ensuring that both mental health and substance use disorder

disciplines are professionally represented on the Regional Boards. By way of strategic planning, Regional Boards will create a Transformation Implementation Plan for their region, and by way of accountability, the Regional Boards will generate an annual report to the Director of Transformation and the Cooperative. To strengthen the fabric of the statewide and regional relationship, each Regional Board will have a representative sit on the Statewide Behavioral Health Planning Council.

To see how the proposed structure streamlines the existing structure, see Table 1 on page 7.

While most participants on the Regional Boards are anticipated to be volunteers who serve because behavioral health is related to their work, a responsibility they have to their clients, or an important aspect of their lives, the BHTWG recognizes that with this focused responsibility support staff for the Regional Boards is critically important. The issue of resources is one that the Cooperative recognizes and will need to work in coordination with the Regional Boards and the Director of Transformation.

7. Accountability [31 respondents]:

Summary:

Accountability was a theme that coincided with several others, including: Funding, Psycho Social Rehabilitation, Measurements and Outcomes and Implementation of Plan. In general, many believe accountability is lax in the existing system, and they are skeptical about whether the transformed system will be any better - especially without a level of detail to examine at this time. Many noted the number of efforts to study and change the system in the past which have resulted in no change.

BHTWG described the process of regional accountability to the Director of Transformation and service provider contractual accountability and standards of care monitored by the State Behavioral Health Authority.

Respondents suggested the system focus on using best practices, utilizing the controls that are on paper but aren't being enforced today, applying penalties for fraud and misuse of the system, increasing transparency to the public and tying costs to outcomes.

Representative Comments:

- *"These are mostly words with no accountability at a state level attached to them. We are creating weak regional boards and asking them to prioritize services."*
- *"Access which services are producing quality outcomes and model others after those."*
- *"The abbreviated look we got indicates that there may be a more detailed plan somewhere that assures accountability. If not, it needs to be a priority. Anything that is not spelled out carefully runs the risk of getting outside the control of those who are responsible but ultimately are not accountable because a firm plan does not exist. It seems to be how the current system got out of control."*

BHTWG Response:

BHTWG is required to propose a structure and system that is "coordinated, efficient, accountable and focused on recovery." Accountability is intentionally built in at all levels, but given the evolution of the system as conceptualized to date, in varying degrees of detail. Accountability will increase with

consistent statewide standards of care that are contractually required and effective measurements and outcomes processes that inform adjustments to the system (see Section 5 above on Measurements and Outcomes). DHW will operate as the State Behavioral Health Authority to specifically monitor that accountability. Furthermore, the Director of Transformation will be held accountable by the Governor to facilitate the transformation process. Regional Boards, Planning Council, and the Cooperative will have executively directed and legislated responsibilities and requirements for which they will be held accountable.

8. Implementation of the Plan [30 respondents]:

Summary:

Participants expressed concern about the fact that previous studies and efforts to transform the system have been attempted and there has been no follow through.

BHTWG discussed that this is in fact a phased-in transformation process, and this first phase involves developing the framework and structure. The second phase will include delving into the details with much more specificity. These details will include how best to phase in the implementation, as this will occur as resources and structures are put into place. It is important to note that these efforts will occur at a pace that each region can endure. BHTWG also pointed out that health care reform might influence funding and implementation of programs and services. BHTWG member's themselves are engaged, focused, and committed to making sure transformation becomes a reality.

Participants indicated concern about previous efforts to transform the system that never were implemented. They are also concerned about the ability to implement a new system with a shortage of funding and resources. Other discussion focused on different treatment models and a potential pilot in a given region.

Representative Comments:

- *"Ensure there is commitment and collaboration with all providers over a sustained period of time."*
- *"Clarify the exact division of resources and the ability of each cooperative member to follow through with their responsibility. Statutory requirements would need to be made to mandate cooperative members return their budget savings to mental health services."*
- *"It seems as though we redesign the system over and over and over again but without much in the way of implementation. This redesign, like the others, will only be as effective as it is resourced and implemented."*

BHTWG Response:

BHTWG recognizes that recommendations for a transformed system have been generated and proposed long before the BHTWG was established. The BHTWG was asked to propose how to make transformation a reality. BHTWG's proposal commits the state to transformation by establishing a behavioral health focused structure with the specific responsibility to implement transformation. Once established, responsibilities for pursuing the elements of transformation for which they are accountable is confirmed; and work to fulfill those responsibilities can be initiated. By establishing the structure, the BHTWG is able to secure the momentum and responsibility for transformation.

The structural changes achieved through executive order and legislation are proposed to occur late in 2010 and in 2011. In 2014, with Health Care Reform making more Medicaid and other insurance benefits available to more people, the transformed system must be positioned to provide the most productive services.

9. Array of Core Services [26 respondents]:

Summary:

Discussion about the array of core services focused primarily on two central themes: 1) ensuring the consumer of services has the programs and resources available to them and 2) understanding what types of programs may be needed for this to be an effective system. One participant asked if this is a "rearranging of the deck chairs" rather than precipitating real change in the system.

BHTWG explained how the core services are intended to be a "floor" to help guide the establishment of minimum services. However, regions are free to develop more programs and services depending on their needs and priorities. Presenters pointed out that 1) there is no intent to displace the private providers or PSR providers even though they are not specifically mentioned, 2) it is anticipated that PSR providers will be among the network of providers for several of the core services, and 3) it is not the work group's intent to dismantle any successes or programs that are working, and that we should all seek out and replicate success.

A couple of regions questioned why PSR was not specifically mentioned, and suggestions were made to 1) ensure that preventative care is included as part of the core services, and 2) that services are made available to children through the school system and not just in special education programs. Some noted that Idaho does not have the types of services that many other states have. In general, most agreed that early prevention and intervention are two areas that are important to address.

Representative Comments:

- *"Clients or potential clients/families need to know the system, what is available to them."*
- *"Early interventions, less privatization, keep people in-patient as long as needed, implement the 10 principles of the recovery model…"*
- *"Idaho is 49th in the nation for mental health services – sad and embarrassing. More services would lower costs even though it would take money – prevention, education."*

10. Psycho Social Rehabilitation [PSR] [22 respondents]:

Summary:

The specific mention of PSR in the Array of Core Services document is a bigger concern in some regions than in others. In those that expressed concern, there is a perceived fear that because the proposed array of core services did not specifically mention PSR, the work group was suggesting PSR be eliminated.

BHTWG pointed out that in the description of core services, it is BHTWG's intent to focus only on the generic service.

This response satisfied some but not others. Concerns were expressed by the PSR's given the new credentialing requirements proposed for 2012. If PSR is going away, this should be told to these businesses as soon as possible given the expensive nature of meeting the new requirements. PSR was also discussed from the consumer and family perspective. Fear exists about losing long-established relationships with providers. PSR providers feel as if they are looked upon negatively due to a few bad examples and subsequently are being left out of the conversation. They feel that with the proper oversight, certification and tracking of outcomes PSR's provide significant value to the system.

Representative Comments:

- *"Private psychiatric care in most areas of Idaho are inefficient. Having private provider's chase funding [like PSR] is not the answer. People will die and suffer."*
- *"The plan should be revised so that clients with current qualified providers are not forced into losing these provider relationships due to sudden changes in requirements at the state level."*
- *"The plan does not have PSR services. Sure there are small components of PSR here and there, however to get rid of such an evidence based service in the state of Idaho is appalling, and we will pay in the long term with more money."*

BHTWG's Response:

BHTWG recognizes the important role of the PSR provider and the dependence and relationship consumers and families have on that provider. BHTWG has deliberately focused its description of core services on the services to be provided, rather than the manner in which those services would be provided.

11. Other Categories:

- Plan is a positive change [21 respondents]
- Make-up of the work group [18 respondents]
- Concerns regarding the combining of services [10 respondents]
- Political concerns [9 respondents]

The BHTWG recommends that the Director of Transformation, Regional Behavioral Health Community Development Boards, State Behavioral Health Planning Council, State Behavioral Health Interagency Cooperative and the State Behavioral Health Authority continue to consider all of the comments collected through this outreach process as the implementation of the transformation effort continues and evolves.