

**Region 2
Behavioral Health Structure Scoping Meeting
Summary Results
October 20, 2011**

In an effort to describe potential structures for an effective, regionally based behavioral health system, the Behavioral Health Interagency Cooperative asked stakeholders in Region 2 to participate in a discussion process. The outcome of the process would be a proposed regional structure that the Region thinks would most meaningfully lead the coordination of community-based behavioral health services. Region 2's product is intended to inform the Cooperative's discussion at its November 2, 2011 meeting. At that time, the Cooperative will consider whether it is possible to pursue a pilot project to test the proposed structure.

The Cooperative is undertaking a similar process in Region 7 as well.

The process for developing the structure includes:

1. Meeting 1: to present the invitation and collect initial thoughts in response to the Cooperative's questions about a structure;
2. Reflect stakeholder comments in a draft document and circulate it electronically with participants for further reflection and regional input and development; and
3. Meeting 2: Refine the proposal and prepare it for presentation to the Cooperative on November 2.

Meeting process included:

- Introductions by each of the participants,
- A power point presentation made by the Facilitator, providing the status of the discussion process relative to the questions presented at the previous meeting, ,
- A round robin discussion presenting each participant's suggestions and preferences regarding the development of that draft,
- A facilitated discussion to capture the group conclusions,
- A presentation of a Regional Mental Health Board subcommittee draft organization chart,
- A discussion to align that chart with the group conclusions, and
- A detailed discussion about the composition of the proposed regional board.

Flip chart notes maintained by the Facilitator to document the group record have been transcribed and are included as Attachment B.

Using the inputs provided at the meeting, the Facilitator will generate a **revised draft** proposal for the Region 2 behavioral health entity. This document is included as Attachment C. This draft specifically reflects the conclusions of the second meeting as revised from the earlier draft document. Participants have been asked to review this material and ensure it reflects the group's collective thought. The document will be distributed to the Cooperative for discussion at its November 2 meeting, and Region 2 stakeholders who are interested are specifically invited to attend and participate in that presentation.

Summary materials prepared by Facilitator Marsha Bracke, Bracke and Associates, Inc.

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October 20, 2011
List of Participants**

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Flip Chart Notes**

FEEDBACK PER LAST MEETING

- Emphasize need for Medicaid on team
- Do we even want to do this?
- If we do – SAMSHA grant? Need that funding.
- Legislative authority early so we can apply for funds...need support for grant writer
- Do it right
- Would like to see us try something – see mental health board ideas
- Missing the boat if you don't tie child protection to it – impacts behavioral health – include everything to get meaningful change
- A lot to bite off bit by bit – do we have the “counsel” needed to know where we're going / do it correctly?
- Bottom line is money – group should focus on what we can do without funding – look hard and fast at those areas
- Brings us together to streamline – get things in the open
- Even with no services, it helps us as a community
- Will see a lot more vets – need to gear up for that. How many? Maybe big and co-occurring (MH and SUDs)
- Sustainability – can develop a lot of great programs, but they are worthless if we can't sustain them. Need funding stream.
- Sit on a lot of boards – lots of planning and paper but no programs – what's' different? Real help? Frustrated.
- Anxious to see end result – how Cooperative can move forward
- Support moving forward – can't answer sustainability question unless we move forward
- Community partnerships – community effort (CP, MH, SUD) – have that be at the forefront
- Consumers, families, parents integral
- Client care at top of pyramid
- Careful to not create more bureaucracy
- Capitalize on minimizing overhead costs
- Ideal world – intervene early – outreach – Community Action Agency, Food Bank – get folks plugged in
- Disappointed legislators aren't here
- Significance of consumer involvement
- How fit with managed care/Medicaid?
- Region 2 commitment
- Always react to state funding
- They ask for our input, blend it into the state mix, comes back and doesn't fit us – we adapt. We know what we need.
- Reliable funding
- We need a plan that makes sense to use that we can act on
- As a starting place – prevention and early intervention
- Variety of stakeholders – one board to address the variety of behavioral health needs in the community
- Huge positive to bring together

- Need to think about how much we're willing to and capable of biting off
- Funding and sustainability to continue
- Voice for region 2 – true issues
- Like public health district model but concerned that behavioral health will be swallowed up.
- Can central office release control and how? Timeline? What comes next?
- What needs to be done? How will state help?
- Evaluate and continue to make sure we are doing better/adding value
- Personal fears – jobs, benefits, raises
- Fears for communities
- Fears at all levels, address fear
- Consumer and advocates need to help build system
- In awe of knowledge and passion in this group
- Flexibility – comes with funding
- Dow hat we're doing better by being local
- Not in public health district but model it
- Thoughtful board regarding Medicaid – consultative, not service, have input in development of contract, coordination and communicate

STRUCTURE DISCUSSION

- Regional Behavioral Health Board
 - Includes child protection, mental health, substance abuse disorders, agencies that fund them, consumers and advocates, Medicaid
 - Coordinates efforts identifies and addresses community issues across sectors
 - Input/coordination with Medicaid and managed care
 - Regional voice, identifies issues i.e. Vets
 - Executive Community – potentially funding entities comprised of people who make decisions
 - Even with nothing more – this adds value
 - Ad a minimum – legislation to establish this Board
- Infrastructure
 - Need funding to Act
 - Legislative authority to purse funding, hire staff, contract
 - With staff, work to fill gaps in the community based on client needs, potentially starting with prevention and early identification
 - Look at what we can do without funding
 - Need to start with grants/counties match
 - Grant writer – need funding to support
 - SAMSHA grant
 - With transition of funding for community based services from DWH
 - With transition of “more-to-all?” behavioral health services
 - Monitor, evaluate, improve
- Concerns
 - Funding – need some funding
 - Sustainability
 - Fear – personal, community, county, region, state agencies, legislators

 - Discussion
 - Two layers – executive – funding decision-makers
 - Regional Advisory Board – diverse

- Governing Board Discussion
 - Education, IDJC, IDOC, DHW, Judiciary, Counties (Commissioner or designee), Medicaid, Families and Consumers (13)
 - Representative from each county – not necessarily a commissioner
 - Designation to commission – delegate
 - State agencies not locally accountable
 - State on Board? Pros and Cons – “devolving responsibilities, integral partner, no local accountability, test question for pilot?”
 - Governor appoints someone to represent state
 - Legislative delegation appoints 1 republican and 1 democrat for state representation – model in other activity

- Advisory Board – doers
 - Where the work is
 - State agencies – in code
 - Consumers and families – in code
 - Medical professionals/providers

- Governing Board
 - Five County Commissioners / delegate
 - Legislators appoint one republican, one democrat
 - Chair of Advisory Board (vote and/or ex officio)

- Feedback
 - See child protection differently -don't know how it fits
 - Impressed in home, make them a part of the solution – control the front door
 - Child protection on Board – start the discussion, pursue referral process
 - Need a plan to review and evaluate
 - Frustrated that we won't get our own proposal in on time
 - Create a Board most responsive to our needs – poised to get SAMSA grant
 - Welfare needs to be more involved in health
 - Concern that this is an exercise in futility and no ability to move forward
 - Legislature won't fund anything new

NOVEMBER AGENDA

- Funding for a regional board to act

MESSAGES/SUGGESTIONS

- It's all about choice
- Present a plan and see if we can sell it.
- Have the numbers
- Develop a proposal with specific funding request (if we don't ask we certainly won't get it) – RAC has some Bring money with pilot

CONCLUSIONS

- Yes – we want to proceed with pilot
- Yes – we want legislation that enables us to pursue SAMSHA funding

Proposal
Region 2 Proposed Behavioral Health Structure
October 20, 2011

This is a draft document prepared by the Facilitator intended to represent the thinking of the group as reflected at the October 20, 2011 Region 2 Stakeholder meeting, building upon the work as documented in the September 15, 2011 meeting. This material is intended for consideration by the Behavioral Health Interagency Cooperative, with the understanding that additional opportunities exist to work with the Cooperative to provide further focus and clarification as a pilot process is considered.

Region 2 behavioral health stakeholders intentionally confirmed their interest in participating in this pilot process (with questions about how it could actually be piloted) and/or to moving toward the proposed configuration, as well as their desire to secure a grant-writer in order to pursue funding opportunities, as soon as possible.

Proposed Legal Form

Region 2 behavioral health stakeholders propose the development of a regional behavioral health entity, established through statute, which features a small, efficient governing body and a regional advisory board featuring a broad spectrum of behavioral health stakeholders.

Specifically, Region 2 proposes a Regional Behavioral Health Governing Body that includes:

- A County Commissioner delegate from each of the five Counties in the Region, and
- Two delegates identified by state legislators, one from the Republican and a second from the Democrat perspective.

The Chair of the Behavioral Health Advisory Board would also participate on the governing body, in either an ex officio or voting capacity, still to be determined.

The Regional Behavioral Health Advisory Board is proposed to feature the participation of a broad range of stakeholders articulated in state code to ensure the range of representation, to include:

- Representatives from agencies which have funding (DOC, IDJC, DHW, Medicaid, SDE, Judiciary, Counties, Veterans, Vocational Rehabilitation)
- Consumers, Families and Advocates
- Providers
- Law Enforcement
- Juvenile Justice
- Public Health District
- Representing: Youth and Adult
- Representing: Mental Health, Substance Use Disorder, Child Protection
- And others.

Specific numbers and construct are still to be determined.

The entity would eliminate the need for the existing Regional Mental Health Advisory Board and Regional Advisory Council structure. Stakeholders embrace the idea of the increasingly integrated approach in order to more effectively discuss and coordinate regional efforts.

Structure

The regional entity would have the capacity to hire, contract, and secure funding. Stakeholders are eager to generate this capacity as early in the legislative session as possible in order to pursue SAMSHA grants to support regional efforts.

Stakeholders seek funding from the outset in order to secure the services of a grant-writer to aggressively pursuing grant opportunities. An Executive Director and staff support are also envisioned for the entity.

The Regional Board would be part of a State Board of Regional Behavioral Health Boards affording them the opportunity to coordinate on the state level and identify and address issues of mutual concern.

Region 2 stakeholders have produced a visual of the new structure, included on the last page of this proposal.

Role and Responsibility

The regional entity will have the ability to pursue funding, hire staff, and contract for services. It will:

- Identify and work fill gaps in the community based on client needs, potentially starting with prevention and early identification;
- Secure the services of a grant-writer and pursue grants;
- Prepare to contract with funding agencies for the provision of community based and other services, as appropriate;
- Monitor, evaluate and improve the system, maintaining accurate/compatible data and reporting on outcomes (including customer, contractor, provider satisfaction)
- Have the authority and flexibility to make adjustments to the system, direct funding, and develop capacity in a manner both proactive and responsive to local needs, leveraging what already works well;
- Work to generate and integrate quality mental health and substance abuse services now and continue that effort to integrate behavioral health with physical health;
- Work to ensure that there is a continuum of services across the life span, providing for supports in those areas where funding restrictions or eligibility process leave consumers and families without supports for periods of time;
- Pay specific attention to finding ways to fill the service needs in rural areas;
- Develop good working relationships and partnerships within the community;
- Generate a system that is easily accessible to consumers and families;
- Provide community education and secure community input;
- Utilize a managed care model;
- Be fiscally accountable.

Core Services

Region 2 stakeholders are less concerned about the list of core services than they are working to ensure that services are provided based on the consumer's need. They see prevention, early intervention and education and transitions as an immediate opportunity, and they see a need to look at the whole system and all categories of service. They continue to emphasize the import of the pending Medicaid managed care contract and the anticipated 2014 adjustments to eligibility requirements. Knowing that providers support all payers of services, including Medicaid, state and private insurers, and that Medicaid is

prevalent, coordination with Medicaid is imperative in order to ensure an effective provider pool. They recommend another column on the list of core services which indicates private insurers.

Funding

Region 2 stakeholders emphasize that they need funding in order to act, and want funding to come with the pilot in order to help position them for success. Existing RAC funding, while minimum, was identified as an initial source. Their first step would be to secure a grant-writer to pursue immediate SAMSHA grant opportunities in order to support the development of the system.

The group confirmed their desire to:

- Minimize funding spent on administration and put as much as possible into programs and services;
- Contract with funding agencies for servicing their clients as appropriate;
- Reinvest savings back into the behavioral health system.

Region 2 stakeholders see an opportunity to focus efforts on prevention and intervention, acknowledging that re-alignments of how some existing services are delivered and pursuing opportunities and efficiencies without funding might comprise initial efforts. And while they discussed the reality that they may need to pursue unfunded initiatives, that if they can make the case for their approach they should make it and sell it.

Concerns and Considerations

- The availability of funding and the sustainability of the effort is a significant concern.
- Stakeholders want to see their efforts go into a program and into the community rather than something on paper that they share in another meeting.
- There is an acknowledgement of the fear of change – personally and by the community, counties, region, state agencies, and elected officials.
- There is a concern that the state is seeking to “devolve” itself of its responsibility, and a desire that the funding agencies are directly involved and engaged at the regional level. Articulating that, as well as the broad representation of the Advisory Board, is a help to address that concern.
- Stakeholders reiterated the need for a common language, and emphasized the use of the term "behavioral health" instead of "mental health" and "substance use disorder," to facilitate the integration of the system. Much of the discussion kept coming back to "mental health" even though it may have intended "behavioral health," and there is a need to be intentional about ensuring that both are addressed and that it truly becomes an integrated system.
- Multiple providers (not one state provider) are required to support the behavioral health system, which also spans multiple payers.
- A question was asked about the implications of the Jeff D lawsuit respective to this work and responsibility as a regional entity.
- A clear delineation of state and regional roles is necessary and helpful, identifying also what services remain with the state and what services come to the region.
- Stakeholders seek clear accountability in state rule regarding the regional role and responsibility. Specifically mentioned was the responsibility to collect needs, comply with the state mental health plan, and determine state requirements respective to the funding so that the region is clear on what it has to deliver.
- There is a recognition that providers support private, state and Medicaid clients to be viable, and this fact must be considered in the proposal and implementation process.

- The Medicaid Managed Care RFP and contract will move forward. Stakeholders seek a meaningful way to interact and coordinate with that effort.
- Stakeholders continue to question how such a structure can be piloted.
- Some stakeholders expressed concern that the region gets asked for its input and what works best for the region, that input goes to the state or the legislature, and then it comes back to them as something else. Then they adapt.

The following materials under "Vision" are intentionally carried over from the September 15, 2011 meeting for the group's future reference.

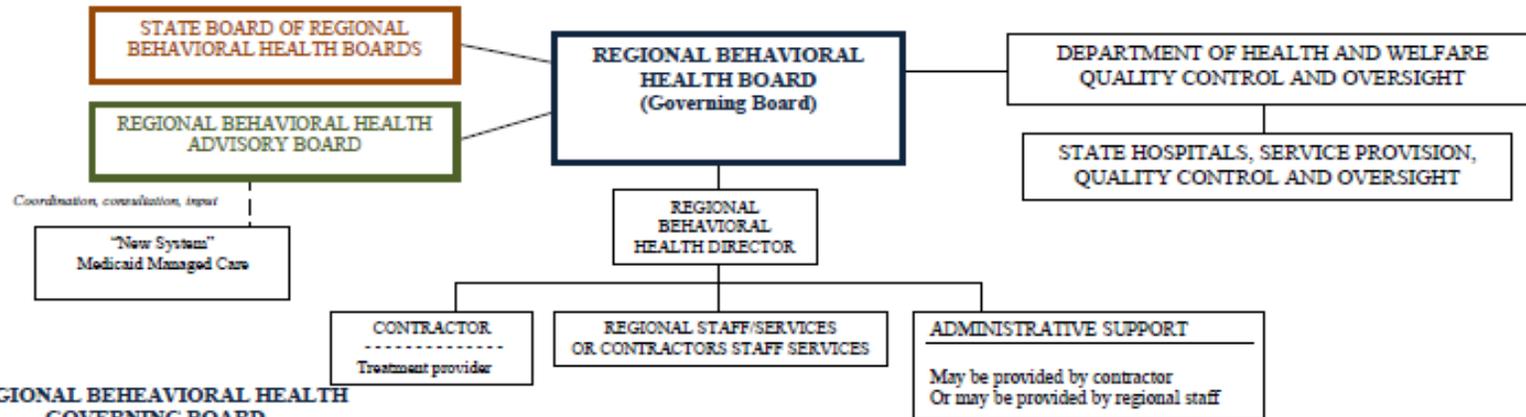
VISION

Region 2 stakeholders expressed their individual visions for a regional behavioral health system that:

- Integrates mental health, substance abuse and physical health and emphasizes prevention;
- Features education, prevention, early identification and support services;
- Is easily and simply accessible and available where consumers are without stigma and the need for criminalization;
- Features an integrated continuum of care that provides high quality care regardless of people's ability to pay;
- Makes quality services accessible to rural areas;
- Is a coordinated, integrated program across age and services;
- Is sustainable, comprehensive, and integrated across life span and Region 2 geography;
- Provides an infrastructure that supports people doing the work;
- Is collaborative - all elements of the system work together and work to meet the gaps;
- Is funded;
- Provides vital lifelines and stability;
- Provides the flexibility to do what will work in the region and the rural area, building on regional strengths.

THIS DOCUMENT IS FOR INFORMATIONAL PURPOSES ONLY

Region 2 Proposed Structure
IDAHO REGIONAL BEHAVIORAL HEALTH SYSTEM
 October 20, 2011



REGIONAL BEHAVIORAL HEALTH GOVERNING BOARD

- ◆ 1 County Commissioner/designee from each County in the Region (5)
- ◆ 2 Legislative delegates (1 Republican, 1 Democrat)
- ◆ Chair of the Regional Advisory Board (ex officio or vote?)

REGIONAL BEHAVIORAL HEALTH ADVISORY BOARD

- ◆ Representatives from agencies which have funding (DOC, IDJC, DHW, Medicaid, SDE, Judiciary, Counties, Veterans, Vocational Rehabilitation)
- ◆ Consumers, Families and Advocates
- ◆ Providers
- ◆ Law Enforcement
- ◆ Juvenile Justice
- ◆ Public Health District
- ◆ Representing: Youth and Adult
- ◆ Representing: Mental Health, Substance Use Disorder, Child Protection

STATE BOARD OF

- REGIONAL BEHAVIORAL HEALTH BOARDS**
- ◆ Chair of Regional Behavioral Health Board from each Region

REGIONAL BEHAVIORAL HEALTH BOARD RESPONSIBILITIES

- ◆ Appoints Chairperson
- ◆ Hires staff, pursues funding, contracts for services
- ◆ Responsible for local policies, procedures, finances and programs
- ◆ Provides for quality improvement
- ◆ Meets legislative intent
- ◆ Maintains accurate, compatible data
- ◆ Reports on outcomes (include customer, contractor, provider satisfaction)
- ◆ Identifies needs and gaps, works to address them
- ◆ Provides community education and solicits community input
- ◆ Provides services consistent with statewide standards
- ◆ Develops collaborate efforts, working relationships, and partnerships

FEATURES OF THE NEW SYSTEM

- ◆ Ability to use carryover funds
- ◆ More flexibility in community decisions
- ◆ Integrated with emphasis on prevention, consistency, early identification, accessible across life span
- ◆ Ability to contract for services
- ◆ Uses existing best practices
- ◆ Baseline policy set by state authority
- ◆ Consistent procedures
- ◆ Community collaboration and awareness (education and anti-stigma)
- ◆ Continuum of care
- ◆ Training
- ◆ Single point of entry/local responsiveness
- ◆ Decentralized/ representation