Second Annual Implementation Progress Report

May 31, 2018

Submitted under the
Settlement Agreement in
Jeff D. et al. vs. C.L. "Butch" Otter et al.

Contents

Youth Empowerment Services
Second Annual Implementation Progress Report

I. Introduction

On June 12, 2015, the State of Idaho finalized a Settlement Agreement with Plaintiffs regarding the *Jeff D. et al. vs. C.L. "Butch" Otter et al.*, Case No. 4:80-CV-04091-BLW class action lawsuit[1]. The Settlement Agreement required that an Implementation Plan be developed and an annual Progress Report be delivered to the Court and Plaintiff's counsel on progress the State has made operationalizing the Plan.

On April 29, 2016, the State submitted the required Idaho Implementation Plan[2] to the Court, which was subsequently approved. The Idaho Implementation Plan describes how the State will develop and implement sustainable, accessible, comprehensive and coordinated service delivery of publicly funded community based mental health services to children and youth with serious emotional disturbances in Idaho. Working with youth to help brand the effort, the state chose the name, "Youth Empowerment Services" (YES) for the new system.

This report, the Second Annual Implementation Progress Report, details the ways in which the State of Idaho, including the Idaho Department of Health and Welfare (DHW), State Department of Education (SDE), and Idaho Department of Juvenile Corrections (IDJC), are working together to meet the requirements in the Settlement Agreement and transform the mental health service systems for children and youth into an integrated system of care. The report provides information on accomplishments and progress on meeting obligations under the Settlement Agreement, remaining tasks, challenges to completing the objectives, and next steps in achieving the objectives of the Implementation Plan.

The Idaho Implementation Plan was organized around seven objectives necessary to accomplish the required outcomes of the Settlement Agreement and meet to the exit criteria. This report follows those seven objectives so that both progress and concerns are tracked and reported as the YES program evolves over time.

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[1] A full description of the history of the Jeff D. class action lawsuit is contained in Appendix A of this progress report.

[2] . Click here to access the full Idaho Implementation Plan. Additionally, some Strategies were reported on in last year's Annual Implementation Progress Report. That report can be accessed here.

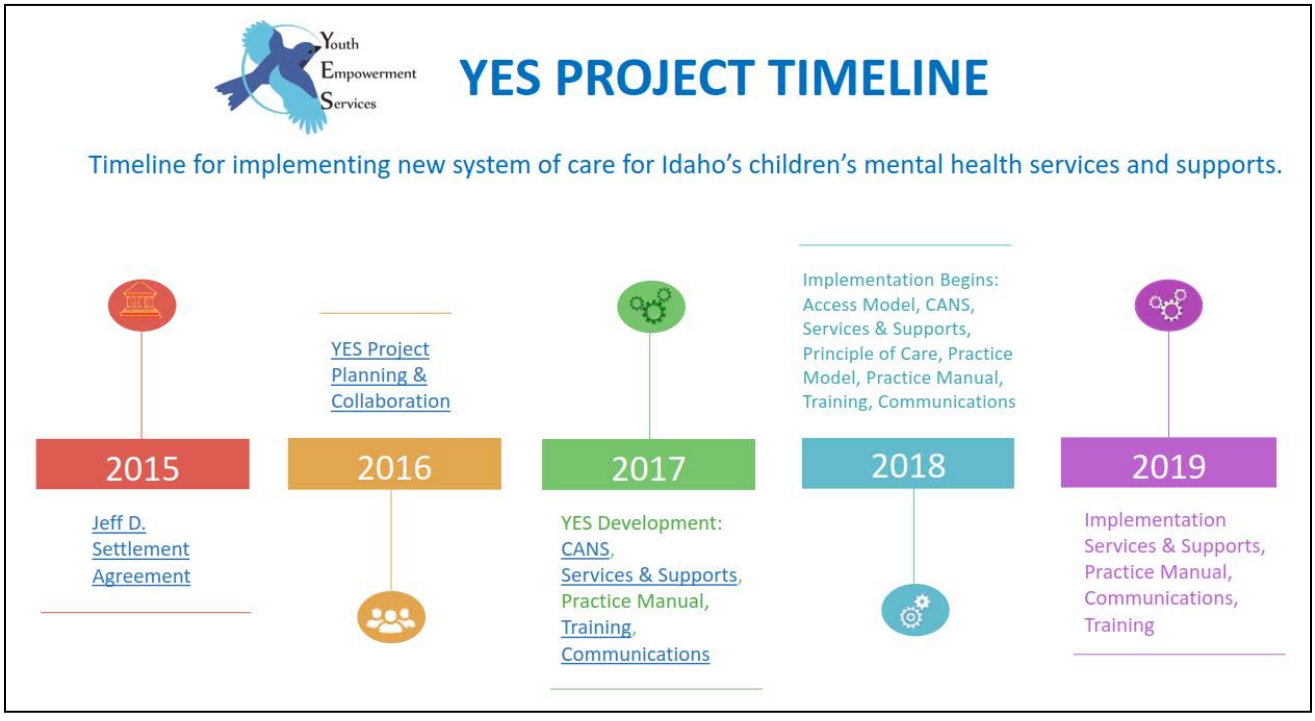
***If you are reviewing this report via printed copy, please visit the YES website to access the digital version/ for quick links to referenced documents provided within the report: www.yes.idaho.gov**

II. Executive Summary

Idaho's YES system partners are committed to developing statewide capacity to provide services and supports that are capable of meeting the needs of children, youth, and families in scope, intensity and duration. The development of the YES system is based on the requirements in the Settlement Agreement for establishment of YES Principles of Care and Practice Model, the YES Access Model, and the YES Workforce Development Plan (WFD). Additional elements of the YES system that will be transformed include building or enhancing the infrastructure that is needed to sustain the YES system such as due process, an interagency governance structure, and a coordinated collaborative process for quality management improvement and accountability.

The transformation of the child serving system into the YES system will take place over the next two years, with services and supports to be available within four years of the Settlement Agreement and a period of three years of sustainability which will begin in 2020.

The following diagram is a high-level overview of planned timelines to implement the YES system:



The planned transformation of children's mental health services in Idaho into the YES System requires the development of infrastructure to support the goal of implementing a sustainable, accessible, comprehensive and coordinated system. A majority of the work and resources have been focused in establishing that framework. There have also been changes made that directly impact children, youth and families that will result in

improved outcomes. Highlights of the achievement of transformation goals over the past year and significant work ahead are noted below.

Highlights of Achievements:

1. Enhanced collaboration and coordination between DHW, IDJC, and SDE to reduce fragmentation.

Key to the state's operationalization of YES has been continued collaboration across state administrative divisions and agencies. There are several collaborative workgroups that have been implemented over the past year that are working to establish the foundations for a system of care that is operating to reduce barriers for children, youth and families. The workgroups and committees include the Interagency Governance Team (IGT), the Quality Management Improvement and Accountability (QMIA) Council, the Communications workgroup, the Practice Manual Workgroup, the Due Process Workgroup, and the Workforce Development Workgroup.

There is a Memoranda of Understanding (MOU) which has not been fully executed[3] that will formalize the relationship between the various components of the child serving systems. With each success and challenge the YES system partners are learning more about how best to transform the system so that it reflects the desires of the community, as well as what is sustainable and achievable in operations, and will meet the requirements of the Settlement Agreement.

The State has also developed the Idaho Transformational Collaborative Outcomes Management (TCOM) Model describing how data will be used to assess and improve the system of care. TCOM is described as a conceptual and practical framework for managing complex systems.

2. Enhanced access to Medicaid benefits to increase access to mental health services.

To increase access to services Medicaid developed and submitted a 1915(i)-state plan option application to the Centers for Medicare and Medicaid Services (CMS) that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level (FPL).

As part of the 1915(i) option, Medicaid-reimbursed respite services were initiated. Full implementation of the Medicaid reimbursed agency-based respite services and companion certification requirements is scheduled for July 2018.

[3] The MOU has been signed by IDJC and SDE and is currently being reviewed by the Director of DHW.

In addition, Medicaid is improving access to Psychiatric Residential Treatment Facilities (PRTF) services by streamlining the review process to better meet its obligations under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for Medicaid programs. The Department of Juvenile Corrections has advanced its Behavioral Health Referral pilot that promotes identification of youth mental health needs to assist staff in determining appropriate placement/treatment as early as possible. IDJC staff is also being trained on how the CANS can help staff improve outcomes for involved youth.

3. Implementation of the Child and Adolescent Needs and Strengths (CANS) assessment to identify and screen potential class members and link them to care according to consistent procedures.

The CANS and ICANS, the automated system for documenting CANS assessments, are operational in all seven regions of the state. As of March 31, 2018, there were 212 individual active CANS certifications. As of April 30, 2018, there were 521 Children's Mental Health CANS administered by Division of Behavioral Health (DBH) staff, and 484 CANS 50s administered by the Independent Assessment Provider. Idaho expects to meet its goal for beginning to use the CANS statewide by July 1, 2018.

4. Engagement and involvement of youth and families of Class Members in system improvement and planning efforts.

Of significant note is the ongoing development of the relationship among the partners and the families in Idaho in the work to build the YES system of care. Organized and branded as the "Parent Network," parents of children with serious emotional disturbance (SED) have joined the project as partners in achieving this transformation.

In recognition of the value of parents' and youth voice in the project the state has developed a method for compensation for their time. The state designated a Family Liaison, and has provided opportunities to youth and parents to participate in developing training content and deliver YES-related trainings that are reflective of family voice. The state is also engaging the Parent Network and youth organizations to help create content for YES materials, and to review content of informational materials to improve readability and comprehension.

Youth have assisted with creating content for the *Introduction to Youth Empowerment Services* guide, Youth Frequently Asked Questions document, and have begun working on a preliminary checklist that youth can use to pre-screen themselves and start the conversation about their mental health needs. Youth have also provided feedback on training content and are currently assisting with the development of a youth-targeted training plan.

Information for parents, youth and other stakeholders about YES have been developed and communicated through:

- YES website with Parent and Youth voice, addition of Spanish translation site, training page for training information and registration links, training videos, calendar of events, and downloadable YES materials
- ICANS website for CANS users which includes announcements, training information, resources and user guides, FAQ's and information for families
- YES Training playlist on Idaho Department of Health and Welfare's YouTube Channel
- Idaho Department of Health and Welfare (DHW) Social Media blog post regarding the Independent Assessment process and Mental Health Assessments available
- Idaho DHW Twitter messaging

To build a program that supports and sustains family and youth involvement at all levels of the YES program, the Department of Health and Welfare's Division of Behavioral Health is developing a *Family Youth Involvement and Support* contract. Details regarding this contract can be found in Appendix G.

5. Established a collaborative governance structure that includes Defendants agencies, Class Member's families and other stakeholders.

The Interagency Governance Team (IGT) began meeting in October of 2016 and continues to meet monthly. The IGT is intended to facilitate collaboration among agencies and stakeholders, increase transparency and accountability, and afford opportunities for team trouble-shooting and problem-solving. The IGT membership includes parents, a former Class Member, family/youth advocacy representatives, providers, and agency representatives from Medicaid, DBH, SDE and IDJC. During this past year, the IGT members have formed both the Family Engagement Subcommittee and the Clinical and Training Subcommittee. The IGT also drafted and approved Operational Guidelines that outline the team's processes and procedures.

6. Implemented Legislative Changes

The 2017 legislative session was successful in terms of advancing the Idaho infrastructure in support of the new system of care. Legislative allocations were secured for adding staffing resources to the Division of Behavioral Health (DBH) needed to implement the project objectives and operate the new system. Further, the legislature approved a modification of state statute to allow children with serious emotional disturbance access to Medicaid up to 300% of the federal poverty level. The Divisions of Medicaid and Welfare developed and presented Idaho Administrative Procedure Act (IDAPA) rule changes to implement this statute change, these rules were approved. Since increased of traditional income limits will enable larger numbers of families to become eligible for Medicaid coverage, the state anticipates that this change will allow additional children with SED in Idaho increased access to care.

7. Planning for a new Adolescent State Hospital Facility[4]

The Idaho State Hospital System is a government not-for-profit healthcare system that serves as a safety net for those who are unable to get their behavioral health needs met in Idaho's community psychiatric hospitals. The goal is to improve the Behavioral Health and wellbeing of individuals emphasizing care that is trauma informed, patient centered and physician led. Idaho State Hospitals are under the Division of Behavioral Health (DBH) within Idaho Department of Health and Welfare.

The current adolescent unit is on the State Hospital South campus located in Blackfoot Idaho. The unit is a 16-bed facility that cares for youth age 12-17. Approximately 65% of the adolescents admitted come from the Treasure Valley. Locating the adolescent care in a new hospital in Nampa Idaho will offer care and treatment closer to most patient families and increase the ability to have family involvement. The location of the of the new hospital will also give greater ability for families to be part of the transition services for the youth.

The new hospitals' planned opening is the summer of 2020.

Idaho still has significant work ahead, including:

1. Developing a comprehensive and collaborative system of care.

Developing and implementing a comprehensive system of care that connects multiple, fragmented service systems operated by a diverse array of state agencies (State Department of Education, Idaho Department of Juvenile Corrections, and within the Idaho Department of Health and Welfare, the Divisions of Medicaid, Behavioral Health and Family and Community Services) in compliance with the deadlines required by the Settlement Agreement was always expected to be a big lift. The leading challenges involve system design and integration, payment mechanisms, and ensuring fidelity to the YES principles of care and practice model.

Children and families who need access to agency respite, or who have income between 185 and 300 percent of the federal poverty line, must use the 1915(i) procedures to access YES. Families and youth who already have Medicaid, and those who are over income, access services in other ways. Moreover, each of these pathways has different funding characteristics, mixing federal, state and, private resources. Managing these multiple access pathways and funding streams poses many challenges that are still being worked out.

[4] While not specifically related to the Implementation Plan the Adolescent Unit of the State Hospital System will improve children's mental health services and was therefore included in the report.

In addition, existing mental health services provided in Idaho—to say nothing of new services—are not yet consistently compliant with the YES Principles of Care or the YES Practice Model, as called for in the Settlement Agreement. Steps to resolve this challenge, including, developing operational policy and standards for provider contracts and provider manuals and training, remain to be completed.

2. Timely delivery of the full array of services required in the Settlement Agreement.

Development of the full array of services for Medicaid is underway, although not all of the required YES services are certain to be fully available statewide by July 1, 2019. The state does intend to have each Medicaid reimbursable service operationally defined and billable by then, as required.

Many YES services will require provider development and business diversification stretching the provider network both in their business and clinical models. As a state with many rural areas it is important to understand that some of the services require a population base and specialty network that is not realistic nor sustainable in those areas. This will require considerations and adaptations to meet the members where they are in their communities, working with the families to fill the gaps and/or linking to services in neighboring areas.

For services that require intensive development and adoption by the network, Medicaid will work with Optum Idaho to ensure availability in the highly populated areas that are likely to have providers with the ability to adopt and implement them. Work will continue to expand service availability based on network capacity and workforce development.

Education and training are key components to prepare the network to provide the services beginning with the foundations of the Practice Model and Principles of Care to support the service delivery. Optum Idaho has contracted with the Praed Foundation to train and support the network for the CANS implementation and changes to the treatment planning process. Implementation of Child and Family Teaming will begin July 1, 2018 and evolve with inclusion of the ICC and Wraparound models in January 2019. Medicaid is working closely with Optum to offer trainings with no/to low cost to support the network in engagement and attendance. Additional considerations include scholarships and financial support for providers in rural areas that could not sustain absences to participate in trainings which would result in significant loss of billable time.

Detail to support the service implementation plan can be found under Strategy 1.J within this report.

3. Workforce issues, such as training, recruitment and retention will be an on-going challenge.

Implementation of the Workforce Development Plan will continue. Included in this plan is the development and training of an adequate workforce and provider network to support and implement the YES compliant array of services, and meet the needs of children, youth, and families.

Foundational trainings about the YES program were attended by 94 agencies and more than 290 individual providers. Topic areas included: introduction to the Settlement Agreement, a high-level introduction of the Principles of Care, Practice Model, Child Family Teams, Wraparound, CANS, and the Access Model.

As the system evolves and develops, evaluating service gaps and reimbursement methodologies will continue. Network capacity reports, utilization data, and provider readiness surveys can assist in informing next steps needed to increase access. Alternative reimbursement methodologies will support quality outcomes and provider development. Also, work continues regarding provider recruitment and the use of telehealth, especially for rural areas.

4. Guidance and Communications about the nature and purpose of services and how to access them.

The intended purpose of the YES Practice Manual is to provide information to all Stakeholders about YES services and supports and how they can be accessed. There were several challenges which delayed the publication of this document, however a smaller introductory guide was developed to satisfy the immediate need for information. Going forward, the state will make amendments to the guide periodically as more services come on line and as managers, providers, and families test and work to improve the system. More information regarding Practice Manual progress, challenges and next steps can be found here.

5. Developing quality monitoring of mental health services for children and youth.

The YES quality monitoring processes are covered in the Quality Management Improvement and Accountability Plan (QMIA). In accord with that plan, the QMIA Council has been established and has implemented the Data and Report (D&R) Subcommittee. The D&R Subcommittee is working on identifying methods for collecting meaningful collaborative system data to inform quality improvement, measure processes, outcomes and impact, and communicate about system performance. Reports on YES system quality (QMIA- Quarterly) have been published on the YES website. Reports on system capacity, projected numbers of class members, and the potential need for Intensive Care Coordination/Wraparound are available on the website as well. The data

collection based on CANS is in development and reports are in the early stages of development.

6. Due Process

It is the goal and obligation of the state to operate a Constitutionally and federally-compliant fair hearing system, in part by creating and operating a centralized complaint routing and tracking system. Furthermore, each child-serving agency will implement a process for reviewing compliance to applicable regulations, rules, and policies regarding due process requirements, and periodically report on the metrics of operating this system. This entire process will be included in the Practice Manual and will be coordinated with the Quality Management, Improvement, and Accountability (QMIA) goals, plans, or results.

In seeking to achieve these results, a few challenges have arisen, including a changing federal landscape relating to Medicaid regulations. As a result, there appear to be conflicting requirements in the law and the terms of the Settlement Agreement and Implementation Plan. In addition, procedural variances among agencies need to be ironed out, the fix for which may require changes to Idaho Administrative Code (IDAPA) rules. Finally, improving the notice and appeals process through more family-friendly language and procedures is needed.

III. Structure of the Annual Implementation Progress Report

The Annual Implementation Progress Report is organized as follows.

Sections I and II provide an Introduction and Executive Summary. The Executive Summary provides a brief overview of the State's progress in developing and implementing YES.

This section, Section III describes how the Report is structured.

Section IV reports the progress towards achieving the Objectives of the Court approved Implementation Plan, challenges, and next steps to address any identified problems. The section is organized into the following chapters which correspond with the Implementation Plan Objectives:

1. Services & Supports
2. Principles of Care and Practice Model
3. Access Model
4. Workforce Training and Development
5. Due Process
6. Governance and Interagency Collaboration

7. Quality Management, Improvement, and Accountability

Each of the seven chapters contains information about the implementation progress and accomplishments, challenges and next steps. The narrative provides a summary of activities taken to achieve the Objective. The Challenge sections describe issues or barriers that have impacted progress, and the Next Step sections include plans to resolve challenges and/or facilitate continued progress toward implementation.

Section V of the Report provides information on the progress towards achieving the Settlement Agreement Outcomes which are the expected results from completing the Implementation Plan. The Outcomes are listed within the table and there is a link provided to narrative that is associated with the section in the Court approved Implementation Plan.

Following Section V is a Glossary and Appendices providing additional information relevant to the Report.

IV. Progress in Achieving Implementation Plan Objectives

This section of the Report addresses each Objective in the Court approved Implementation Plan and detail the progress toward achieving the strategies listed in the plan.

Each **Objective** below is written as stated in the Court approved Implementation Plan and is accompanied by a brief description. The *Strategies* under each objective (bolded) are stated in a summarized version. Some *Strategies* may be grouped together since they may build upon each other or are otherwise connected.

Objective 1: Provide Services and Supports to Class Members consistent with the Agreement

The agencies will progressively make available to Class Members and their families the medically necessary services/supports as described in the Agreement to match the Class Members' strengths and needs in a timely manner.

Strategies 1.A- 1.D

A. Operationally define the array of services and supports.

As noted in the first Implementation Progress Report, a team of agency staff, parents and other stakeholders (the Services and Support Workgroup) reviewed the 26 services listed in the Settlement Agreement Appendix C in 2016, researched what was being provided, looked at how other states were providing services, and made some recommendations about how to improve services in Idaho. A second group (the Clinical Advisory Workgroup), also reviewed the services to add clinical details to the service definitions.

These service definitions and clinical recommendations were provided to Medicaid to determine which of the services, as defined, could be reimbursed through Medicaid and if there are any parts of the services that cannot be reimbursed under Medicaid authority. The result of Medicaid's analysis was a determination that most of the services and supports will be Medicaid reimbursable, and the services or parts of services that cannot be reimbursed by Medicaid will be developed by the other partners.

The Medicaid reimbursable services include:

1. Child and Adolescent Needs and Strengths (CANS)
2. Comprehensive Diagnostic Assessment
3. Neuropsychological
4. Psychological Testing
5. Case Management
6. Integrated Substance Use Disorder Services
7. Treatment Planning
8. Case Consultation
9. Intensive Care Coordination
10. Medication Management
11. Psychotherapy
12. Respite
13. Transportation
14. Psychoeducation
15. Family Support
16. Youth Support
17. Skill building
18. Behavioral Therapeutic Aide
19. Therapeutic After School and Summer Programs
20. Intensive Home and Community Based Services
21. Day Treatment
22. Inpatient Hospitalization
23. Treatment Foster Care (partial coverage)
24. Psychiatric Residential Treatment Facility (PRTF)
25. Crisis Response
26. Crisis Intervention
27. Crisis Respite

The non-Medicaid reimbursable services include:

1. Flex funds
2. Respite provided by family members
3. Treatment Foster Care (partial coverage)

B. Determine which services and supports are currently available

The following mental health services are currently available to children and youth when they will correct or ameliorate the child's behavioral health condition:

- Comprehensive Diagnostic Assessment
- Neuropsychological Testing
- Psychological Testing
- Medication Management
- Psychotherapy (Individual, Group and Family)
- Case Management
- Community Based Rehabilitation Services (CBRS)
- Respite
- Family Support Services
- Intensive Outpatient Services/Day Treatment
- Wraparound
- Inpatient Hospital Services
- Psychiatric Residential Treatment Facility (PRTF)
- Treatment Foster Care
- Transportation of Participant (or Participant and Family)

Not all services are available in all regions. PRTF is currently only available at an out-of-state facility. There are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho, although we expect one facility to become licensed in Summer 2018.

These services will not be YES compliant until implementation of the Practice Model and Principles of Care is complete, June 2019.

C. Determine which existing services and supports need to be modified

The mental health services provided in Idaho (e.g. those listed above) are not consistently compliant with the YES Principles of Care or the YES Practice Model, as called for in the Settlement Agreement.

In order to assure that services are YES compliant The Divisions of Medicaid and Behavioral Health (DBH) plan the following:

- Develop operational policy and standards for application of the Practice Model and Principles of Care to be referenced in contracts and incorporated into provider manuals, practice standards, and training.
    - Medicaid collaborated with DBH and the State's consultant, Dr. Lynn Thull, a contractor of the Praed Foundation, to create operational documents to support the education and implementation of the Practice Model and Principles of Care
    - Optum Idaho's provider manual will include the reference and requirements for providers to adopt these in their practices

- Optum Idaho will include these components in their training curriculum

- Implement CANS as the required assessment and communication tool for mental health providers serving children and youth.
  - Optum Idaho has contracted with the Praed Foundation to provide CANS training over the next year with the goal for all providers serving youth to utilize the CANS by June 2019
  - Optum has collaborated with DBH to focus on high volume providers serving youth to become compliant in use of the CANS on the web-based ICANS platform beginning July 1 2018
- Provide CANS Training for all qualified providers (CANS training details here)
  - To support the network fully utilizing the CANS by July 2019, Optum Idaho has contracted with the Praed Foundation to conduct trainings throughout the next year and with DBH to provide ongoing trainings for the ICANS platform. Plans also include how to maintain training availability based on growth and addition of new providers in the network.
- Provide training for DBH Children's Mental Health Regional Clinic staff
  - 2nd session of 4-day Wraparound Coordinator training by Portland State University (June 25-28)
- Provide training for all Medicaid contracted mental health providers
  - 2017 and planned 2018 training to improve current and implement new services include;
    - YES Navigation Series (YES foundation, services, level of care guidelines, Treatment Planning, Provider Manual, Practice Manual, Reimbursement)
    - Child and Family Team, Person-Centered Planning, and Wraparound participation
    - Skill Building/Community Based Rehabilitation Services Series
    - Respite Series
    - Crisis Intervention
    - Psychoeducation
  - 2019 Planned training to improve current and implement new services include;
    - Case Management
    - ICC
    - Child and Family Team, Person-Centered Planning, and Wraparound participation and facilitation
    - Crisis Response
    - Crisis Respite
    - Family and Youth Support
    - Day Treatment
    - Therapeutic After school and summer based programs
    - Integrated Substance Use Disorders
    - Behavioral Therapeutic Aide
    - Intensive Home and Community Based Services

- Develop the Medicaid Provider Manuals, Medicaid Member Handbooks, and the YES Practice Manual.
- Conduct QA including Fidelity based on the Quality Management Improvement and Accountability (QMIA) Plan, the Transformational Collaborative Outcomes Management (TCOM) Model, and the Quality Review.

YES Focus on Case Management

Medicaid is working to develop a new service coordination and case management model with requirements for the case management network serving children with mental health needs. Medicaid has issued an Request for Information (RFI) regarding System of Care navigation, person-centered plan development, child and family team facilitation, case management, service coordination, Intensive Care Coordination, and monthly monitoring of Medicaid SED Program participants to gain information for implementation in early 2019.

D. Determine which services and supports need to be added

The Medicaid implementation team has been developing strategies for the implementation of additional Medicaid Mental Health services and supports based on technical assistance provided through interactions with The Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA) and the Technical Assistance Network (TAN). As explained above, Medicaid is working on the development of the new services that will meet Medicaid authority and reimbursement requirements. These include:

1. Psychoeducation
2. Youth Support
3. Behavioral Therapeutic Aide
4. Day Treatment
5. Therapeutic After School and Summer Programs
6. Intensive Home and Community Based Services
7. Crisis Respite
8. Crisis Response

YES Focus on adding Respite and Wraparound

Respite

In the Fall of 2017, Medicaid focused on implementation of the new Medicaid reimbursable respite service for initial rollout in January 2018. This required collaboration with DBH to transition agency-based respite from DBH to a Medicaid-reimbursable service. This work will continue for a full launch of respite in July 2018.

Wraparound

Wraparound is a collaborative, team based, principles driven, planning process. Through the wraparound process teams create one individualized plan of care to meet the needs and improve the lives of multisystem involved youth and their families.

Wraparound

"Wraparound is a planning process that follow a series of steps to help children and their families realize a life that reflects their hopes and Dreams. Wraparound also helps to make sure children and youth grow up in their homes and communities. It is a planning process that brings people together from difference parts of the family's life. With help from one or more facilitators, people from the family's life work together, coordinate their activities, and move closer together in their view of the family's situation. The process of coming together always includes the family as a central partner in building as coordinated view. "

National Wraparound Initiative, Wraparound Implementation Guide

A sub-committee was created by the YES Clinical Advisory Committee in early 2017 which included parents, Regional Clinicians, and Children's Mental Health Chiefs to assess viable wraparound models to consider for the YES Program. The sub-committee identified the model of the National Wraparound Initiative (NWI) as an option for YES. The sub-committee presented their findings to the Clinical Advisory Committee and DBH leadership to inform decision making for implementing Intensive Care Coordination (ICC).

In July of 2017, seven Regional Program Specialists were hired by DBH as the first step to developing the workforce of Wraparound Coordinators. These Program Specialists were also selected to be the regional subject matter experts on the upcoming changes in the system of care.

DBH led the development of a contract with Portland State University (PSU) System of Care Institute (SOC-I) to provide a series of trainings on Wraparound, Child and Family Teams (CFT), and System of Care. In August of 2017, a contract was in place for the trainings, and the first System of Care trainings occurred in September for the Regional Program Specialists, Children's Mental Health Chiefs, Regional Managers, and other YES stakeholders.

The training phase for Wraparound began in February of 2018. During the training phase:

- The Wraparound roll-out started with offering services to existing DBH Children's Mental Health children, youth and families.
- Each Regional Program Specialist trained in Wrapround coordination skills began with a target to serve 2 -4 families by the end of May.

Within two to three months of being trained, all seven Program Specialists are expected to be serving at least 4 families, and within 6 months up to 8 families. Additional DBH

staff (15 staff) will be trained to provide Wraparound June 25-28. This will increase the capacity for Wraparound services to approximately 130 families by the end of December.

Challenges

1. In order for YES services to be Medicaid payable, the following prerequisites must be met:
    - CMS approval of authority documents,
    - Legislature approval of rule changes,
    - Medicaid contracts or amendments to meet requirements,
    - Network capacity, access, qualification, and training.
    - As these conditions evolve and information is gleaned from reports and surveys, implementation timelines may accelerate or be delayed based on the network's readiness.
2. Medicaid and DBH are working together to identify all services that are required and which will not be Medicaid payable by June 2019. If required services are not Medicaid payable, DBH along with YES System partners will evaluate alternative funding options.
3. Access to Respite services is not Statewide as there are limited number of providers.

An additional challenge was contributed by parents working within the YES project:

- Making sure services are available to both Medicaid and non-Medicaid Class Members, including those over the 300% Federal Poverty Limit (FPL). Thus far, only a piece of this has been part of the discussion which is the sliding fee scale concept. There is more work to be done to be able to deliver coordinated services for all children.

Next steps

- Medicaid is developing a crosswalk that compares services that are payable or will be payable by Medicaid as of June 2019 with services that are required in the Settlement Agreement. This crosswalk will assist in identifying services that require alternative funding mechanisms.
- Medicaid is gathering the feedback received from families, providers and vendors regarding the Person-Centered Plan/ Case Management/ Monthly Monitoring Request for Information. Medicaid will discuss that information with both the IGT and IWG and, based on their feedback, will proceed with the development of a Request for Proposal for these services. Target implementation date is January of 2019.
- In concert with the Praed Foundation and Optum Idaho, the behavioral health managed care entity, Medicaid is developing targeted training and communications for all stakeholders, including Medicaid participants and the provider network.

- Optum Idaho, is working to increase the number of respite providers.
- An addendum to the contract with PSU to be completed by the end of June 2018 offers an opportunity to increase the trained wraproud workforce so the DBH can expand access to Wraparound. The goal is to train 45 additional DBH staff by the end June of 2019.
- DBH will co-train Wraparound trainings with PSU beginning in early 2019 and will be the primary trainers for Idaho Wrapround by fall of 2019.
- Work to align services and supports with the CANS (i.e., refining algorithms to improve accuracy) began in late Fall of 2017 after the CANS algorithms were finalized. This work continues as new information becomes available. Medicaid engaged the behavioral health managed care entity and the Praed Foundation to create a CANS/Level of Care Guidelines (LOCGs) crosswalk to assist DBH staff in developing the person-centered plan. This work will continue throughout the implementation of Medicaid YES services.

Services and Supports: Parent Perspective

"The Jeff D. settlement requires that all children with SED have access to the services and supports listed in the agreement. While many of these children will access services through Medicaid, others will access through Division of Behavioral Health or even through private providers. Meeting this requirement of the settlement agreement, a coordinated system of care that involves multiple payers, will require an intense level of collaboration among divisions and agencies that hasn't historically occurred in Idaho's children's mental health system. While much progress has been made in getting all of the partners to the table, the project faces challenges in making sure everyone is communicating in a way that encourages a coordinated system of care for ALL of the children represented by the Jeff D. settlement agreement."

Strategy 1.E

Determine reimbursement methodology and guidance to providers 60 to 120 days prior to rollout of each service

The service reimbursement methodology and guidance will be available to the provider network through the following process. 60-120 days in advance.

- Provider Alerts distributed via Fax, e-mail and website notifications to contracted providers
- Provider Newsletter Updates
- Training Announcement: Training overview, type and objectives of training certification/credentials/CEUs, and logistic details provided
- Service Notification: Service overview, reimbursement detail, service requirements, and level of care guideline

- Additional communication and support is provided by Optum staff statewide when interacting with providers in a variety of supportive roles

30-60 days prior to service implementation:

- Provider Manual Update Notification: Includes the updated provider manual content for review which is a contractually binding document
- Provider Agreement Update (if required): Provider contract updates if necessary
- Distribution of updated provider fee schedules

Next Steps:

- Quarterly provider training scheduled for June 2018 on YES services, Level of Care Guidelines, Provider Manual, /Reimbursement.
- Optum will implement an Evidenced Based Program (EBP) Library on-demand for Skills building topics, July 2018.
- Optum plans to provide training on Crisis Intervention September 2018.
- During the fourth quarter of 2018 Optum plans to provide training on Multi Family Therapy, Crisis Respite, and Psychoeducation.
- Additional training is planned for Quarters 1-4 of 2019.

Strategy 1.F

Reevaluate gaps and reimbursement methodologies to increase access to services statewide over time.

Plaintiffs requested that a crosswalk of all required services be developed to evaluate gaps in planned implementation of services, and the reimbursement methodologies to which the Defendants agreed. The crosswalk will delineate variations between the services required by the Settlement Agreement and the services that are billable by Medicaid. Once the differences between the requirements and the payable services have been identified the YES system partners will assess options for funding the remaining services.

As the system evolves and develops, evaluating gaps and reimbursement methodologies will continue. Network capacity reports, utilization data, and provider readiness surveys can assist in informing next steps needed to increase access. Reimbursement methodologies will support quality outcomes and provider development. Also, work continues for provider recruitment and the use of telehealth, especially for rural areas.

Strategy 1.G

Estimate and report the number of Class Members on an annual basis.

The Department of Health and Welfare (DHW) contracted with Boise State University (BSU) School of Social Work to evaluate the methodology used by the DHW to estimate Class Member potential service utilization in 2017. BSU's evaluation ultimately recommended that DHW continue using the 2016 estimation methodology as an interim strategy for monitoring progress toward meeting the needs of youth with a serious emotional disturbance (SED). Additionally, BSU recommended the Department work to

leverage data collected by national surveys to eventually develop a more robust Idaho estimate of SED. The full report, titled *Evaluation of a Methodology to Estimate the Prevalence of Serious Emotional Disturbance in Idaho*, can be found on the Idaho YES website. Click here to view this report.

The Class Size Estimation Team (CSET), made up of both DBH and Medicaid staff, have developed an updated Class Membership estimation report utilizing recommendations from BSU when possible.

The CSET estimated that there may be 35,000-40,000 children in the state of Idaho with SED. Of those, they estimated that 12,000-22,000 may seek to access mental health services at some point, either through the YES Program or through private insurance sector. It is expected that the initial engagement rates may be substantially lower based on many studies that have found that engagement rates vary between 34% (Zachrisson et al., 20006) to 56% (Bourdon et al., 2005) of eligible youth.

Intensive Care Coordination Utilization Estimate

To monitor progress toward meeting the needs of Idaho youth with serious emotional disturbance (SED), an estimate was needed of the number of youth who are likely to need/ utilize Intensive Care Coordination (ICC). The Department of Health and Welfare (DHW) contracted with BSU School of Social Work to estimate the need for ICC. For this projection, one of BSU's two methodologies utilized clients-served data from DBH, Medicaid and Family and Community Services (FACS). The second methodology resulted in three different projected levels of ICC utilization. This subsequent methodology was based on ICC utilization data from 11 other states and criteria outlined by the Centers for Medicare and Medicaid Services (CMS). The CMS criteria categorizes ICC programs into three phases of implementation, from newly emerging to well-established.

Projected number Youth to utilize ICC per year[5]

Level of Program Implementation	*Implementation Benchmarks*	*Projected # of Idaho Youth to utilize ICC per year, per 100,000*	*Projected # of Idaho Youth to utilize ICC per year*
Emerging	*High quality wraproud being piloted or in early stages*	*65*	*284*
Evolving	*Program is established and expanding Statewide*	*144*	*628*
Established	*Program is fully established and includes a full array of services and supports*	*318*	*1,389*

[5] Extracted from BSU report: *Estimated Need for Intensive Care Coordination among Idaho Youth*.

Based on BSU's full analysis, in 2016 there are approximately 1,400 Idaho youth who likely need ICC. The full report, titled *Estimated Need for Intensive Care Coordination among Idaho Youth*, can be found here.

Challenges

1. The defendant agencies do not share an electronic health record system and do not identify data variables in the same way, therefore data from each agency indicative of Class Membership status could not be consolidated or unduplicated.

Next Steps

- Continue to refine the methodology for estimating the expected number of Class Members. Refined methodology will need to consider ways to avoid duplicated counts of clients served across agencies.
- Explore the National Health Interview Survey (NHIS) restricted release data files application process to develop an Idaho-specific SED prevalence estimate based on Idaho state data.
- Use the Class Membership estimate to routinely evaluate system progress in meeting the needs of Idaho youth with SED.
- Develop reports addressing the current utilization of "intensive services" in order to establish a baseline for comparison as the YES system develop over time.

Strategy 1.H

Assess system capacity.

Building statewide capacity for services and supports began with understanding what the capacity is now in Idaho. The Workforce Development Team identified the methodology for this assessment would be in-depth provider survey and report on provider profiles. The purpose of the research was to assess current behavioral health workforce capacity and gaps in publicly funded services, synthesize the findings, and include this synthesis in a final Workforce Capacity and Gaps Analysis report.

To perform the work of analyzing the system capacity DBH contracted with BSU School of Social Work. Medicaid agreed to collaborate and utilize the results of that survey as a baseline before creating additional capacity studies specific to the Idaho Behavioral Health Plan (IBHP) network. A draft report has been delivered to DHW, and the final report will be published by the end of June 2018.

The survey that was conducted reached 250 organizational leaders of mental health programs and 142 solo practitioners. The response rate was 60%+ for both groups. Of the 152 organizational providers that responded 125 serve children and youth between the ages of 4-18, and of those 47 provide services to children between the ages of 0-3. Of the 92 solo providers 69 provided services to serve children and youth 4-18, and only 20 provide services to children 0-3. A large majority of the providers were white and female.

The BSU Provider Survey Report also has information about the communities they serve, types of services they provide, the languages they speak, how they provide services, how they conduct recruitment and what they do to retain staff at their programs. BSU's report includes recommendations that will be reviewed by the Workforce Development Team.

Next Steps

- DHW will utilize the gap analysis information to make informed decisions about what is needed to close gaps and improve workforce and service availability as the YES system continues to develop.
- The QMIA Plan includes measures to assess network capacity specific to services with provider-scarcity challenges (e.g., residential care, treatment foster care, therapeutic after-school and summer programs, etc.), as well as to evaluate the training needs, the impact on access to those services and identify the support the provider agencies need in growing and diversifying their businesses.

Strategy 1.I

Draft a Project Plan

The YES Project Plan was completed in 2016 and reported in the 2017 Annual Implementation Progress Report.

Strategy 1.J

Implement the full array of services and supports based upon prior Strategies by June 30, 2019.

The order in which the services will be implemented has been in flux. The information provided below is the current anticipated order of service implementation (as of May 31, 2018) and was built with input from the Plaintiffs and consultant Lynn Thull as well as considering clinical and network readiness concerns. The implementation timeline below targets all Medicaid reimbursed services being *available* by June 30, 2019; *this is a compressed timeline as the Defendants have consistently reported to the Plaintiffs and the Court that Medicaid reimbursed services would be rolled out through June 30, 2020. Based on the definition of available below*, Medicaid is working to make all Medicaid reimbursable services available by June 30, 2019.

Each service will be considered *available* when the following tasks are complete:

1. The service has been updated in or added to Medicaid authority documents,
2. Contracts and provider agreements have been updated to include the service,
3. Medicaid providers have access to the training,
4. The service has been added to the provider manuals and fee schedules,
5. Providers are able to enroll to bill for the service.

The actual *availability* of Medicaid-funded services shown below will depend on each provider's ability to engage in training and add these services to their scope of practice. Providers in the urban areas of Idaho are much more likely to be early adopters as they

serve larger populations, are more likely to be agencies rather than sole proprietors, and most likely have more resources available to expend on new service implementations. Medicaid and Optum Idaho have considered these challenges and are providing the following incentives to encourage the provider network to participate in training and provide the new services as quickly as possible.

- Training modules will be available through in-person classes, webinars, and online self-paced courses
- Training modules will provide Continuing Education Units (CEU)s at little or no cost to the provider network
- Some trainings and certifications may allow the provider to be eligible for a higher service reimbursement rate

Medicaid Service Implementation Timeline:

July 2018 – October 2018:

- Child and Adolescent Needs and Strengths (CANS)
- Comprehensive Diagnostic Assessment
- Neuropsychological & Psychological Testing
- Respite
- Medication Management
- Psychotherapy
- Treatment Planning
- Case Consultation
- Child and Family Team Interdisciplinary
- Skill building/Community Based Rehabilitation Services
- Crisis Intervention
- Psychoeducation

January 2019:

- Crisis Respite
- Case Management
- Intensive Care Coordination
- Multi-Family Therapy
- Crisis Response

April 2019:

- Family and Youth Support
- Integrated Substance Use Disorder Services
- Therapeutic After School and Summer Programs

June 2019:

- Transportation
- Day Treatment

- Inpatient Hospitalization
- School Based Skill building
- School Based Case Consultation
- Behavioral Therapeutic Aide
- Intensive Home and Community Based Services
- Treatment Foster Care (therapeutic portion)
- Psychiatric Residential Treatment Facility

Crisis Services

Several crisis services are required by the Settlement Agreement including Crisis Intervention, Crisis Response, Crisis Respite, and Inpatient services. These services are planned to be rolled out as YES compliant services as follows:

- Crisis Intervention- Fall 2018
- Crisis Respite- January 1, 2019
- Crisis Response- January 1 2019, and
- Inpatient services (not under Optum)- June 2019

At the Implementation Work Group (IWG) meeting in April of 2018, the Plaintiff attorneys expressed a specific concern about Idaho's plans for a Crisis System. The Implementation Plan does not identify strategies about how the YES partners will implement a system for Crisis Response. There was some initial work done by the Clinical Advisory Committee to identify the core elements of services currently available in Idaho and to recommend additional services that would have to be developed to augment the current system.

Core elements in Idaho currently include:

- Idaho rule IDAPA 16.07.30 Outpatient Crisis Services, and Behavioral Health Standards
- Requirements in the Optum contract,
- Statewide Suicide Hotline
- Statewide Crisis Text Line
- Mobile Crisis Response (not available statewide)
- Crisis Intervention Teams (CIT)
- Crisis Triage
- Emergency Rooms and Hospitals
- Residential programs

The Defendants Workgroup (DWG) has implemented monthly planning sessions to finalize an initial plan for the development of the YES Crisis System, to be completed by December 31, 2018. The DWG will utilize SAMHSA's manual on Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies, the US Dept. of Health and Human Services Practice Guidelines: Core Elements in Responding to Mental Health Crises, and other nationally recognized best practices for enhancing the current services and developing YES Crisis System for children, youth and families.

Challenges

1. The service implementation timeline is significantly impacted by the provider network's availability to engage in training and ability to add these services to their scope of practice. Medicaid's contractors have considered these challenges and are proactively evaluating the use of incentives to encourage the provider network to participate in training and provide the new services.
2. The original plan to utilize a SAMHSA System of Care grant to fund the development of a system for Crisis Response was eliminated when SAMHSA changed their grant to a focus on First Episode Psychosis. The state will have to seek alternative funding to support the development of a YES Crisis System.
3. Regional differences in access to crisis services will impact the local options for crisis services.

Next Steps

- YES system partners will work together building upon Medicaid crisis services to develop a plan for the YES Crisis System by December 31, 2018.

Objective 2: Principles of Care and Practice Model

The agencies adopt, implement and, once implemented, consistently provide services statewide in accord with the Principles of Care and the Practice Model, as amended over time.

2.A **Each agency, when serving Class Members, will use the Principles of Care and the Practice Model as practice standards for their agencies, contractors, and providers by June 30, 2018.**

2.B: **Class Members, their families, agencies, and other stakeholders participate in the System of Care consistent with the Principles of Care and Practice Model.**

The Principles of Care and Practice Model(POCPM) plays the foundation for a transformative shift in the children's mental health system toward the concept of Child and Family Teams (CFT). The YES system partners have adopted the POCPM as their practice standard.

The Principles of Care and Practice Model have been included in YES Foundational trainings that are being presented to DBH staff, Optum providers, as well as families and other stakeholders. Please see Workforce Training for more information on the YES Foundations trainings.

The implementation of Medicaid's 1915(i) and federal requirements for Person-Centered Planning, which were implemented in January of 2018, aligns with the Child Family Team

(CFT) model in engaging the family and treatment providers in the development of the plan. Training for the Medicaid network on CFT is planned for July 2018-October 2018.

Medicaid introduced the Principles of Care and Practice Model to the provider network in the Foundational trainings conducted in November 2017. This laid the groundwork to build on in the spring of 2018 toward moving the network to YES compliant services. It is recognized that many of these components exist in the service system today, and additional training and support will be provided to ensure the network attains full compliance.

An *Introduction to Youth Empowerment Services* guide has been developed. Within this guide, there is a section dedicated to explaining the Principles of Care and Practice Model and how these elements are applied to practice. Providers, family members and youth are each provided with an audience-specific description of what the Principles of Care and Practice Model might mean to them. Also found in this guide are legal definitions of the Principles of Care and Practice Model accompanied by narrative descriptions that highlight how each Principle and Practice Model component will apply within the YES system. More information about the *Introduction to Youth Empowerment Services* guide can be found within this report, under Objective 4: Sustainable Workforce and Community Stakeholder Development.

In April of 2018, a Principles of Care and Practice Model guidance document was created. The purpose of the document is two-fold. Most immediately the document will be used for training the provider network on how to incorporate the Principles of Care and Practice Model into their current practice. Long term, the document will be used as a reference document in agency contracts and to measure compliance through the Quality Review (QR) process.

Challenges

1. Questions remain concerning what the partners need to have in place to require contractors to adhere to the Principles of Care and Practice Model.

2. Implementing a system of care that requires the inclusion of the youth, family, and other treatment providers in the development of a holistic treatment plan is foreign to the Idaho Behavioral Health Provider network. Although the philosophy is well received, it will take significant time and effort to fully realize and implement this change.

Next Steps

- Operationalize the Principles of Care and Practice Model by including language in service contracts.
- Develop training materials for providers specific to the Principles of Care and Practice Model and Child Family Teams.
- In 2018 Medicaid will increase the network providers' capacity for providing compliant services by working closely with the IBHP contractor to train its current

network providers as well as to recruit additional providers into the network who may already be delivering comparable services to clients.

- Optum will provide training on Child and Family Teams beginning summer of 2018
- Medicaid and Optum Idaho are working to develop key indicators to measure network providers compliance to the Principles of Care and Practice Model.

Strategy 2.C

Develop methodologies to assess attainment of the purposes of the Settlement Agreement, practice improvement, and accountability by June 30, 2018.

The Division of Behavioral Health is in the process of identifying how to measure and manage fidelity to the Principles of Care and Practice Model. The Division has been conducting research on how the Principles of Care and Practice Model concepts are operationalized and measured in other states and is working with a consultant on drafting operational measures.

A large part of the methodology to assess attainment of purposes of the Settlement Agreement are based on the use of the CANS and ICANS systems. The QMIA Council has adopted a protocol called the Transformational Collaborative Outcomes Management (TCOM) Model that is focused on key decision points in care.

Transformational Collaborative Outcomes Management (TCOM)

"Transformational Collaborative Outcomes Management is a conceptual framework for managing complex systems. Within this framework there is a philosophy, a strategy, and a set of tactics all designed to facilitate an effective and integrated approach to addressing the needs of people."

-The John Praed Foundation

The YES TCOM Model contains information about the data and reports that will be utilized to identify system needs and strengths and to better meet the needs of the children, youth and families that it serves. The model was developed based on the five key decision points that have been identified within the TCOM framework to capture the full picture of a child, youth and family's transit through the system of care. These key decision points represent major activities of the system, and represent areas of high potential impact in improving the child, youth and family's experience, as well as outcomes of care.

Reports contained in the TCOM Model will:

- Identify which areas or key decision points within the system are successful

- Identify where there are areas that need improvement
- Identify which practices and procedures are most effective, and create a feedback mechanism that allows different parts of the system to learn from one another

The YES TCOM Model can be found in Appendix C of this report.

Challenges

1. The CANS tool will not be used statewide until June 30th, 2019. As the full implementation of the TCOM system will be based primarily on reports from the CANS this will impact the timing to have TCOM fully operational.
2. The Quality Review plan must be developed and then approved by the Plaintiffs prior to implementation.

Next Steps

- Once concepts are operationalized, fidelity measures will be developed with Quality Management Improvement and Accountability (QMIA), including Quality Review.
- The Division of Medicaid is developing and documenting examples of how the IBHP network can demonstrate the implementation of the Principles of Care and Practice Model in the delivery of services and supports.

Objective 3: Access Model

The agencies establish and operate statewide an access system or protocols for Class Members and their families that timely identify, assess, and link them to the services/supports they need and are entitled to under the Agreement. The work of this Objective will be accomplished through the Services/Supports Workgroup, chaired by the DHW. The work of operating an access process, as described in the following Strategies and Tasks will be described in the Practice Manual.

Strategy 3. A

Progressively implement the Access Model to identify and serve Class Members.

Full implementation of the Access Model occurred in January of 2018. Full implementation of the CANS will occur by June 30, 2019.

Division of Medicaid Access

The Division of Medicaid has worked with defendants to put in place a targeted access model for both currently Medicaid-eligible and potentially Medicaid-eligible Class Members to access YES services effective January 1, 2018.

As part of the YES System of Care, Medicaid has developed the Medicaid SED Program that allows children in families with income up to 300% of the Federal Poverty Level, diagnosed with a Serious Emotional Disturbance (SED) and confirmed through Medicaid's independent assessment process access to Medicaid eligibility and 1915(i)

services. Services available under the 1915(i) State Plan option (i.e. Respite) are services not traditionally covered by Medicaid dollars.

Children that may have SED can be referred to the Medicaid independent assessment process by anyone. However, Medicaid expects most referrals will come from existing Medicaid providers, education, juvenile justice professionals, and families. If a child already has Medicaid and the family does not want 1915(i) services, there is no need for this family to go through the independent assessment process.

There are two reasons a child should be referred to the Medicaid independent assessment process:

1. If the child currently has Medicaid and the family needs 1915(i) services
2. If the child does not currently have Medicaid and needs mental health services

Once a child is referred, the Independent assessor will conduct a face-to-face assessment with the child and family to determine whether the child meets Medicaid SED Program criteria. After the determination has been made all non-Medicaid applicants will be referred to Self-Reliance to apply for Medicaid. Individuals who meet Medicaid SED criteria can qualify for Medicaid with a family income up to 300% of the FPL. Those who do not meet Medicaid SED criteria can qualify for Medicaid up to 185% of the FPL.

All children who meet Medicaid SED Program criteria and have been determined to be Medicaid eligible will be contacted by a DHW Person-Centered Plan Facilitator to begin the person-centered planning process.

Children who have gone through the independent assessment process and meet Medicaid SED Program criteria will have access to all Medicaid State Plan services and 1915(i) services. To remain in the Medicaid SED Program the child and family must maintain a person-centered plan and complete the independent assessment process annually.

The 'Access to Medicaid Mental Health Services and the Medicaid SED Program' diagram can be found here.

The CANS 50 is a subset of the Children's Mental Health CANS used to determine YES Class Membership and subsequent Medicaid eligibility. The CANS 50 in conjunction with a Comprehensive Diagnostic Assessment (CDA) was implemented January 1, 2018, as part of the access model for children/youth interested in Medicaid SED services and supports. The CANS 50 and CDA are provided by the Division of Medicaid's Independent Assessment Provider, Liberty Healthcare.

CANS 50 data through April 30th have been provided on following page.

CANS 50

January 1, 2018-April 30, 2018

CANS Taken

484

CANS Clients

471

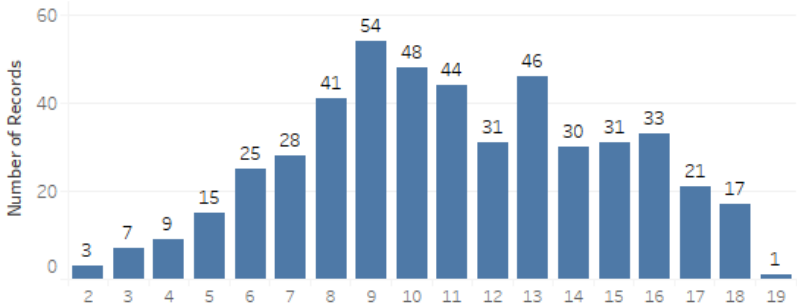
Race

American Indian and Alaska Native	2.27%
Asian and Pacific Islander	1.03%
Black/African American	3.10%
Other and Unknown	20.45%
White/Caucasian	73.14%

Ethnicity

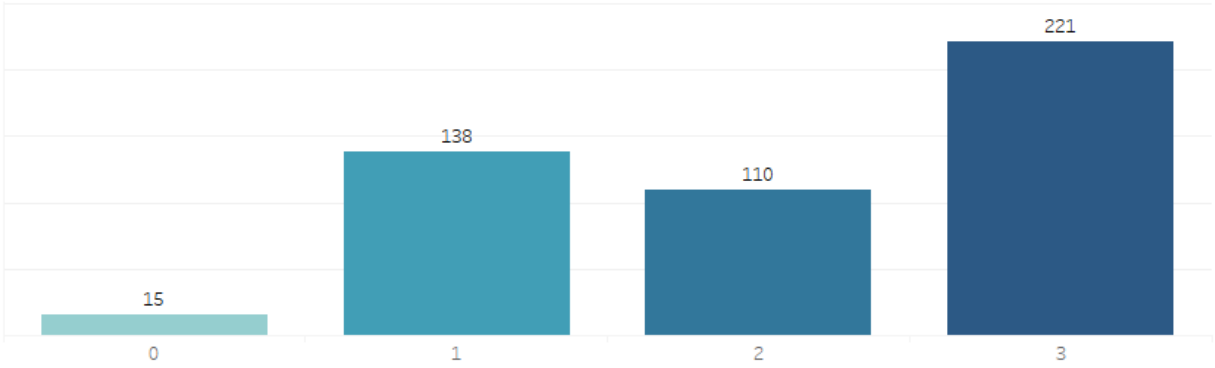
Hispanic or Latino	19.63%
Not of Hispanic or Latino Origin	76.65%
Unknown/Refused	3.72%

Age at Assessment Date (Years)

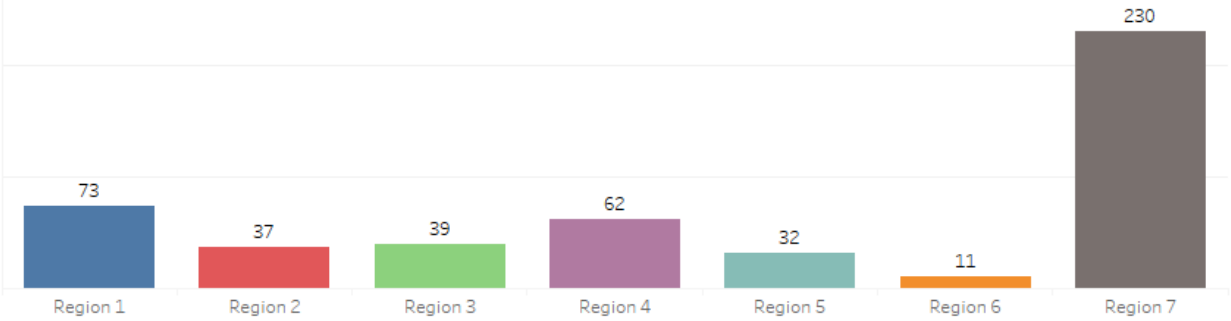


LoC Outputs

Recommended LoC Output: a recommended level of care output is generated by the ICANS. The recommended level of care is calculated according to established algorithms, developed by the IDHW. *Null* values indicated here represent an assessment that has not yet been completed (status of In Progress or Incomplete). A recommended level of care is generated only after a CMH CANS is signed and finalized.



Assessments by Facility



Interpretive Guidance: Idaho CMH CANS-50

The Children's Mental Health Child and Adolescent Needs and Strengths-50 (CANS-50) is administered by the contracted independent assessment provider (Liberty Healthcare) staff within in the determination process for Medicaid eligibility. Clients may be administered more than one CANS-50.

Division of Behavioral Health (DBH) Access

Families seeking mental health services can contact the Department of Health and Welfare Division of Behavioral Health regional clinics. If the family and child have Medicaid they will be referred to the Medicaid network by calling the Optum member line at 1-855-202-0983. If the family does not have Medicaid they will be referred to Liberty Healthcare at 1-877-305-3469. If the family requests that DBH Children's Mental Health (CMH) complete an assessment, CMH staff will schedule an appointment and conduct the assessment, to include the CANS, to help determine the child and family's eligibility for services. Based on results of the assessment CMH staff will work with the family and child to provide services or refer to the community or (if they become Medicaid eligible) to the Medicaid network to provide services.

For families who are not eligible for Medicaid or other insurance, a sliding fee scale is used to determine their share of costs.

Division of Family and Community Services (FACS) Access - Developmental Disabilities

The Developmental Disabilities program within FACS will identify potential YES Class Members in two ways:

1. FACS will review reports from the Independent Assessment Provider to identify children and youth who are also currently receiving developmental disability services. The Developmental Disabilities program will assist families of these children and youth in accessing mental health services, working collaboratively with a mental health provider and DBH staff.
2. FACS Case Managers will identify children and youth currently on developmental disability caseloads who have a mental health diagnosis, or who may need a mental health assessment. If needed, the Case Manager will refer the child or youth to the Independent Assessment Provider for eligibility determination and will collaborate with DBH staff to assist the family in finding a community mental health provider for services.

Department of Juvenile Corrections (IDJC) Access

Outreach to the Idaho Association of Counties Juvenile Justice Administrators, IDJC detention centers, the Idaho Supreme Court, and defense attorneys has been conducted. This outreach has included providing educational material on the foundations of YES, how children youth and families can access the YES system, how IDJC can utilize the CANS and ICANS system, and how YES can be integrated into the current juvenile justice court rooms. Our overall goal for judicial outreach is to build the judicial systems' confidence in the new children's mental health system of care. We plan to educate on how the system we are currently building can successfully be integrated into their current practices; and ensure that family and youth are using the enhanced access to care and receiving appropriate services.

Regional IDJC staff will be certified in the CANS tool to include Juvenile Service Coordinators, Clinical staff, or a combination of the above. Juvenile Corrections will have access to the ICANS system at each regional state institution. The CANS assessment will be administered as needed during the juvenile's reintegration to assist with discharge planning and service eligibility. The CANS tool will be administered to youth prior to returning to the community; this will facilitate connecting them to services, allow for continuity of care, and prevent gaps in services.

State Department of Education (SDE) Access

The Individuals with Disabilities Education Act (IDEA) includes emotional disturbance in the definition of a disability. Children ages 3-21 evaluated as having an emotional disturbance and who, because of the disability, need special education and related services are eligible for services under the IDEA. A referral for a special education evaluation for a child suspected of having a disability may be made by anyone involved in the child's education, including the parent. Signed parental consent is required before any evaluations are conducted. The parent must be involved in decisions once a formal referral has been made. After receiving consent, the evaluation team shall schedule assessments and ensure they are conducted. The evaluation must be sufficiently comprehensive to identify all of the child's special education and related-service needs. Next, the evaluation team reviews the assessment data, the response to general education targeted interventions, and parent/adult student input and recommendations, to determine whether the student is eligible for special education services.

The Child Find system involves three basic steps leading to the determination of whether or not a student has a disability and requires special education. The steps are location, identification, and evaluation. The local school district is responsible for establishing and implementing an ongoing Child Find system to locate, identify, and evaluate students suspected of having disabilities, ages three (3) through the semester they turn twenty-one (21), who may need special education, regardless of the severity of the disabilities. For infants and toddlers, birth through two (2) years of age, Child Find is provided by the Idaho Infant/ Toddler Program (ITP). Although lead responsibility for the ITP has been designated to the Department of Health and Welfare, interagency agreements provide for collaboration and coordination. The identification component of Child Find includes screening, early intervening through a problem-solving process, and referral to consider a special education evaluation. The procedural rights under the IDEA are afforded when the student is referred for a special education evaluation by the parent/legal guardian/adult student or the district.

The 'State Department of Education- Reevaluation Guidance Document Flow Chart' can be found here.

Next Steps

- DHW will continue to monitor the Access Model and seek member feedback utilizing process data indicators and a Quality Review (QR) process. The Quality Review process is planned to be implemented in 2019.
- DBH will continue to work with IDJC to ensure our two systems are collaborating successfully. DBH will also be providing live webinars to judges, providing outreach material to the Western Juvenile Defender Center Leadership Summit in May, presenting at the Idaho Juvenile Justice Association Conference in September, and the Idaho Judicial Conference in September. Additionally, outreach efforts have begun which targets prosecuting attorneys.

Person-Centered Planning

The Division of Medicaid worked with DBH and Optum Idaho to create a Person-Centered Planning process that meets the Code of Federal Regulations (CFR) requirements for utilizing a 1915(i). The Division of Medicaid recognizes this is an additional step class members need to go through to access 1915(i) services or Medicaid eligibility at the expanded Federal Poverty Level (FPL). This is a mandatory requirement when utilizing the 1915(i), and it also ensures there is collaboration to ensure treatment plans are aligned and there is no duplication of services.

In August 2017, it was determined that DBH Regional Children's Mental Health Clinicians would complete person-centered plans on behalf of all youth/families in Idaho requiring these plans.[6]

In October 2017, a workgroup consisting of representatives from the Divisions of Medicaid and Behavioral Health, and Optum Idaho began meeting for collaboration and work related to Person-Centered Planning. During this time, much of the operational groundwork for Person-Centered Planning was laid down.

In November 2017, an initial training was presented to DBH representatives throughout the state by Dr. Lynn Thull, a contractor with the Praed Foundation. Workgroups also began developing the automation support needed to complete the Person-Centered Planning work, including electronic health records requirements and developing a Person-Centered Planning coordination site. Additionally, Dr. Nate Israel from the Praed Foundation presented essential information on the incorporation of the CANS into person-centered plans.

In December 2017 Person-Centered Planning process flows were finalized. Additionally, fifty-seven (57) Regional DBH staff were trained by DBH Central Office staff on both process flow requirements and clinical guidance, and the first statewide Person-Centered Planning support call was held for all staff trained on completing person-centered plans.

[6] DBH will transition this function in the future.

Finally, a Person-Centered Planning toolkit for Regional DBH staff was developed. The person-centered plan template belonging to Medicaid was finalized in collaboration between DBH, Optum and Medicaid, and Person-Centered Planning became a topic in the YES Foundations training.

The Person-Centered Planning process launched in January of 2018.

More recently, the Divisions of Medicaid, Behavioral Health, and Family and Community Services began working to implement the Person-Centered Planning workflow for children/youth who are dually diagnosed with both mental health and developmental disabilities. This process will be piloted during the spring and summer of 2018.

Challenges

1. Feedback from families indicates that the Release of Information and Informed Consent paperwork may not be easily understood or family-friendly. Additionally, some families reported that they wanted more information about the process, while others reported feeling overwhelmed by the amount of information that they had received.

2. Four points have been identified within the process where families may disengage, either by choice or other circumstances.

3. Family led and Person-Centered Planning is a new concept which requires consistent implementation and practice. Early plans required additional documentation to ensure strengths capacities, preferences, needs, and desired outcomes were clearly and thoroughly documented.

4. As with any new process, there have been automation and operational challenges, such as methods that will be used for receiving a referral, confirming Medicaid eligibility, and the submission of the completed plan. A variety of sub-processes and automation systems are utilized that staff must become familiar with.

5. Developing and implementing appropriate need-based service descriptions is difficult. Documentation to assist plan developers to request services and supports evidenced to meet specific mental health needs has been developed and will be updated regularly to reflect effective treatment options.

Next Steps

- Medicaid is working collaboratively with CMS and DBH on closure guidance and letters to send to families to re-engage them in the Person-Centered Planning process. This is part of the continued development of efforts to keep families engaged and to ultimately receive needed services.
- Assessment of the Person-Centered Planning process which deployed 1/1/2018.
- Exploration and development of a Request for Proposal for community based Person-Centered Planning, monthly monitoring, Intensive Care Coordination, and Wraparound.

Strategy 3.B

Inform and guide the delivery of services and supports by providers and contractors consistent with the Access Model, Principles of Care and Practice Model by December 30, 2017.

A Foundational training was delivered to DBH staff in December of 2017. Foundational training on YES includes the current Access Model, Principles of Care and Practice Model Overview.

The Divisions of Behavioral Health and Medicaid provided more in-depth Access Model training to DBH clinicians in December as part of their Person-Centered Planning training. This training was provided in-person around the state.

YES Foundations, CANS, and Person-Centered Planning trainings have been recorded to provide a sustainable training approach. Recordings are in the editing process and will begin rolling out, along with training materials, to appropriate audiences for training at their convenience. Frequently Asked Questions (FAQ's) for each training topic are in development and will accompany online training materials.

For more information about YES trainings, please see Objective 4; Strategy Part I 4:C.

For more information on the Principles of Care and Practice Model guidance for providers and contractors, please see Objective 2.

An *Introduction to Youth Empowerment Services* guide has been published. This document explains changes to the access model and introduces the purpose and concepts of the Principles of Care and Practice Model. More information on the *Introduction to Youth Empowerment Services* guide can be found here.

Strategy 3.C

Develop an identification and referral process across child serving systems to link potential Class Members with the assessment process for the identification of Class Members by December 30, 2017. Activities under this Strategy include the using the CANS algorithm, screening, and checklist.

The Division of Behavioral Health worked with Praed Foundation on the updating and refinement of the initial level of care (LOC) decision-support algorithms (eligibility threshold levels). The threshold levels were revised and finalized on 5/22/2017.

Current LOC algorithms are in place for the following levels of care:

- 1 Serious Emotional Disturbance (SED) identified. Services should be coordinated but functioning is stable
- 2 Serious Emotional Disturbance (SED) identified. Child/youth generally involved in multiple systems and require extensive service collaboration

- 3 Serious Emotional Disturbance (SED) identified. Child/youth is considered to have high treatment needs and is at risk of out of home placement

Initial review of CANS Pilot data on December 1, 2017 with Dr. Nate Israel of the Praed Foundation indicated that the Youth Empowerment Services LOC decision-support algorithms are identifying LOCs as expected; therefore, no revisions are anticipated within the next 12 months.

Algorithms have been integrated into the ICANS system to facilitate eligibility determinations for Class Membership by the Independent Assessment Provider and DBH clinical staff.

A CANS Screener was developed to identify potential YES Class Members. The algorithm for the CANS Screener was developed by Dr. Nate Israel of the Praed Foundation and finalized on May 22,17.

The YES Youth Mental Health Checklist is a tool that can be used by parents and caregivers to help determine if a youth may benefit from a full mental health assessment. Use of this Checklist is not mandatory and a full mental health assessment can be requested without the Checklist being completed.

This checklist will be promoted within the schools as well as on the YES website and other public-facing avenues such as conferences and events. In addition, school problem solving teams may present this tool to further communicate with parents the importance of seeking additional services outside of the school setting.

The Youth Mental Health Checklist Workgroup, launched in May of 2017, consisting of school counselors, Department of Health and Welfare staff, school psychologists, teachers, school social workers, Special Education Directors and parents.

In July of 2017 a draft checklist for families was developed. The Checklist content was informed by 'needs' items from the CANS tool. If one or more boxes are checked, the Checklist indicates that a more comprehensive assessment through YES should be considered. The draft Checklist can be found in Appendix F.

The state has also been working with parents and youth to develop a youth-facing version of the Checklist that can be completed by the youth themselves.

Challenges

1. Challenges with the CANS Screener thus far lie in determining the most effective channels to engage Primary Care Providers, and other targeted users of the CANS Screener.
2. For the Youth Mental Health Checklist, the most significant challenge has been determining how families and youth connect to the YES program if the Checklist indicates that there is a need for a full mental health assessment. Not all families

will choose to access YES through the Independent Assessment process. There is not a universal YES contact entity in place at this time.

Next Steps

The next steps that will be taken to advance development of the CANS Screener include:

1. Refine and publish online and paper versions.
2. Establish guidance materials for use.
3. Involve Medicaid and other YES system partners in the development of the Screener
4. Engage Primary Care Providers and other stakeholders in the adoption and integration of the Screener into practice.
    - Paper-based Screener (Phase 1)
        - Primary Care Physicians
        - Developmental Disabilities providers
        - Juvenile Justice personnel (Probation, Detention, Corrections)
    - Web-based Screener (Phase 2)
        - Implementation plan development to begin 6/1/2018.
        - Phase 2 will focus on the procurement of a web-based screening platform.

CANS Screener Projected Timeline for Next Steps	
Finalize CANS Screener implementation plan	4/15/2018
Develop and release informing materials for the CANS Screener	6/1/2018
Explore automated platform for the CANS Screener	7/1/2018
Initiate procurement process for web-based Screener platform	7/1/2018
Release paper-based version of the CANS Screener	7/1/2018

Next steps regarding eligibility and level of care determination:

1. Decision-support algorithms will be integrated into the method for determining Medicaid SED program Class Membership beginning 1/1/18 through the Independent Assessment Process. This method will expand to the provider network throughout 2018.
2. Level of care (LOC) recommendations generated from ICANS will also be integrated into existing DBH Children's Mental Health (CMH) processes to determine eligibility for existing Children's Mental Health Services

Next steps regarding the Youth Mental Health Checklist:

1. Determine contact information for families seeking a mental health assessment.

2. Publish the Youth Mental Health Checklist family and youth-facing versions (Timeline TBD).

Strategy 3.D

Department of Health and Welfare will develop and implement an assessment process to identify Class Members by January 1, 2018.

Medicaid's behavioral health provider network must meet standard requirements in the completion and documentation of the Comprehensive Diagnostic Assessment (CDA). The CDA will be utilized in conjunction with the CANS to determine whether a youth's mental health diagnosis and functional impairment meets the requirements for class membership.

Strategy 3.E

Use the CANS tool statewide beginning January 1, 2018.

The Department made considerable progress toward the implementation of the CANS statewide in Idaho but did not meet its goal for use of the CANS statewide by January 1, 2018. However, statewide deployment is scheduled to be in place July 1, 2018.

The state did implement CANS for all DBH Regional Clinics and the Independent Assessor so CANS is available across the state, but implementation for the Optum network providers was delayed. There were several reasons for the delay:

- Informing providers of the requirements was delayed until the timing for training was determined.
- The need to train providers on the CANS and the ICANs required substantial planning, including having the Praed staff do in person training which has shown to be more effective.
- The amount of other training that providers needed prior to the CANS Training

A web-based CANS assessment platform for the administration, scoring and sharing of CANS data has been developed; this platform is called the ICANS.

A three-phase implementation plan was established to facilitate the deployment of the ICANS. Phases 1 and 2 have been completed. Key elements and more detail of each phase can be found in Appendix D.

The ICANS pilot started on 9/11/2017 and continued through 11/14/2017.

Key components of the ICANS pilot included:

- Training and CANS certification of all pilot members and related staff
- ICANS training for all pilot members and automation helpdesk staff
- ICANS user documentation for phase 1 functionality completed and posted online for ICANS users

- Weekly ICANS Pilot Group technical coaching calls
- Weekly CANS Coaching calls with Praed consultant Dr. April Fernando

Family and Community Services (FACS) CANS Implementation

The Child and Family Services state-led CANS workgroup has representation from all regions, and all levels of the program, including social workers, supervisors, regional chiefs, program managers, policy team staff, and a representative from Casey Family Programs. The primary goals of this workgroup are to identify the phases of the updated statewide rollout plan, and determine how the CANS can be utilized throughout the lifetime of a child or youth's case. The following are topics of workgroup discussion regarding the rollout plan:

1. Identifying priority populations
2. Identifying how, when and where phases will occur
3. Identifying who will be included in each phase
4. Determining training needs associated with the rollout

The goal of the workgroup is that every child in FACS care will have a CANS by December of 2020, including new entries and children and youth that are already in care.

An overview of the Child and Family Services CANS workgroup planned phases is below:

Phase	Expected Timeframe	Target Population
Phase 1	September 2018- October 2019	30% of population- identified
Phase 2	November 2019- May 2020	35% of population- not yet identified
Phase 3	June 2020- December 2020	35% of population- not yet identified

Children's Mental Health (CMH) CANS data through April 30th have been provided on following page.

CMH CANS

January 1, 2018-April 30, 2018

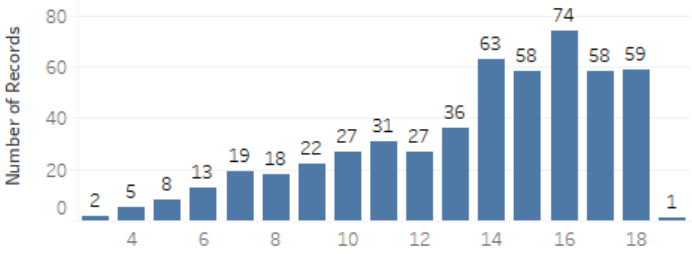
CANS Taken

521

CANS Clients

477

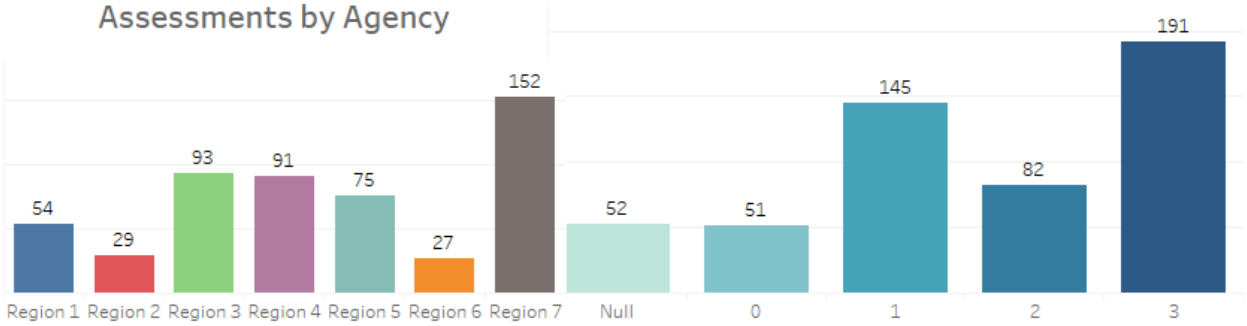
Age at Assessment Date (Years)



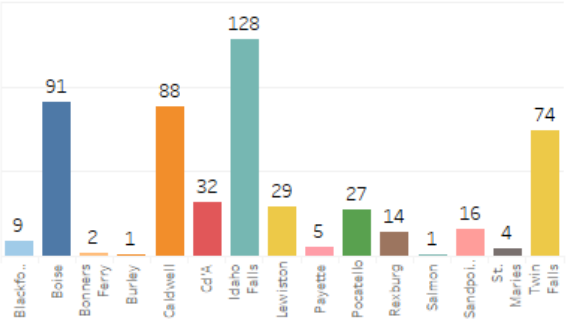
LoC Outputs

Recommended LoC Output: a recommended level of care output is generated by the ICANS. The recommended level of care is calculated according to established algorithms, developed by the IDHW. *Null* values indicated here represent an assessment that has not yet been completed (status of In Progress or Incomplete). A recommended level of care is generated only after a CMH CANS is signed and finalized.

Assessments by Agency



Assessments by Facility



Assessment Status

Finalized: an assessment is completed, signed by a CANS Certified assessor, and is no longer editable in the record.
In Progress: an assessment is in the process of being completed
Incomplete: an in-progress assessment will transition to a status of "incomplete" if a new CANS is initiated prior to the finalization of the in-progress assessment. Assessments with a status of *Incomplete* are no longer editable.

Race

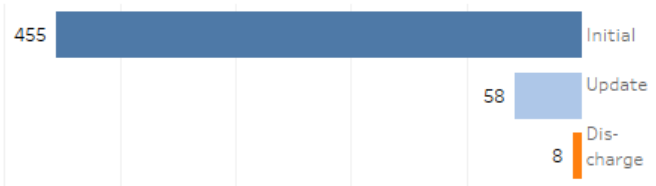
American Indian and Alaska Native	2.50%
Asian and Pacific Islander	1.54%
Black/African American	2.50%
Other and Unknown/Refused	19.58%
White/Caucasian	73.90%

Ethnicity

Hispanic	17.47%
Not of Hispanic or Latino Origin	68.33%
Unknown/ Refused	14.20%

Assessment Type

Initial: the first CANS completed for a client in the ICANS episode.
Update: any CANS completed for a child after the initial CANS.
Annual: the CANS completed 12 months after the initial CANS for a child.
Discharge: a CANS completed at the time when a child exits current services.



Interpretive Guidance: Idaho CMH CANS

The Children's Mental Health Child and Adolescent Needs and Strengths (CMH-CANS) is administered by IDHW staff within the Division of Behavioral Health and Developmental Disabilities Program. Clients may be administered more than one CANS.

Challenges

1. The ICANS pilot identified key issues with the existing Idaho CANS Manual developed by the Praed Foundation. A comprehensive revision of the manual by Praed was completed on 10/31/2017, however revisions to the manual required significant modifications to existing ICANS functionality to address discrepancies between versions of the manual. System accommodations were required due to the changes which are currently under review by the DBH Automation unit.

Next Steps

- Plan for a second ICANS Pilot to test and evaluate ICANS system and related processes with all stakeholders related to the 7/1/2018 deployment. Pilot group will likely include representatives of DBH, FACS, Medicaid contracted provider network and independent assessment providers, IDJC and County Detention Facilities.
- Deploy ICANS Phase 3 functionality across the state by July 1, 2018.

CANS/ICANS Projected Timeline for Next Steps	
All existing Division of Behavioral Health Children's Mental Health Clients administered a CANS	Beginning 2/1/2018
Use of Idaho Children's Mental Health (CMH) CANS within the Developmental Disabilities program	3/1/2018
Deployment of the ICANS to the Developmental Disabilities user group	3/9/2018
Beta version of Idaho CMH CANS reporting completed	3/15/2018
ICANS Phase 3 A-D final technical requirements completed	4/1/2018
Deployment of the Idaho CMH CANS to the Medicaid network of providers	7/1/2018
All existing CMH clients will have a CANS completed	7/1/2018
Idaho Department of Juvenile Corrections (IDJC) Clinicians trained, certified in the CANS	7/1/2018
IDJC access to ICANS for all identified authorized users (if indicated)	7/1/2018
Division of Behavioral Health training of all identified authorized ICANS users	7/1/2018
ICANS Phase 3 completed	12/31/2018

- FACS Child and Family Services CANS workgroup will work with leadership to set timelines
- FACS Child and Family Services CANS workgroup will continue to work to develop a statewide workflow that will specifically guide when and how the CANS will be utilized at key junctures; including how the information is utilized to inform planning and decision-making for youth involved in Child Welfare.
- FACS Child and Family Services CANS workgroup will determine what training components are needed to meet the individualized needs of the FACS program

Strategy 3.F

Develop and implement a statewide Communication Plan that includes outreach and education of the community, stakeholders, and families by January 1, 2017.

A statewide communication plan was developed and implemented by January 1, 2017. The Communications Plan included the following information:

- How and when communication needs are being addressed for the YES transition.
- A distribution protocol identifying partner and stakeholder roles in communication distribution.

In 2017, Medicaid worked closely with the partners to support communication plans and efforts in the early stages of the YES implementation, including using consistent content for the development of communication and training materials.

As 2018 brings forth additional communication needs to implement and support, Medicaid is tailoring its communication plan to support its internal and external customers. A major component is working with the behavioral health managed care entity to align all Idaho Behavioral Health Plan (IBHP) provider communications with the implementation of services and supports.

YES stakeholders were identified for communication and outreach activities. Stakeholder groups were broken out into three types: 1) direct impact, 2) information and referral and 3) future opportunity role. Initial outreach included messaging and materials on 'what is YES', a general transition timeline, how to access services, who to contact, and YES website resources and training available.

The Communication Workgroup, made up of agency and stakeholder representatives, contributed to the enhanced YES website content and the development and distribution of YES communication pieces.

The parent representative within the Communications Workgroup is an active member of the team; she has been involved in writing content, worked on the YES communications and style guide, and continues to provide valuable feedback that is incorporated into final communication materials. Additionally, part of her role is sharing materials with other parents and providing their feedback to the Workgroup.

An engagement strategy for the stakeholder groups is in development. The engagement strategy for types one and two has been developed, while the type three engagement strategy is in process. Stakeholder groups were contacted to seek understanding of impact, role and needs.

A YES Communications and Style Guide was developed to require that workgroups are using YES brand guidelines, styles and terminology.

A monthly YES Outreach and Training Report has been developed to record the events, number, and type of stakeholders reached in each event. The events include stakeholder meetings and formal trainings. Additionally, tracking of how frequently the YES website

is visited is now possible. The YES Communications Team worked with partners and stakeholders to develop communication materials that describe and explain the Settlement Agreement and its components.

Youth Empowerment Services information is distributed through the YES website, http://yes.idaho.gov. This website was redesigned in 2017 to deliver user-friendly navigation and provide a forum for family, youth and provider voice, along with an easy Contact Us form to submit questions and comments directly to the YES team.

Communication items can be found on the YES website and include:

- YES 101 Brochure – 12-page booklet (English and Spanish versions)
- YES Trifold brochure
- CANS description
- YES: From a Lawsuit to a System of Care
- Frequently Asked Questions (FAQs) for Families and Youth
- Definitions of YES terms
- YES Talking Points for information and referral agencies
- Principles of Care and Practice Model handout for providers

Click here to view the Communications page of the YES website where the materials can be found.

Information is also shared through presentations, meetings, workshops and trainings. Additionally, printed YES brochures and handouts were distributed at community events and conferences.

A variety of communication and outreach and education activities occurred during the reporting period, including:

- Outreach at the Governor's Task Force on Children at Risk conference
- Outreach at SDE's Family and Community Engagement Conference
- Presentations to SDE Directors, Special Education Advisory Panel (SEAP)
- Outreach at the Idaho Association of Juvenile Justice Administrators

Challenges

Challenges regarding implementation of the statewide Communication Plan included the following:

1. There are more than 150 stakeholder groups characterized by various levels of impact and involvement. Identifying their communication needs and how best to reach these groups with information on YES is time-consuming, but is underway.

2. Ongoing program changes that need to be communicated, requiring frequent updates to the same outreach and education materials.

3. The stakeholder engagement model includes all partners and community representatives. While the Department remains committed to this model, it takes

significant amounts of time to route content through the review and approval process.

4. Agency operations and communication plans regarding resource availability and timing vary widely among partners. Acknowledging that communications need to be tailored to each audience, and having the ability to operationalize the communications for this purpose.

5. Sequencing of communications with respect to the impact area of the other stakeholders.

Challenges regarding communication materials have also been identified:

1. The number of stakeholders involved in communication development, review and feedback to 1) create communications that follow the Principles of Care and Practice Model and 2) incorporate the needs and voice of various groups has greatly extended the timelines necessary to create and complete communications pieces.

2. Stakeholders have identified a need to create a consistent brand and identity for Youth Empowerment Services, which has also required additional time to gather input and finalize design decisions. Consistent messaging regarding YES information to prevent stakeholders from receiving outdated or misrepresentative messages from partners.

3. Maintaining independent provider representation on the Communication Workgroup. It has been difficult for providers to meet during the workday and devote time needed to contribute to work products.

Next Steps

- Updating the Communication Strategy, incorporating lessons learned and decisions made, ongoing communications and outreach.
- Updating the YES website based on feedback, and adding new materials.
- Ongoing outreach activities.
- Continuing to develop and update communications and materials, presentations and outreach activities to stakeholder groups as the system of care is developed, including:
    - Handouts that provide easy to understand information on what is next for Youth Empowerment Services, access model, CANS for families.
    - Communications regarding materials available on the website such as:
        - Practice Manual availability.
        - Recorded trainings availability.
        - Other YES materials focused on System of Care.
        - Communication Catalog listing all materials and where to access them.

    - Family-friendly short videos to provide alternatives to written materials about Youth Empowerment Services, and CANS for families, available on the DHW YouTube channel with links from the YES website.
    - Additional updates to the YES website that incorporate user feedback and increase usability and access to resources and training information.
- Continue to use the YES Outreach & Training Report.
- Develop a periodic report on access and use of the YES website.

Objective 4: Sustainable Workforce and Community Stakeholder Development

The agencies participate in workforce development and stakeholder education to create the infrastructure necessary to provide education, training, coaching, supervision, technical assistance and mentoring to providers and community stakeholders to enable them to consistently and sustainably provide quality care in accord with the Practice Manual as described in the Agreement. The work of this Objective will be led by the Workforce Development Workgroup.

Strategy Part I 4.A

Establish a Workforce Development Workgroup by June 30, 2016.

The Workforce Development Workgroup was established in November of 2015. Progress and accomplishments are detailed in the previously published Annual Implementation Progress Report, which can be found here.

Strategy Part I 4.B

Develop an initial Workforce Development Plan by February 28, 2017.

The previous Annual Implementation Progress Report addressed the progress of strategy B, indicating that the Workforce Development and Training Plan Workgroup would finalize input on the initial Workforce Development and Training Plan by February 28, 2017. The Workforce Development and Training Plan would then be edited into a final draft in March and sent out to stakeholders for comment and review. The finalized Workforce Development and Training Plan was expected to be published by May 1, 2017.

The Workforce Development and Training Plan was completed and finalized May 1, 2017 and posted to the YES website. Please click here to access this document.

Part II of the Workforce Development and Training Plan is in development and is expected to be published in July of 2018.

Challenges

1. Identifying individuals to participate in the Workforce Development Workgroup with knowledge of the systems needs statewide.

2. Resolving the workforce gaps reported by BSU in the IBHP network will involve extensive training and subject matter expertise, changes in rules and finances to shore up issues with recruitment and retention, and cultural disparities.

Next Steps

- Adjust the Workforce Development Plan based on Gaps identified in the BSU Survey.
- Formalize Family and Youth Education and Training Plan.
- Develop YES Core Competencies for Workforce and Leadership.

Strategy Part I 4:C

Implement the Workforce Development Plan beginning May 1, 2017.

Phase 1 training of the Workforce Development Plan has begun. YES Foundational Training for the Optum Network was developed and provided in collaboration with the Divisions of Behavioral Health and Medicaid in November 2017. The training content was split into two sections, with each section offered twice to accommodate the providers' schedules. The first training covered the History of YES, System of Care, Principles of Care and Practice Model. The second training covered the Access Model, CANS, Child Family Teams, Person-Centered Planning, and Wraparound. The trainings were attended by 94 agencies and more than 290 individuals. These counts do not include additional attendees that were not formally logged in and were participating in a larger group setting. Feedback from the trainings was positive and a subsequent FAQ was developed and posted on the Optum website.

The Foundational training was delivered to DBH Staff in December of 2017. Foundational training on YES includes the current Access Model, Principles of Care and Practice Model Overview. Based on training surveys, the audience felt the information was important and relevant but it was not new information and most had already heard it. Many participants asked for less philosophy and more operational training specific to Person-Centered Planning. Independent Assessors received the Foundational Training in December 2017. Families and community stakeholders had the opportunity to attend Foundational and CANS training beginning January 18th through February 2nd, 2018.

The Divisions of Behavioral Health and Medicaid provided more in-depth Access Model training to 63 DBH clinicians in December 2017 as part of their Person-Centered Planning training. This training was provided in-person around the state. Training surveys revealed that participants appreciated receiving the long-awaited information and training. All four Person-Centered Planning surveys indicated the attendees would benefit from more practice vignettes.

YES Foundations, CANS and Person-Centered Planning trainings have been recorded to provide a sustainable training approach. Recordings are in the editing process and will begin rolling out, along with training materials, to appropriate audiences for training at

their convenience. FAQ's for each training topic are in development and will accompany online training materials.

The Division of Behavioral Health completed training and certification of all DBH staff on the use of the CANS prior to December 2017.

Details on CANS training and certifications are listed below:

- As of 5/8/18, DBH provided 577 DBH, Medicaid, and other individuals access to the CANS Certification at no cost
    - As of 5/8/18, there were 245 active registered Praed Training/Certification Accounts for agencies listed in Idaho
    - As of 5/8/18, there were 147 individuals actively certified in the Idaho Children's Mental Health CANS

Several DBH-sponsored trainings, which were provided by the Praed Foundation, took place throughout the state:

- Dr. Lyons presented CANS training to providers, parents, and others in Idaho Falls in May 2017.
- Dr. Lyons presented CANS training to all Children's Mental Health Staff in Lewiston in September 2017.

Dr. April Fernando provided statewide CANS Training (including CANS informed treatment planning) to DBH Staff and members of the Independent Assessment Contractor staff. Optum and Medicaid personnel were also invited to attend. Training sessions were delivered in Boise, Idaho Falls, and Coeur D'Alene in November and December of 2017. CANS training sessions for youth, parents and stakeholders were scheduled for January 2018; these trainings took place in Coeur D'Alene and Boise. An additional CANS training for youth, parents and stakeholders was held in February of 2018 in Idaho Falls. A broadcast webinar was available for some of these trainings. These trainings opened with a parent perspective and the importance of the use of the CANS. Those in a supervisory role received an additional CANS in Supervision training. The survey data from these trainings revealed most attendees benefitted from the training. There were several suggestions for a more interactive learning experience with requests for videos and activities to engage all learning types. Another suggestion was to provide more direction in CANS implementation for multiple cultures.

The DBH Automation Helpdesk team began providing ongoing ICANS technical training in November 2017, for DBH users, Independent Assessors, and non-DBH users. Additional ICANS technical trainings were provided in December 2017.

Division of Behavioral Health Hosted Trainings Summary

YES - DBH Hosted Training Schedule

	Date	Time	Training	Presenter	Presenter Location
Complete	11/14/2017	8:00AM-4:00PM	PCP: Pilot	Janelle J/Jeniffer B/David W	Boise, PTC 05 Rm 5
Complete	11/16/2017	9:00AM - 4:00PM	CANS Intro/CANS Clinical DAY 1	Pat Martelle/Janet Hoeke/Dr Fernando	Boise, Westgate
Complete	11/17/2017	9:00AM - 4:00PM	CANS Clinical/Supervisory DAY 2	Dr. Fernando	Boise, Westgate
Complete	11/30/2017	9:00AM - 4:00PM	CANS Intro/CANS Clinical DAY 1	Pat Martelle/Janet Hoeke/Dr Fernando	Idaho Falls,150 Shoup Ave CFS Lg Conf Rm
Complete	12/1/2017	9:00AM - 4:00PM	CANS Clinical/Supervisory DAY 2	Dr. Fernando	Idaho Falls,150 Shoup Ave CFS Lg Conf Rm
Complete	12/5/2017	8:30AM - 5:00PM	PCP: Operationalization	Janelle J/Jeniffer B/David W	Lewiston, 16th Ave Conf Rm
Complete	12/7/2017	9:30AM - 11:00AM	DBH Staff Foundations Webinar Part 1	Pat/Janet/Jeniffer B/Janelle J	Boise, PTC 7th Floor Training Rm
Complete	12/11/2017	8:30AM - 5:00PM	PCP: Operationalization	Janelle J/Jeniffer B/David W	Pocatello, HDC Conf Rm 124
Complete	12/13/2017	9:30AM - 11:00AM	DBH Staff Foundations Webinar Part 2	Pat/Janet/Jennifer B/David W	Boise, PTC 7th Floor Training Rm
Complete	12/14/2017	8:30AM - 5:00PM	PCP: Operationalization	Janelle J/Jeniffer B/David W	Boise, Westgate D Mtng Rm 207 VCE
Complete	1/18/2018	9:00AM - 12:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Boise, Westgate Rm 131
Complete	1/18/2018	1:00PM - 4:00PM	CANS for Stakeholders	Dr. Lyons	Boise, Westgate Rm 131
Complete	1/19/2018	9:00AM - 12:00PM	CANS for Stakeholders	Dr. Lyons	Boise, Westgate Rm 131
Complete	1/19/2018	1:00PM - 4:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Boise, Westgate Rm 131
Complete	1/25/2018	9:00AM - 12:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/25/2018	1:00PM - 4:00PM	CANS for Stakeholders	Dr. Lyons	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/26/2018	9:00AM - 12:00PM	CANS for Stakeholders	Dr. Lyons	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/26/2018	1:00PM - 4:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Coeur d'Alene, 1120 Ironwood LG Conf Rm
Complete	1/29-2/2/18	9:00AM - 4:00PM	Clinical Wraparound	SOCI	Boise, Westgate D Mtng Conf Rm Side B
Complete	2/6/2018	1:00PM	CANS/YES Update (IACJJA)	Seth/Pat	Boise
Complete	2/12/2018	3:00PM - 4:00PM	PCP Optum LOCG	Optum	Webinar broadcast
Complete	2/14/2018	9:00AM - 12:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Complete	2/14/2018	1:00PM - 4:00PM	CANS for Stakeholders	Dr. Lyons	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Complete	2/15/2018	9:00AM - 12:00PM	CANS for Stakeholders	Dr. Lyons	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Complete	2/15/2018	1:00PM - 4:00PM	Foundations for Stakeholders	Pat/Janet/Jennifer B/Janelle J/David W	Idaho Falls, 150 Shoup Ave 2nd floor LG Conf Rm
Scheduled	2/20/2018	2:00PM - 3:00PM	ICANS Training for DBH Staff	DBH Automation	Boise CO - Webinar
Scheduled	3/8/2018	10:00AM - 11:00AM	ICANS Training for DBH Staff	DBH Automation	Boise CO - Webinar
Scheduled	3/15/2018	2:00PM - 3:00PM	ICANS Conference Call for ALL USERS	Seth Schreiber	Boise CO

*Trainings listed on this schedule are DBH hosted trainings only

As of: February 20, 2018

Medicaid, in collaboration with Optum Idaho and the Independent Assessment Contractor Liberty Healthcare, conducted many trainings to educate and inform providers about the new Access Model and YES foundational components to include the Practice Model for the January 2018 changes. Medicaid's contractors have participated in CANS training both for direct use in the independent assessment process and for knowledge and implementation for the Idaho Behavioral Health Plan (IBHP) network.

In collaboration with DBH, Medicaid has supported the plan for the statewide network capacity survey that will assist in informing workforce training and development needs. In addition, the Optum Idaho continues to address network capacity and needs throughout the project-planning phases in relation to development of services and supports.

IDJC is in the process of revising Peace Officer Standards Training (POST) updates to include more emphasis on adolescent development, brain development, trauma and mental health concerns. The following classes have been implemented in all IDJC State Facilities and now will be a formal piece of the POST training curriculum:

- Mental Health for Juvenile Justice
- Think Trauma
- Shield of Care- Self-harm and Suicide Prevention

Additionally, IDJC has implemented a Case Management University as well as a Juvenile Service Coordinator Workshop. Community partnerships have allowed for the following trainings to be provided:

- Policing the Teen Brain
- Acing the ACEs (Adverse Childhood Experiences)
- Youth Level of Service Case Management Inventory
- Resilience Training
- Restorative Justice

Challenges

1. Medicaid has noted the challenges of multiple trainings, opportunities and venues for providers to receive information in the context to which it applies. For example, an Idaho Behavioral Health Plan (IBHP) provider may attend a training that is not a part of the Optum training and may not understand the area of impact in relation to both contractual and reimbursement requirements.

2. There are also challenges involved in gathering the necessary information to assess network training and development needs without burdening the providers in responding to multiple surveys and inquiries.

3. Idaho's diverse geographic areas create challenges in developing provider capacity, and sustainability in certain areas of the state.

Next Steps

- The initial YES Foundations and Person-Centered Planning trainings have been recorded with the intent to make them available on the YES website. Training recordings are going through an editing process and are being prepared for web-based delivery.
- ICANS user trainings will take place on an ongoing basis in 2018.
- Optum is developing Respite training for existing network providers to be delivered in Spring of 2018.
- All YES planned trainings will be listed in the YES Training Plan which is scheduled to be posted on the YES website in early 2018.
- A plan for a YES training team in support of sustainability is being developed. The goal is to develop individual role training plans to support all staff who participate in YES and work toward regional training plans to support those individuals. Training related to the use of CANS reports and a Train the Trainer model is being planned for agency sustainability.
- Medicaid is revising and enhancing the 2018 training plan for its internal and external stakeholders. Optum Idaho is finalizing the Praed contract and revising their training plan to coincide with anticipated rollout dates for services.

- Utilize the BSU Workforce Capacity and Gaps Analysis report to develop next steps.
- Continue network capacity and training evaluations throughout the duration of implementation.

Strategy Part I 4.D

Evaluate the Workforce Development Plan over time for adherence to the Settlement Agreement and to adjust the Plan for system improvement.

The Workforce Development Workgroup reviews the plan during their meetings to assure that the plan is followed and is adequate to meet the needs of the developing system of care. The Workforce Development Plan will be formally evaluated every two years, beginning July 2018.

Challenges

1. Identifying the appropriate resources to evaluate the plan as the plan covers a variety of systems and stakeholders statewide.
2. Using data and outcomes to monitor the results and impact of the Workforce Development Plan on children, youth and families.

Next Steps

- Create a plan for evaluation of the Workforce Development Plan which includes timelines, resources, and a protocol. The Plan should address the development of or outline solutions for expected workforce gaps or shortages.
- Work with Praed and Portland State University to develop the protocols and utilize the TCOM Model in the evaluation process.

Strategies Part II 4.A-B

A. Develop the Practice Manual utilizing workgroups. Publish the first version of the Practice Manual by July 1, 2017.

B. Begin development of the Practice Manual by July 30, 2016.

The Annual Implementation Progress Report addressed the progress of strategy A, indicating that the Practice Manual workgroup would begin meeting in March 2017. This workgroup would review the approval process for the Practice Manual and provide input on any necessary changes to the process. Additionally, this workgroup would coordinate with other project workgroups such as Clinical Advisory, Workforce Development and CANS, by including members from those workgroups in the Practice Manual workgroup.

The first Practice Manual Workgroup was held in March of 2017 and then met every other Wednesday from April to November. The workgroup was led by a Clinical Advisory Workgroup lead from DBH and co-facilitated by a representative from Medicaid. The

workgroup currently has robust participation by stakeholders, including the Division of Medicaid, DBH, State Department of Education, parents and providers.

The Practice Manual Workgroup drafted a final charter, content review process and a workgroup task plan. The workgroup also developed a vision of the core principles that they wanted to see reflected in the manual, including incorporating youth and parent voice in each section.

Work toward the drafting of the Practice Manual began when subject matter experts were identified for each content area and tasked with developing content with input from parents, providers and other stakeholders.

DBH contracted with Idaho State University (ISU) in June of 2017 to assist with initial development of a ready-to-publish manual. Contracted work included format mock-ups, vignettes, and content review surveys for Practice Manual Workgroup members. Subject matter expert Dr. Lynn Thull, a contractor of the Praed Foundation was also onboarded as a consultant in mid-June.

A Practice Manual sub-team was created in August of 2017 to help finalize key decisions. Membership on the initial sub-team included staff from the Divisions of Behavioral Health and Medicaid and consultant Dr. Lynn Thull. Additionally, a parent and a provider were added to the sub-team in October.

In early 2018 it was determined that publishing the full Practice Manual was impractical because the full array of YES services are being developed and implemented in phases over the next few years with the first services beginning in July 2018. Therefore, the Practice Manual could not be developed or published until the system changes were developed and ready to implement. The IWG agreed this was an appropriate step under the circumstances.

Instead, An *Introduction to Youth Empowerment Services* guide has been published. Prior to publishing, the guide was distributed to the Implementation Workgroup, Defendant's Workgroup and Interagency Governance Team for comment and feedback. The guide was revised to incorporate the feedback that was received and a final draft was submitted to the Implementation Workgroup. The *Introduction to Youth Empowerment Services* guide can be found here.

Medicaid participated on both the Practice Manual Workgroup and sub-team to meet the requirements of providing documentation for the first version of the guide. Medicaid offered support through a project manager in the Fall of 2017 to assist in tracking the outstanding items, and version and content control. Medicaid engaged the behavioral health managed care entity for review and input specific to services and supports in conjunction with parent and provider feedback.

Challenges

The Implementation Plan required the publication of an initial version of the Practice Manual by July 1, 2017. The publication has not yet been accomplished for several

reasons. The initial plan to publish a full version of the Practice Manual was rejected as being confusing if it addressed services that were not yet available. The full array of YES services are being developed and implemented in phases over the next few years with the first services beginning in July 2018. Therefore, the Practice Manual could not be developed or published until the system changes were developed and ready to implement. The first publication will be the *Introduction to Youth Empowerment Services* which will explain changes to the access model and introduce the purpose and concepts of YES. A subsequent version is scheduled to be published in October of 2018 to introduce the services launching later this year with additional versions to be published as each new system change is happening.

Additional challenges included the following:

1. Writing a single guidance document with multiple authors, systems, and for multiple audiences is a continuing challenge. To produce the *Introduction*, the team overcame this by assigning smaller sub-teams to draft and review content. In addition, DBH hired a technical writer who started March 2018, to compile the information and finalize the Practice Manual to address these concerns.

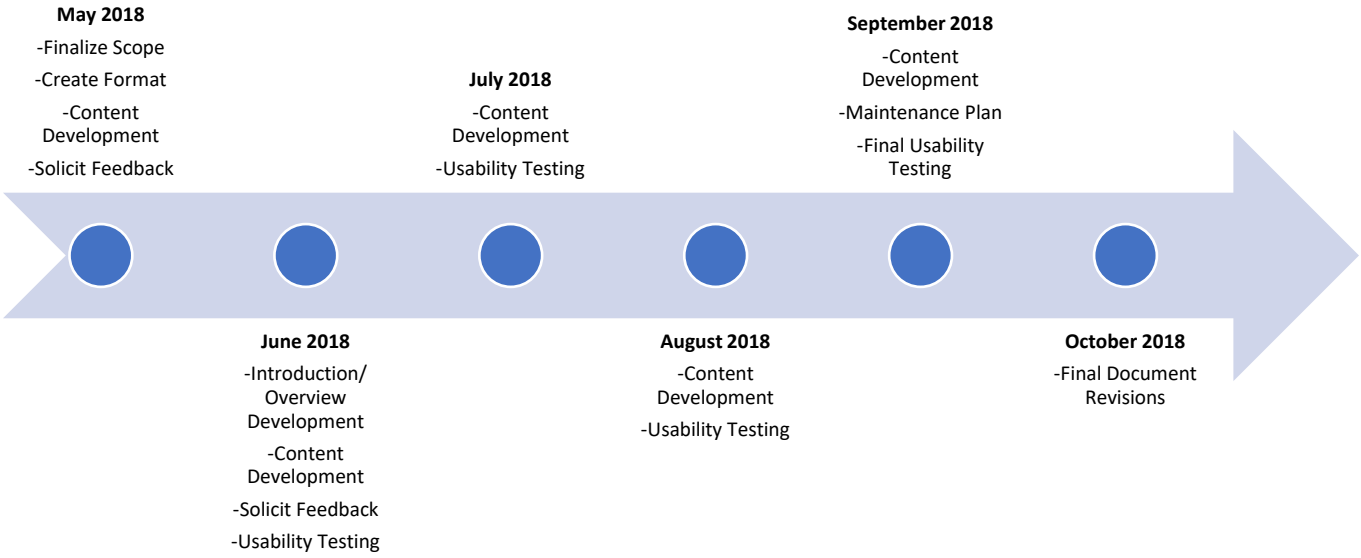
2. Decision making process and authority over the Practice Manual were often unclear or changed based on content topic. In the future, the team will establish clear roles, responsibilities, and authority prior to routing the document.

3. Content is dependent on system development and project decisions, as these are delayed or changed, manual content timelines are necessarily pushed back.

Next Steps

- Develop training and testing plan.
- Review first draft for material relevant for second draft:
  - Identify areas of Paragraph 40 A-K of the Settlement Agreement that need to be added or improved.
  - Identify subject matter experts and authors for each section.
- Publish the next version of the Practice Manual and establish a routine for publishing amendments/updates.

YES Practice Manual Planned Development Schedule



Strategy Part II 4.C

Update the Practice Manual until completed on June 30, 2019. Train and provide technical assistance on the Practice Manual.

The Practice Manual will be updated periodically until completed. Training and technical assistance will continue to be provided. Practice Manual updates will follow the Provider Network training schedule.

Objective 5: Due Process

The agencies will develop and operate constitutionally and federally-compliant fair hearing systems, and will create and operate a centralized complaint routing and tracking system. Furthermore, the agencies will implement a process for reviewing compliance to applicable regulations, rules, and policies regarding due process requirements, and periodically report on the metrics of operating this system. The work of this objective will be led by IDHW in consultation with Idaho Deputies Attorney General. The work of this Objective does not apply to services provided to Class Members on an involuntary basis, such as services provided involuntarily to Class Members in the custody of the state or those services required by a Court Order. See Agreement paragraph 3 and Appendix B, third introductory paragraph. This entire process will be included in the Practice Manual and will be coordinated with the Quality Management, Improvement, and Accountability (QMIA) goals, plans, or results listed in Objective 7 to avoid a duplication of efforts with this Objective.

Strategy 5.A

Operate a standardized complaint and administrative hearing system beginning October 1, 2018.

Idaho's child and youth serving mental health systems have begun to develop, adopt and consistently use systems for complaints and due process that reflect the YES Practice Model approach. The Due Process Workgroup, which includes representation of all parties including families, has been meeting throughout the year to address the requirements for establishing due process associated with YES.

It was determined by the Due Process Workgroup that all parties had a complaint process that was established. It was also determined that Medicaid's complaint process meets CFR and YES requirements as outlined in the objective above, with the exception that recent Medicaid regulations required the Medicaid complaint system to be utilized prior to requesting a State fair hearing. Both the Settlement Agreement and Implementation Plan requires the complaint process to run concurrently with appeals process which contradicts the new Medicaid regulations.

The Division of Behavioral Health enhanced its existing complaint system by adding a toll-free number and new resources within the Division's Quality Assurance Unit to address concerns about behavioral health services for children and youth. The toll-free number, 855-643-7233, is answered by DBH staff between 8:30 am and 4:30 pm (MST) each business day. DBH has also added its complaint process to the language to the Idaho Administrative Code (IDAPA) rules to formalize its process and to align it Medicaid practices to make the process look similar and less confusing to participants.

There is a Memorandum of Understanding (MOU) that is in the process of being signed by YES system partners that will allow collaboration regarding complaints across all child-serving systems.

All system partners are required to have an appeal process, DBH, Medicaid and SDE, currently have processes in place that meet their specific state and federal requirements.

Medicaid has systems in place for appeals and fair hearings. A link to requests for Fair Hearings are posted on the Medicaid Idaho Behavioral Health Plan (IBHP) website: http://healthandwelfare.idaho.gov/Portals/o/Medical/MedicaidCHIP/OMHSAFairHearingRequestForm.pdf

While DBH utilized these procedures for appeals of its children's mental health program, it was identified that these rules did not always align with Medicaid requirements for fair hearings. DBH determined that they would more closely align their notices and procedures to Medicaid requirements so that the process would look similar and therefore less confusing to participants.

State Department of Education has systems in place. On the SDE website under link for Special Education there is information about the processes for dispute resolution, including mediation and hearings: https://www.sde.idaho.gov/sped/dispute/

The Due Process Workgroup began reviewing the written notices of action that are currently in use by DBH, Optum, and Medicaid. It is expected that compliant and family friendly notices will be finalized by October 2018.

Challenges

1. Idaho's Medicaid program must follow federal Medicaid regulations requiring utilization of the complaint process prior to accessing a formal appeals process. As stated above, this conflicts with both the Settlement Agreement and Implementation Plan which allow for the complaint process and appeals process to be used concurrently. Since the federal regulations cannot be changed, it is suggested that the Implementation Plan may need be amended to accurately reflect federal Medicaid regulations.

2. DBH had existing processes in place for complaints at the regional level, but did not have informing materials that were distributed to families as part of the intake process. As work began, it came to the attention of the Due Process Workgroup that families may not be aware of the existence of a complaints process. DBH complaints and due process informational materials are currently under development and are expected to be completed by October 2018.

3. IDAPA 16.05.03 governs administrative appeals of public benefits administered through the Idaho Department of Health and Welfare. DBH had appeal process in place, but the process did not match the Medicaid process. DBH has made the necessary process changes, including adding language to the Idaho Administrative Code (IDAPA) rules to establish the authority to provide for "expedited appeals" for "non-Medicaid eligible YES individuals".

4. Although the Settlement Agreement requires Idaho to allow people to appeal and request Fair Hearings concurrently, the appeals process as required in Federal Medicaid regulations (42 CFR 438) has changed to allow states to require exhaustion of the first-level appeal process prior to fair hearing. Because of this change in Federal Medicaid regulations and the determination that Idaho will require exhaustion of the grievance process prior to appealing, the processes that have been implemented will not align with the Settlement Agreement. It is suggested that the Implementation Plan be amended to accurately reflect Medicaid regulations.

5. There are various federal and state rules that each party must follow, which has made it difficult to streamline processes. While DBH did change the language in the Idaho Administrative Code (IDAPA) rules to more closely align with Medicaid practices, Federal regulations governing both State Department of Education and Medicaid do not align. Discussions within DHW continue to look for methods to streamline the processes whenever possible.

6. Although the existing written notices of action comply with rule criteria, it was determined that these notices are not family-centered. Written notices will need

to be enhanced to better meet the needs of children, youth and families. There have also been challenges in revising written notices of action, which are embedded into electronic systems that cannot be easily changed. The Due Process Workgroup continues to review all notices and make recommendations for improvements.

Next Steps

The goal is for the complaint and due process system required by the Settlement Agreement to be fully operational on 10/1/2018. The following are next steps that have been identified to meet this goal:

- The Defendants Workgroup (DWG) formed a workgroup to review options for a centralized complaints process, which will include the possibility of using parents in a role of liaison for families as recommended by the Due Process Workgroup. The DWG will evaluate the option and make a recommendation with the potential for a short term and longer-term solution, The goal is to complete the process and implement the system by October 1, 2018.
- The Due Process Workgroup to complete the review of written notices using criteria from the Settlement Agreement paragraph 45 items A-I by Sept 1, 2018.
- Identify which electronic systems allow for changes to be made to written notices by Sept 1, 2018.
- Identify any contracts that require modification to establish the complaint and due process protocols.
- Develop, adopt, and use a process to monitor and periodically report on compliance with the complaint and due process protocols.
- Publish a link for the YES complaints process and appeal procedures.

Strategy 5.B

Implement a due process tracking and reporting system beginning October 1, 2018.

The Data and Reports Team is working collaboratively to develop standardized terms to be used in tracking and reporting complaints and appeals by Oct 1, 2018. The focus for the reports will be based on the key decision points in care established by Dr. Lyons and Dr. Israel: screening, engagement, appropriateness, effectiveness, and linkages. The reports will be mainly targeted to DHW.

Challenges

1. Each system has their own existing method for tracking and reporting complaints and appeals. Changes to the existing systems are limited by State and federal rules that mandate reporting.
2. Systemwide information will be limited to systems that are required to report. School districts are not required to report complaints or appeals to SDE.

Next Steps

- Complete and implement the plan for a centralized objective process for tracking and addressing complaints by October of 2018.
- Collect and report data on complaints and outcomes from all five parties by October of 2018.
- Collect and report data on appeals and fair hearing requests and outcomes. The QMIA Data and Reports Subcommittee have set a goal for reporting on this data by July of 2019.

Objective 6: Governance and Interagency Collaboration

Establish governance and interagency collaboration within the authority of the Idaho Behavioral Health Cooperative (IBHC) to collaboratively coordinate and oversee the implementation of the Agreement.

Strategy 6.A

The Department of Health and Welfare authorizes a Project team and Project sponsorship to provide structure and framework for initiating, planning, executing, controlling, and closing the Project work needed to achieve the Settlement Agreement outcomes and exit criteria.

The previous Annual Implementation Progress Report addressed the progress of strategy A, indicating that pending legislative approval, staff hired by the CMH program would assist with carrying out the activities outlined in the project plan. In addition, identification of inter-dependencies and critical path for updates of the project plan would be completed. Updates were to be drafted in February of 2017 and delivered for review and stakeholder feedback in March of 2017. It was also indicated that staffing requests would be sent to the legislature for approval in 2017.

Strategy 6.B

Establish and implement the Interagency Governance Team (IGT) by July 30, 2016.

The Interagency Governance Team (IGT) has met monthly since July 30, 2016. The IGT held several extended meetings designed to promote education and improve understanding of the Youth Empowerment Services (YES) project, the Settlement Agreement, Implementation Plan, and IGT Charter. Extended half day meetings included the following:

- March 2017- Meeting to begin work on completing the Transformational Collaborative Outcomes Management (TCOM) Team Development Guide. Dr. Nate Israel of the Praed Foundation provided consultation. The work from this meeting was used to update and revise the IGT charter.
- May 2017- Training with Dr. John Lyons from the Praed Foundation on the CANS tool.
- December 2017- Meeting focused on drafting an Operational Governance Plan and developing the purpose of the Training and Clinical Subcommittees.

- April 2018- Meeting focused on the Principles of Care and Practice Model, Services and Supports timeline, access for non-Medicaid Class Members, Case Management, and the Independent Assessment process.

The initial IGT membership appointments expired in October 2017. The Idaho Behavioral Health Cooperative (IBHC) reappointed members of the IGT which included three parents, one former Class Member, two family/youth advocacy representatives, and two providers. The Family Engagement subcommittee is working to recruit youth and young adults to both the subcommittee and to the IGT. This recruitment strategy began by introducing youth to the YES Foundations training content to provide them with an initial basis of understanding.

The IGT has 17 members. Members representing various departments have identified proxies to provide representation when appointed members are unable to attend. The Divisions of Behavioral Health and Medicaid have designated staff to provide technical assistance for the IGT.

Additional progress of the Interagency Governance Team includes the following:

- Adopted a revised charter.
- Adopted IGT Request Form; the purpose of this form is for the IGT to submit official requests for information and receive a response back from the YES Project Team.
- Appointed a new Chair and Co-chair.
- Adopted Family Engagement subcommittee statement of purpose.
- Operational Guidelines were approved in March of 2018.
- The Clinical and Training Subcommittee was established in April of 2018.

The state is also leveraging the value of youth voice in this work and has actively engaged with existing youth organizations, such as Idaho Youth M.O.V.E. and the Idaho Foster Youth Advisory Board (IFYAB) to identify youth who may be interested in participating on or working with the IGT. There is currently one youth member of the IGT and an additional youth representative on the Family Engagement Subcommittee.

Challenges

1. The scope of oversight and decision-making authority was a challenge for the IGT over the past year, as members had differing perceptions on its role and purpose.

2. The IGT membership initially struggled with the purpose of the mandatory Clinical and Training subcommittees. Due to the ambiguity, members of the IGT were reluctant to volunteer to lead these subcommittees. A decision was made to combine the subcommittees initially, but two distinct statements of purpose were created. In April of 2018 the subcommittee convened and identified leadership.

3. The Interagency Governance Team meeting times often conflict with schedules of parents and former Class Members. This resulted in the departure of a former Class Member, and has made recruitment a challenge.

Next Steps:

- Continue to develop the Training and Clinical subcommittee/s.
- Continue to identify the data, reports and other information that the IGT needs to conduct its work.
- Through the Family Engagement Subcommittee develop a recruitment strategy to enhance stakeholder membership representation.

Interagency Governance Team: Parent Perspective

"It has been a struggle to make sure that all the right players are at the table for the IGT. Decision makers are overbooked and putting their time in to the Implementation Workgroup rather than governance. IDJC has consistently sent a qualified representative to IGT who has coordinated closely with decision makers at that agency. SDE struggled to have a consistent representative available at first, but in May 2017 identified a new representative who has provided coordination and follow up with that agency. Medicaid had a similar struggle and identified a representative around the same time frame, though that representative has not been completely consistent in attendance. Medicaid has been sending additional people to answer questions and take on action items which has been helpful. Sometimes it feels that the extra people are making the meeting too crowded and therefore less efficient, though it is nice when the right person is able to answer a question.

The Settlement Agreement states that the governance partnership will be led by the Administrator of the Division of Behavioral Health. It has been difficult for this person to actively participate, especially during the legislative sessions. A representative from the QMIA council does attend consistently. Many other DBH staff attend each meeting. Some provide crucial support with meeting logistics and note taking. Others answer questions and take on action items. Some present information when requested. Some listen silently. Again, the number of people in the room seems to grow with time and make it difficult to keep track of who is truly representing DBH as well as Medicaid. A system of large and small name tags has been devised to keep track of voting members versus support staff.

Returning to the point about the governance partnership being led by the Administrator of DBH, this has been another struggle for the stakeholder representatives. It was decided early on that the Chair of this team should not be an employee of any of the defendant agencies. The balance between the Chair leading the discussions and the Administrator leading the partnership and DBH staff providing support continues to be a challenge. The Chair person is a volunteer and does not have a lot of time to work on preparations outside the meeting times. In order to provide leadership, that person needs extensive support from staff for things like distribution of documents, scheduling, tracking requests and action items. A new request tracking sheet and action item system were developed by the DBH support staff in collaboration with the Chair which we hope will streamline these tasks."

Objective 7: Quality Management, Improvement, and Accountability (QMIA)

The agencies will develop and implement a QMIA plan to establish and maintain a collaborative QMIA system that includes monitoring, measuring, assessing, and reporting on Class Member outcomes, system performance, and progress on implementation and completion of this Agreement. The collaborative QMIA system will increase system-wide capabilities for quality improvement at the clinical, program and system levels associated with increasing effectiveness of services and improving access to services. The parties jointly develop a Quality Review (QR) process to be used to objectively assess and improve clinical practice and program effectiveness system-wide.

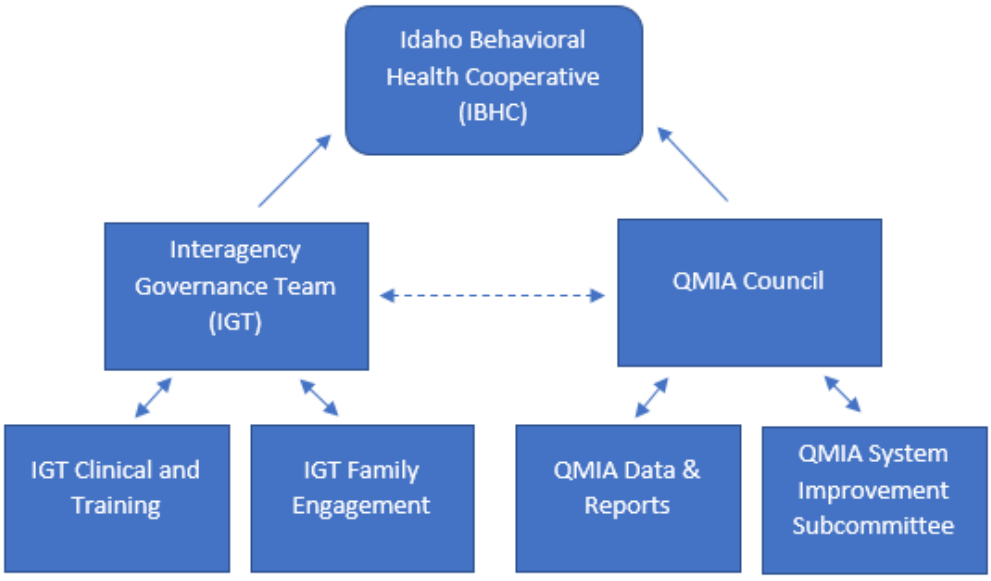
Strategy 7.A

Develop and implement a QMIA plan by March 31, 2016

The QMIA Plan was developed and approved by March 31, 2016. The establishment of the collaborative Quality Management Improvement and Accountability (QMIA) infrastructure noted in the QMIA Plan is in progress.

The QMIA Council, which includes representatives from each of the involved partners has been meeting throughout the past year. Notably the QMIA Council was enhanced through the addition of a family representative in 2017, and a second family representative in 2018.

The QMIA Council has been working collaboratively with the Interagency Governance Team (IGT) on creation of planned QMIA subcommittees. Changes have been made to the original QMIA subcommittee structure based on other groups that have been formed. The revised organizational structure is diagramed below:



The QMIA Council has been working on a Quality Improvement Plan (QIP) Issues that have been experienced by families. Concerns have been logged and desired performance improvement outcomes have been indicated. The QMIA Council is working with the QMIA Data and Reports Subcommittee to identify how data can be collected around problem statements and how improvement could be measured. QIPs will continue to be created by the QMIA Council as needed and delivered to the QMIA System Improvement Subcommittee for facilitation.

In addition, CANS implementation will continue to focus on development of the automated CANS system over the next ten months.

Challenges

1. The original QMIA Plan was written prior to Idaho's recent work with Praed in the development of a TCOM system. QMIA Plan will be reviewed in June and July of 2018 and revised to match with and assure consistency with the Settlement Agreement, Implementation Plan and TCOM.

2. The QMIA Council has experienced some difficulties in membership attendance at meetings due to conflicting priorities.

Next Steps

- Achieve continuous quality structure and improvement through TCOM implementation and training.
- Review a proposal for Quality Review (QR) which will then be reviewed by the IGT and by the Plaintiffs' counsel.
- Establish a QMIA System Improvement subcommittee to facilitate work on Quality Improvement Plans approved by the QMIA Council.

Strategy 7.B

The QMIA Council will adapt and enhance existing quality assurance infrastructure activities.

Each of the YES system partners has existing quality assurance activities in place. The partners use record review, site review, credentialing, complaints, appeals, and review of serious incidents and the mechanisms to assess the current quality issues in each of their programs. The QMIA Council has completed an inventory of each parties' current quality improvement projects which are reported in the QMIA Quarterly Report #5, click here to access the full report.

The following quality improvement activities were noted as "in process" within this report:

- Division of Behavioral Health (DBH)
    - Due Process: Assessment of regional due process procedures and implementation of statewide DBH procedures.

  - Creation of informing materials for families related to the complaints process.
  - Hospital Discharges: Review of state operated hospital discharge policies to make discharge process and post-discharge easier on families.
- Division of Medicaid
  - Pharmacy Quality Improvement Project: The Idaho Medicaid Pharmacy Program has had a major focus on improving the use of psychotropic medications in children since 2011. Many efforts and interventions have been directed toward those children in foster care. Some of the most successful interventions were establishing red flags for when psychotropic medication may be excessive or outside other best practice parameters and doing individual case management with Family and Community Services (FACS) staff, a Medicaid pharmacist, a physician representative from Optum and the foster child's case worker. In 2016 and 2017 there was a focus on the antipsychotic drug class use in children. The goal was to ensure that use of second generation antipsychotics in children younger than 6 years old was appropriate and resulted in positive outcomes. Guidelines were established for antipsychotic use in children younger than 6 years old, which is to be operationalized with a prior authorization form we have created that includes a requirement for informed consent.
  - Psychiatric Residential Treatment Facility Review Process: Medicaid focused on reviewing and improving the process for Psychiatric Residential Treatment Facilities (PRTF) placements in 2017. Application tracking and weekly staffing with management quickly showed areas Medicaid could focus improvement activities. The primary focus was decreasing the time between receipt of the completed application, approval of the request, and completed placement. Medicaid successfully decreased the average turn-around time of 60-90 days in 2016 to 27 days in 2017.
  - Expansion of Cross-Functional Team: Cross-functional team expanded to add additional medical and behavioral health experts.
- Division of Family and Community Services (FACS)
  - Foster Parent Training: Improve foster parent training through the development of Professional Resource Family development plans and specialized, competency-based training curricula.
  - CANS Tool: Continue implementation of Family and Community Services CANS tool.
  - Stakeholder Engagement: Improve stakeholder engagement in Continuous Quality Improvement initiatives with technical assistance from the Capacity Building Center for States
- Department of Juvenile Corrections (IDJC)
  - "Think Trauma": Trauma-informed care training for direct care staff.
  - Funding pass through to Mental Health Program: Approximately 25% of funding passed through to counties and local communities to support effective programming and reintegration. Mental Health Program is one

stream. Last year 245 juveniles were served with a 90% success rate (not being committed to IDJC).
    - Behavioral Health Referral (pilot): Early identification of youth to assist staff in determining most appropriate placement/treatment as early as possible.
    - CANS information for IDJC staff: Information provided re: what the CANS means to IDJC, how to work with it, information for case managers.
- Department of Education (SDE)
    - Idaho Lives Project: School-based suicide prevention initiative involving the Sources of Strength program. Currently, around 47 schools are involved and data is collected on an ongoing basis. Feedback indicates that the schools implementing the program with fidelity and that have local buy-in are seeing improvements in school climate, student support and help-seeking behavior.
    - Safe and Drug Free Schools / ESSA Title IVA: Funding sources with requirements / allow for school districts to budget for crisis response efforts, bullying prevention, violence prevention, substance abuse prevention and general school climate / school safety measures.
    - Idaho Prevention Conference: Annual statewide conference focusing on creating optimal learning conditions with a heavy focus on bullying / harassment prevention, trauma informed instruction / disciplinary policy and diversion.

Challenges

1. The QMIA Council reconsidered the original QMIA structure which included five subcommittees.
    - The first System Improvement Subcommittee will be implemented in June 2018 and will be tasked with working on developing a quality improvement plan to address issues with hospital discharges and transitioning home from residential care. Two issues identified by families involved with IGT, IWG and QMIA-Council.
    - It was determined not to implement the Youth and Family Partnership Subcommittee as there were already other committees and workgroups that had been implemented and the Council felt the need was being met by the other workgroups (the Family Engagement Subcommittee of the IGT and the Parent Network).
        - Note that the work being done with the Youth is being spearheaded by DBH staff and the Boise chapter of Youth MOVE. Youth MOVE is assisting with the development and leadership of the Youth Voice Project initiative. Details regarding youth voice within YES were provided earlier in this report, and can be accessed by clicking here.
    - The Implementation Progress Workgroup was replaced by the various YES workgroups that were doing project management.
    - The Provider Advisory and Clinical Quality Subcommittees were put on hold as well as many providers were also involved in other workgroups

(such as the Clinical Advisory, Workforce Development, Communications, Practice Manual, and IGT).

Next Steps

- Collect data related to hospital discharges and transition home from residential facilities from a survey distributed to families participating in the Family Network.
- Implement the System Improvement Subcommittee by June 30, 2018.

Strategy 7.C

The QMIA Council will monitor, assess, and report system performance using performance metrics.

The previous Annual Implementation Progress Report addressed the progress of Strategy C, indicating that the QMIA Council would continue to use existing data in conjunction with Dr. Israel's consultation and publish quarterly reports.

Idaho's child serving systems have been measuring, assessing and reporting on Idaho's children and youth who need mental health services, YES system performance, and monitoring their progress on implementation of the Settlement Agreement.

The QMIA Council and Data and Reports team is working closely with Dr. Nate Israel of the Praed Foundation to develop the structure needed to use data for management, measuring what needs to be managed, and implementing improvement projects to address issues that are identified. The State has developed the Idaho Transformational Collaborative Outcomes Management (TCOM) Model describing how data will be used to assess the system of care which can be found in Appendix C and has also been referenced earlier within this report; Strategy 2.C.

The QMIA Data and Reports Team established the following methodology for prioritizing data collection:

- Identify and utilize existing reports from each of the parties.
- Utilize data that is easily accessible in published reports and on websites.
- Develop contracts with universities to assist with data collection needed based on QMIA and Workforce Development.
- Identify gaps in collection of data specified in the Settlement Agreement and begin the establishment of systems to collect the data.
- Work collaboratively to define data elements and identify a method for creating a unique identifier for each child to reduce duplication.

The standing report for QMIA, the QMIA Quarterly, has been published on a quarterly basis as required. Input from stakeholders has been solicited to improve the content and usefulness of the report. The QMIA quarterly reports can be accessed by clicking here.

QMIA has also assisted with informing the contract work with Boise State University, for development of reports on Class Membership, projected Intensive Care Coordination

(ICC) utilization and the workforce development provider survey and the provider profiles mentioned previously.

Challenges

The following challenges were noted regarding QMIA data and reports:

1. Data sharing is currently limited between partner agencies due to Health Insurance Portability and Accountability (HIPAA) restrictions which are intended to protect patient's medical records.

2. Data elements tracked by each partner vary based on their federal and state requirements. The Data and Reports team has developed a YES Report Profile and Data Dictionary.

3. Limited CANS data is available as use of the CANS tool has only recently begun. Data will become available on an ongoing basis as more CANS are completed for existing as well as new clients.

4. It's early in the implementation of YES services so there is only limited system performance to measure and evaluate. How well the QMIA works will be tested in the coming months as more services come on line and more children are served.

Next Steps

- As CANS data becomes available the QMIA Quarterly reports will include the number and characteristics of children and youth assessed for YES.
- A beta version of CANS reporting is targeted to be completed Spring of 2018.
- DBH is in the process of creating YES data and outcomes dashboards. A timeline for automated public-facing data dashboards has not yet been confirmed but plans are for data to be available in the Fall of 2018.

Strategy 7.D

Develop a Continuous Quality Improvement culture within the Children's System of Care beginning June 1, 2016.

Considerable system management work has been done through a contract with the Praed Foundation. Praed consultants have been assisting with the implementation of the Transformational Collaborative Outcomes Management (TCOM) approach. TCOM is described as a conceptual and practical framework for managing complex systems. The TCOM approach is based on the concept that the multiple perspectives in a complex service system creates conflicts. The conflicts that arise are best managed by focusing on a common goal, or a shared vision. In the YES system, the shared vision is to improve the lives of children, youth and families. With assistance from the Praed Foundation, the state is working toward creating a continuous quality improvement culture within the YES system where all stakeholders continue to return to this shared vision.

Challenges

1. The QMIA Council and IGT are still developing an understanding of TCOM. An assessment of TCOM implementation indicates that while some system partners have begun to establish a baseline comprehension of the TCOM, most are still just assimilating the basic concepts.
2. To fully develop TCOM each system partner will need to clearly designate individuals as subject matter experts.

Next Steps

- Continue training on TCOM for the QMIA Council and IGT.
- Repeat the TCOM implementation protocol and provide targeted education on each aspect of implementation.
- Continue training on TCOM to further develop subject matter experts in each of YES system partners.
- Individuals clearly designated for each YES system partner to be subject matter experts in TCOM.
- Idaho is working with the Praed Foundation to host a Regional TCOM Conference in May 2019.

Strategy 7.E

Provide accountability by monitoring Idaho's progress toward completion of Outcomes and Exit Criteria required by the Settlement Agreement beginning June 1, 2016.

The QMIA Plan identified the measures and indicators that are being used or will be used to monitor the progress towards completion of the Outcomes and Exit Criteria.

One of the established methods of assuring accountability to the Settlement Agreement is through the monthly IWG meetings with regular status updates provided to the Plaintiffs.

Another method is through the QMIA-Q report and Annual Implementation Progress Report address both the progress made toward implementation and the progress toward completion of Outcomes and Exit Criteria.

In the Annual Implementation Progress Report the focus of the report is on the Implementation Plan, however there is direct relationship between the specific outcomes and exit criteria listed in the Settlement Agreement and the objectives and strategies in the Implementation Plan. This relationship is identified in the tables in the following section of the report.

Next Steps

- The status updates will continue to be improved through input by Plaintiffs so that the level of detail they want to have included is in the reports.

- Complete matrix with each Strategy and Sub strategy from the Implementation Plan.
- Use the matrix as part of QMIA review process to ensure that implementation is on track.
- Identify resources for QMIA of implementation plan.

V. Settlement Agreement Outcomes

This section of the Report provides information on the progress towards achieving the Outcomes defined in the Settlement Agreement which are the expected results of completing the Court approved Implementation Plan. A three-year sustainability period shall begin once the Court has determined substantial compliance with the Outcomes. The Outcomes are listed within the table and there is a link provided to narrative that is associated with the section in the Implementation Plan. The Status column is reflective of the Defendant's perspective on the progress of achieving the outcome and does not imply Plaintiff's agreement nor Court determination as to the achievement of the Outcome. Status clarifications for the following tables are listed below:

- In-Progress: Work has begun toward satisfying this Outcome or Objective, however, the work is not yet considered completed. Details on progress, challenges and next steps can be found within the assigned narrative.
- On-Going: Work is either in-progress or completed, however this is an Outcome or Objective with components that do not come to an end, such as a process, and therefore work will be continuous.
- Completed: Defendants believe all planned work has been completed and the Outcome or Objective is considered satisfied.
- Delayed: Work has begun toward satisfying the Outcome or Objective, however, the target completion date has not been met. Details on progress, challenges and next steps can be found within the assigned narrative.
- Not yet Started: Work on this Outcome or Objective is planned for a future date and therefore has not yet begun. Timelines and Dates are noted for these items.

A. Services Outcomes

Services Outcomes		
Outcome	Status	Link to Details within Report
a. Establish and annually update the range of expected Class Members service utilization, as set forth in paragraph 24;	Completed	Objective 1, Strategy G
b. Develop statewide capacity to timely provide Services and Supports in appropriate scope, intensity	In-Progress Target date for	Objective 1, Strategy J

and duration to Class Members for whom it is medically necessary;	completion June 2019	
c. Provide the full array of Services and Supports, as defined in Appendix C, statewide as needed by and clinically appropriate for Class Members;	In-Progress Target date for completion June 2019	Objective 1, Strategy J
d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to their individual strengths and needs, as described in paragraphs 18, 22, 23 and 36; and	In-Progress	Objective 1, Strategy J
e. Provide ICC, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21.	In-Progress	Objective 1, Strategies A-D

B. Principles of Care and Practice Model Outcomes

Principles of Care and Practice Model Outcomes		
Outcome	Status	Link to Details within Report
a. Develop, adopt, and deliver Services and Supports to Class Members with fidelity to the Practice Model statewide and consistent with the Principles of Care and the Agreement, as set forth in paragraphs 25 through 27; and	In-Progress, On-going	Objective 2, Strategy A, Objective 2, Strategy B
b. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Principles of Care and Practice Model	In-Progress, On-going	Objective 2, Strategy A

C. Access Outcomes

Access Outcomes		
Outcome	Status	Link to Details within Report
a. Develop, adopt, and consistently use the Access Model statewide to identify, screen, assess, refer, and link Class Members to services and supports, as described in paragraphs 28 through 36 and Appendix A;	In-Progress	Objective 3, Strategy A
b. Implement and use the CANS tool statewide, as described in paragraph 32, to: i. Screen potential Class Members for unmet mental health needs; ii. Assess Class Member's individual and family strengths and needs; iii. Support clinical decision-making and practice; and iv. Measure and communicate client outcomes; and v. Improve service coordination	In-Progress, On-going	Objective 3, Strategy D
c. Develop, adopt, and use statewide a uniform, age-appropriate screen, described in paragraph 33, to identify potential Class Members with unmet mental health needs;	In-Progress, On-going	Objective 3, Strategy C
d. Develop, adopt, and use statewide a standard mental health assessment, described in paragraph 34, to determine class membership status for potential Class Members referred for an assessment;	Completed	Objective 3, Strategy D
e. Establish threshold levels of functional impairment as measured by the CANS tool, in consultation with clinical expert(s) mutually agreed by the Parties, as described in paragraph 35, to be used by Defendants in determining eligibility (i) to become Class Members and (ii) to receive ICC services;	Completed	Objective 3, Strategy C.1
f. Use the threshold levels of functional impairment established pursuant to paragraph 35 when determining eligibility for class membership;	Completed	Objective 3, Strategy C.1
g. Make descriptions or explanations of this Agreement, the Services and Supports, the Principles of Care and Practice Model, and the Access Model easily and publicly accessible to Class Members, their families, and other stakeholders, including but not limited to, posting information on Defendants' websites as described in paragraphs 36 and 37;	In-Progress, On-going	Objective 3, Strategy F
h. Develop and implement a statewide communication plan for outreach and education of the community,	In-Progress, On-going	Objective 3, Strategy F

stakeholders, and families, as described in paragraph 38; and		
i. Require that contracted mental health providers or mental health managed care contractors deliver services to Class Members consistent with the Access Model.	In-Progress	Objective 3, Strategy B

D. Workforce Training and Development Outcomes

Workforce Training and Development Outcomes		
Outcome	Status	Link to Details within Report
a. Develop and implement a workforce development plan, as described in paragraph 39;	Part II of the Workforce Development and Training Plan is in development and is expected to be published in July of 2018	Objective 4, Part I, Strategy B
b. Develop and adopt a Practice Manual, as described in paragraph 40;	Planned for Oct 2018	Objective 4, Part II, Strategy A-B, Objective 4, Part II Strategy C
c. Consistently use a Practice Manual to guide clinical and programmatic activities statewide, as described in paragraph 41;	Planned for Oct 2018	Objective 4, Part II, Strategy C.5
d. Educate and train agency staff, providers, and other community and system partners, as set forth in paragraphs 41 and 42, to use and follow the Access Model, Practice Model, and Practice Manual: i. To identify and refer potential Class Members for screening; and ii. Deliver services and supports to Class Members; and	Foundational Training completed, CANS Training in progress, Clinical and Operational Training on going	Objective 2, Strategy B.2, Objective 3, Strategy C, Objective 4, Part II, Strategy C

e. Educate and train agency staff and providers to use the CANS tool	Piloted with DBH Fall 2017, Implementing Statewide starting July 2018	Objective 3, Strategy D

E. Due Process Outcomes

Due Process Outcomes		
Outcome	Status	Link to Details within Report
a. Develop, adopt, and consistently use a complaint process, as described in paragraph 43, as part of the Practice Model's CFT approach;	In-Progress. Due Oct 1, 2018	Objective 5, Strategy A
b. Provide written notices of action when the circumstances defined in paragraph 44 apply;	In-Progress	Objective 5, Strategy A
c. Provide written notices of action that comply with the criteria defined in paragraph 45;	In-Progress	Objective 5, Strategy A
d. Provide informational materials regarding the circumstances in which Class Members have a right to receive a written notice of action and request a fair hearing on their respective websites;	In-Progress	Objective 5, Strategy A.4
e. Make modifications to contracts necessary to establish the complaint and due process protocols as defined in paragraphs 43 through 46;	In progress	Objective 5, Strategy A.3
f. Develop, adopt, and use a process to monitor and periodically report on compliance with the complaint and due process protocols as defined in paragraphs 43 through 46; and	Not started – Planned for Oct 2018	Objective 5, Strategy B
g. Collect and report data on written notices of action, complaints, and fair hearing requests and outcomes.	Not started – Planned for Oct 2018	Objective 5, Strategy B

F. Governance and Interagency Collaboration Outcomes

Governance and Interagency Collaboration Outcomes		
Outcome	Status	Link to Details within Report
a. Establish and use an Interagency Governance Team, as described in paragraph 49 and Appendix D;	Completed	Objective 6, Strategy A
b. Adopt and use operational guidelines for the Interagency Governance Team, as described in Appendix D; and	In-Progress	Objective 6, Strategy B
c. Include a current or former Class Member representative, a parent or family member of a current or former Class Member representative, and a children's mental health consumer or family advocacy organization representative as part of the Interagency Governance Team.	Completed, On-going	Objective 6, Strategy B

G. Quality Management Improvement and Accountability (QMIA) Outcomes

Quality Management, Improvement and Accountability Outcomes		
Outcome	Status	Link to Details within Report
a. Develop and implement a QMIA plan, as described in paragraph 52;	Completed	Objective 7, Strategy A
b. Develop and operate a QMIA System with capabilities consistent with the criteria defined in paragraph 53;	In-Progress	Objective 7, Strategy B
c. Measure and publicly report QMIA indicators, including, but not limited to, those required in paragraph 55;	In-Progress	Objective 7, Strategy C
d. Jointly develop with Plaintiffs' counsel a QR process, as described in paragraph 56;	Not Started-Planned for Aug 2018	Objective 7, Strategy D.4
e. Conduct QRs, as described in paragraph 57;	Not Started-Planned for July 2019	Objective 7, Strategy D.5
f. Publicly report on the results of the QRs, as described in paragraph 58; and	Not Started-Planned for January 2020	Objective 7, Strategy D.5
g. Achieve improved overall outcomes for Class Members, as measured by improvements in aggregated	Not Started – Planned to	Expected outcome of

CANS domain scores and/or relevant clinical items from the CANS tool, in each Region.	begin July 2018	Implementation Plan

GLOSSARY

Algorithm: A set of instructions for a process that leads to a predictable result; set of rules to be followed in calculations or other problem-solving operations; business flow diagrams.

Class Members: Are Idaho residents with a Serious Emotional Disturbance who are eligible under the Settlement Agreement for services and supports provided or arranged by Defendants and:

a. Are under the age of eighteen (18);
b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; [7] and
c. Have a substantial functional impairment that is measured by and documented using a standardized instrument conducted or supervised by a qualified clinician or would have been measured and documented had an assessment been conducted.

Child and Adolescent Needs and Strengths (CANS): A multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Child and Family Team (CFT): A teaming process that brings together the family and individuals that the Class Member and family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals; the CFT may be small or large.

Commitments: As described in the Settlement Agreement, the commitments are the items or actions that the State will pursue to achieve the intended results of the Settlement Agreement.

Community Based Services: Refers to a continuum of services, from support to intense levels, that operate in targeted population's community that is reflective of the community and meets the community's needs for services; includes hospitals and residential settings. Communities are defined on a continuum from neighborhoods to the whole state.

Completed: Refers to an Objective from the Implementation Plan that has been finished.

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[7] A substance use disorder, or development disorder alone, does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis.

Continuum of care: The array of services and supports as defined in the Settlement Agreement. spanning all levels and intensity of care.

Idaho Behavioral Health Plan (IBHP): Idaho Medicaid's managed care behavioral health plan that is a carved-out program from the overall fee-for-service medical assistance program. Read more about the IBHP on the DHW website.

Intensive Care Coordination (ICC): A case management service that provides a consistent single point of management, coordination and oversight for ensuring that children who need this level of care are provided access to medically necessary services and that such services are coordinated and delivered consistent with the Principles of Care and Practice Model.

In-Progress: Refers to an Objective from the Implementation Plan that is still being developed.

Interagency Governance Team (IGT): A collaborative interagency governance team, including stakeholders, responsible to coordinate and oversee implementation of the Settlement Agreement

On-going: Refers to an Objective from the Implementation Plan that has been developed and is continuing to be implemented.

Parties: Parties in the Jeff D. class action lawsuit: Plaintiffs' counsel, Idaho Department of Health & Welfare, Idaho Department of Juvenile Corrections, State Department of Education.

Partners: YES System Partners to the Jeff D. class action lawsuit: Idaho Department of Health & Welfare, Idaho Department of Juvenile Corrections, State Department of Education.

Person-Centered Planning: A process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the Person-Centered Planning process. The process includes participants freely chosen by the family or individual who can serve as important contributors. The family or participants in the Person-Centered Planning process enable and assist the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff. The identified personally-defined outcomes and the training supports, therapies, treatments, and or other services the individual is to receive to achieve those outcomes becomes part of the plan of care.

Potential Class Member: Any Idaho resident with unmet mental health needs who has not yet reached their 18th birthday and who IDHW has not yet determined to be a Class Member.

QMIA Council: A quality management, improvement and accountability entity within the YES system structure that is a cross-agency collaborative made up of executive level staff and children's mental health stakeholders with responsibilities specific to meeting the terms of the Settlement Agreement.

Serious emotional disturbance (SED) (Idaho Code, 16-2403 (13)): An emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability, and which requires sustained treatment interventions, and causes the child's functioning to be impaired in thought, perception, affect or behavior. A disorder shall be considered to "result in a serious disability" if it causes substantial impairment of functioning in family, school or community. A substance abuse disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

Settlement Agreement or Agreement: The legal document that spells out the terms of the comprehensive agreement reached by the Parties and plaintiffs in the Jeff D. class action lawsuit. The Settlement Agreement includes the requirements necessary to be fulfilled by the State of Idaho for the lawsuit to be dismissed.

Stakeholders: Individuals and organizations that affect or are affected by the changes in the Settlement Agreement. This includes but is not limited to youth with SED, their parents, advocates, providers of youth and children's mental health services, higher education organizations, and defendant agencies.

Status: Refers to the progress towards completion or implementation of an Objective from the Implementation Plan. An Objective may have more than one status.

System of Care (SOC): "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" *Stroul, Blau & Friedman, 2010*.

Transformational Collaborative Outcomes Management (TCOM): A set of collaborative processes and information which consistently point people to the shared vision of helping children and families achieve their health and wellness goals, making it is easier to create and manage effective and equitable systems.

Workgroup: A group of representative stakeholders chartered to perform tasks to accomplish objectives in the Implementation Plan. Unless otherwise noted, workgroups include, at a minimum, parents, advocates, providers, and defendant agency staff.

Wraparound: Wraparound is a collaborative, team based, principles driven, planning process. Through the wraparound process teams create one individualized plan of care to meet the needs and improve the lives of multisystem involved youth and their families.

APPENDIX A

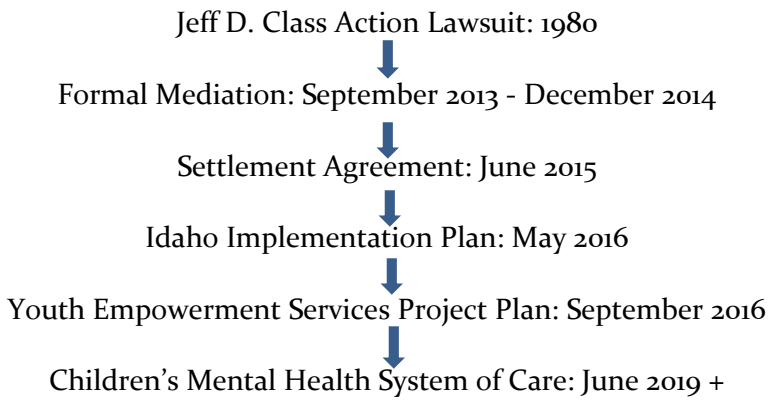
History of the Jeff D. Class Action Lawsuit

In August 1980, children who had or could be diagnosed with a serious emotional disturbance (SED), commenced a lawsuit against the Governor of Idaho, the Superintendent of Public Instruction (representing the State Department of Education, SDE), the Director of the Idaho Department of Health and Welfare (IDHW), and the Administrator of State Hospital South. The Director of the Idaho Department of Juvenile Corrections (IDJC) was joined as a Defendant in 2000 after the IDJC became an independent state agency. The Complaint alleged that adequate mental health programs and services, including community based treatment and educational services, were not being provided in violation of the Class Members' rights under the United States Constitution, the Idaho Constitution, and several federal and state statutes. The lawsuit sought to address two primary issues: 1) the intermixing of adults and juveniles in facilities at State Hospital South and 2) the lack of community-based mental health treatment services and programs provided to children and youth with SED.

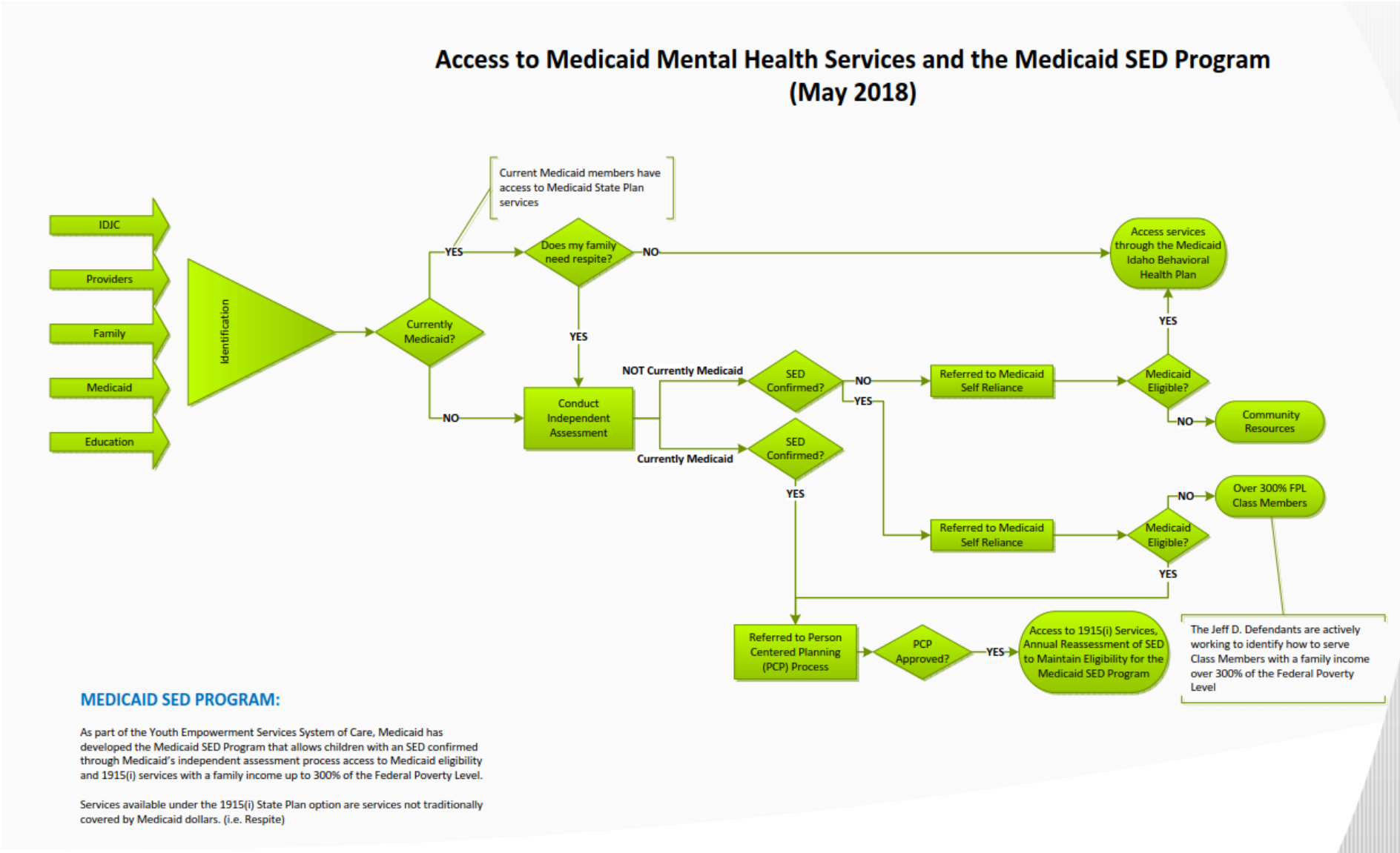
In 2013, under the direction of the Court, representatives of Parties in the lawsuit and stakeholders began negotiations on a Settlement Agreement that would achieve substantial compliance and fulfill the purposes of the Consent Decrees that had been agreed to and approved by the Court over the past 32 years. The Parties negotiated and the Court approved the *Jeff D.* class action lawsuit Settlement Agreement (Agreement) in 2015. The Agreement required the creation of an implementation plan (now known as the Idaho Implementation Plan) within nine (9) months after approval, a four (4) year implementation period, and a three (3) year sustainability period of successful operations to be completed before a final order will be issued dismissing the lawsuit and ending court monitoring by the issuance of a permanent injunction. The detailed procedural history of the *Jeff D.* case and additional detail about requirements and timelines that must be met is documented in the Settlement Agreement, which can be found at: http://youthempowermentservices.idaho.gov.

As part of constructing the Implementation Plan, the issue of officially naming the project for inclusion in the legal document was considered. In May 2015, the project was recognized as "Children's Mental Health Reform Project" and accepted by the District Court. Later in the summer of 2015, the Youth Empowerment Services (YES) logo and byline were included on Project documents.

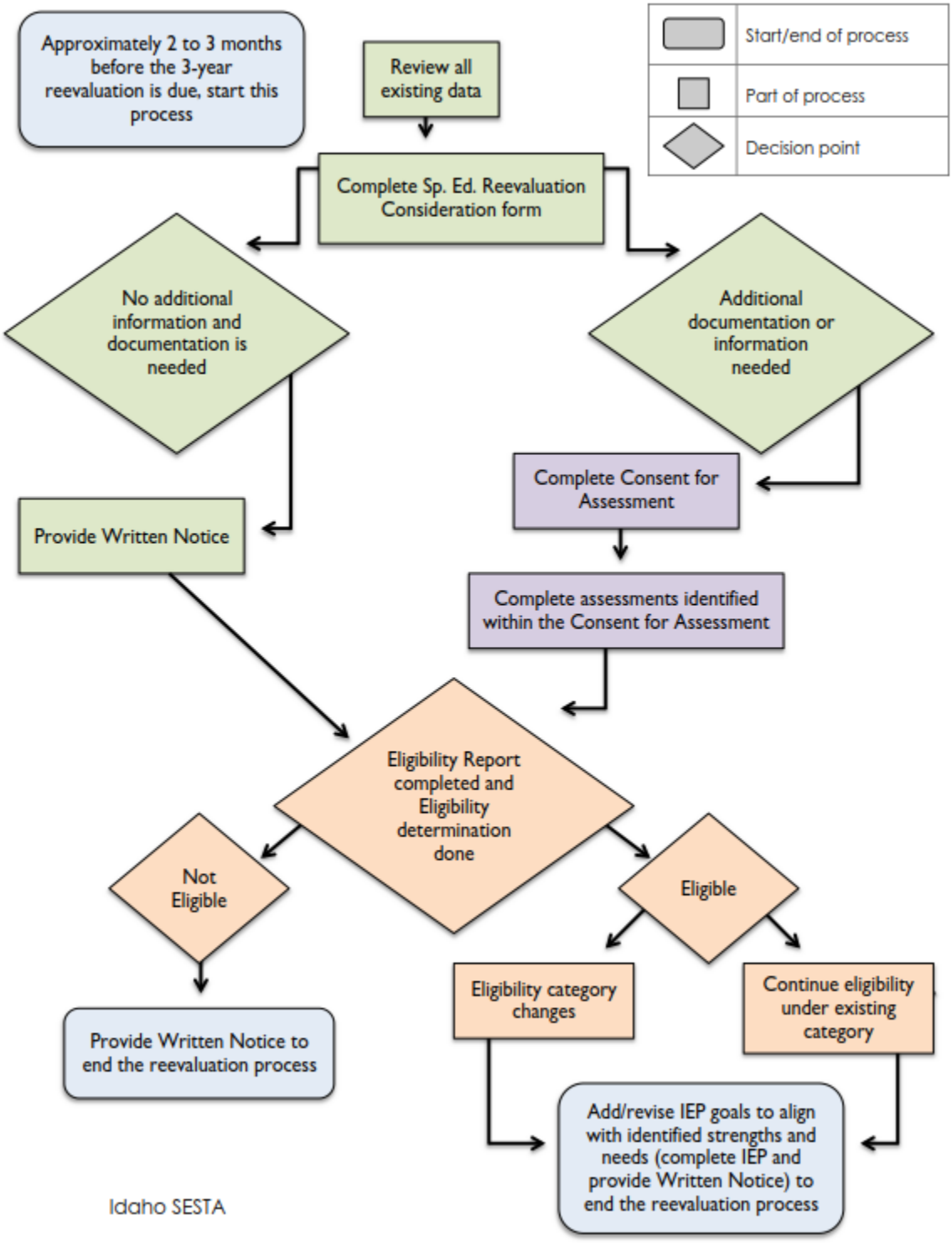
Settlement Agreement Timeline:



APPENDIX B

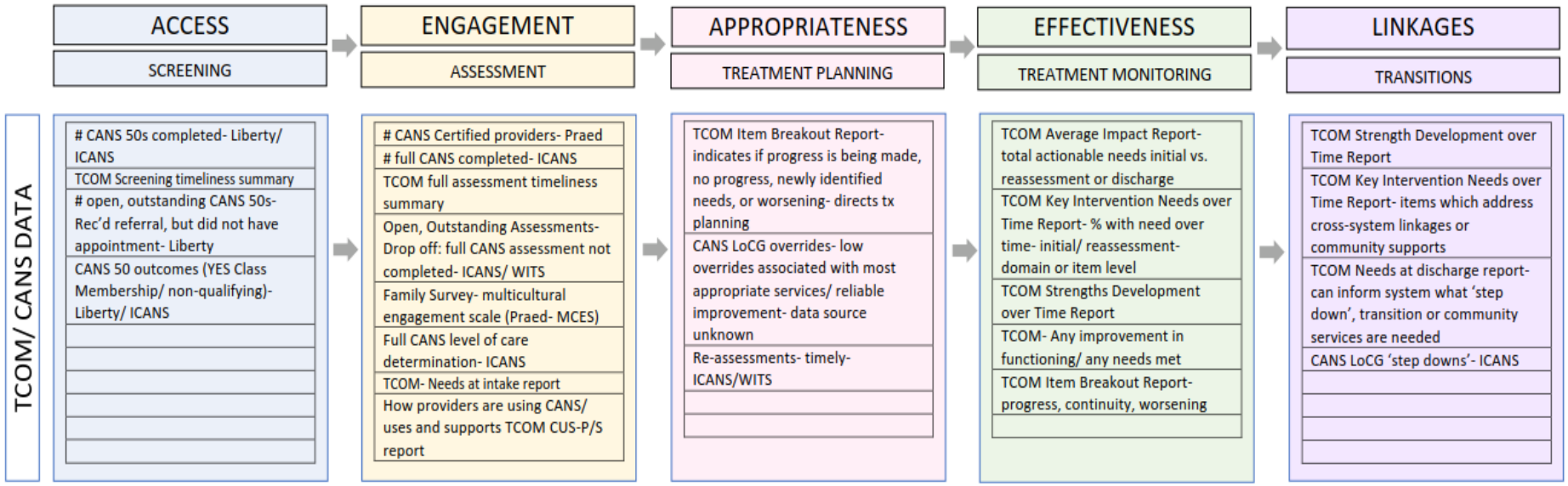

Access to Medicaid Mental Health Services and the Medicaid SED Program
(May 2018)
IDJC
Providers
Family
Medicaid
Education
Identification
Current Medicaid members have access to Medicaid State Plan services
Currently Medicaid?
YES
NO
Does my family need respite?
YES
NO
Access services through the Medicaid Idaho Behavioral Health Plan
Conduct Independent Assessment
NOT Currently Medicaid
Currently Medicaid
SED Confirmed?
NO
YES
Referred to Medicaid Self Reliance
Medicaid Eligible?
YES
NO
Community Resources
SED Confirmed?
YES
Referred to Medicaid Self Reliance
Medicaid Eligible?
NO
YES
Over 300% FPL Class Members
Referred to Person Centered Planning (PCP) Process
PCP Approved?
YES
Access to 1915(i) Services, Annual Reassessment of SED to Maintain Eligibility for the Medicaid SED Program
The Jeff D. Defendants are actively working to identify how to serve Class Members with a family income over 300% of the Federal Poverty Level
MEDICAID SED PROGRAM:
As part of the Youth Empowerment Services System of Care, Medicaid has developed the Medicaid SED Program that allows children with an SED confirmed through Medicaid's independent assessment process access to Medicaid eligibility and 1915(i) services with a family income up to 300% of the Federal Poverty Level.
Services available under the 1915(i) State Plan option are services not traditionally covered by Medicaid dollars. (i.e. Respite)

State Department of Education- Reevaluation Guidance Flow Chart



APPENDIX C

YES TCOM Model



For more information regarding specific TCOM reports, please visit PraedFoundation.org.

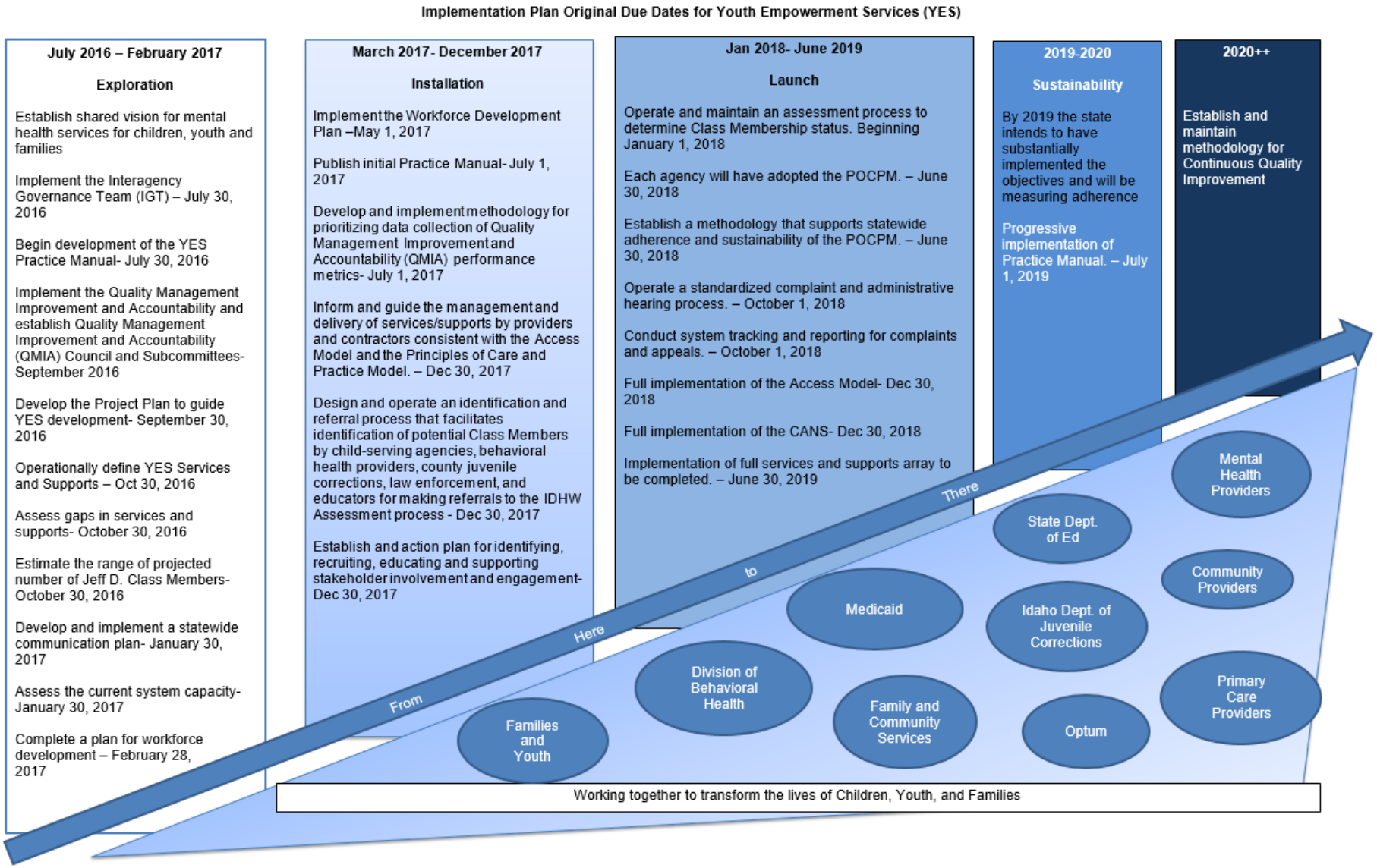
APPENDIX D

Key Elements of ICANS Phases 1-3

ICANS Phase	Key Elements	Additional Information: March 2017-May 2018
Phase 1	ICANS basic platform and assessment functionality for use in the ICANS Pilot 1	Business and technical requirements were completed for the ICANS system for all 3 development phases Phase 1 functionality was released and made available to a limited pilot group of users on 9/11/2017
Phase 2	Enhancements to the ICANS platform that allow the Independent Assessor to complete the CANS 50, a subset to the Children's Mental Health CANS used in the determination of Youth Empowerment Services Class Membership and Medicaid eligibility	Business and technical requirements were completed for the ICANS system for all 3 development phases Phase 2 ICANS functionality (Part 1) released for testing in late November. -Testing completed 12/1/17. -Multiple non-critical issues (no-limited impact to workflow) identified for resolution. -Phase 2 ICANS functionality (Part 2) scheduled for release on 12/15/2017. - Phase 2 functionality was made available statewide as of 1/1/18 to Independent Assessors and Division of Behavioral Health staff.
Phase 3	Additional enhancements to the ICANS that will allow users to consent, transfer, and share ICANS records to other authorized users. Enhancement will also include targeted prompts when high-risk items (i.e. those related to suicidality) are assigned a rating of 2 or 3, enhanced administration modes (i.e. Detailed-mode),.pdf upload capability to facilitate offline administration of the CANS, the addition of the Idaho Department of Health and Welfare Family and Community Services (FACS) CANS tool into the system (CFS-CANS), and the integration of CANS Certification information with the Praed Training site	Business and technical requirements were completed for the ICANS system for all 3 development phases Targeted for completion in 2018, the following enhancements will be made to the ICANS system: 1. Targeted high-risk prompts 2. Detailed administration mode 3. .pdf upload for offline CANS administration 4. Integrated certification management for CANS. 5. Initial steps to establish the technical framework for the inclusion of the CFS-CANS in the ICANS system. 6. Initial release of Phase 3 functionality available for DBH testing 5/7/18. 7. Additional releases to introduce remaining Phase 3 functionality components will occur routinely through November 2018.

APPENDIX E

Visual Representation of Implementation Plan Dates



APPENDIX F

What is YES?

The Idaho Youth Empowerment Services (YES) is a new system of care for Idaho's children and youth who meet criteria for a serious mental health condition.

It will provide a new way for families to find the mental health supports they need for their children and youth. It will be strengths-based and family-centered, and it will incorporate a team approach that focuses on providing individualized care for children.

Through a coordinated and collaborative effort, multiple child-serving agencies will work with the family to build a treatment plan around the unique needs and strengths of each child.

How do I use the Checklist?

This checklist tool can be used by anyone to help determine if a child may benefit from a full mental health assessment.

Families may also request a full mental health assessment without first going through the checklist.

In addition, school problem-solving teams may present this tool to further communicate with parents the importance of seeking additional services outside of the school setting. More information on these services can be found at:

www.yes.idaho.gov

Mental Health Checklist

If you check one or more boxes below, your child may be eligible for a more comprehensive assessment through YES: www.[website pending]

- ☐ My child has shown recent dramatic changes in behavior, mood, or interest level.
- ☐ My child has difficulty making and keeping healthy relationships with others.
- ☐ My child often worries or feels sad.
- ☐ My child often complains about not feeling well which impacts his/her activities (for example, stomachaches, headaches, etc.).
- ☐ My child has difficulty sleeping (too much or too little).
- ☐ My child often challenges, disregards, or defies authority.
- ☐ My child has trouble controlling his/her behavior when upset.
- ☐ My child does or says things that physically/emotionally hurt themselves, others, or animals.
- ☐ My child is often convinced of something that is not really true.
- ☐ My child has difficulty in various community settings such as school, church, clubs, and activities.
- ☐ My child or family experiences frequent, intense arguing and conflict.
- ☐ My family has experienced one or more stressful events that may continue to affect my child today.
- ☐ My family has difficulty understanding and meeting my child's needs.
- ☐ My family may require additional supports to meet my child's needs.

IDAHO DEPARTMENT OF HEALTH & WELFARE

450 W. State Street, Boise, ID 83702

Contact: YES@dhw.idaho.gov

www.yes.idaho.gov

Youth Empowerment Services (YES) is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 211.

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 211.

Youth Empowerment Services

Empowering the mental wellness of children, youth and their families

Youth Mental Health Checklist

www.yes.idaho.gov

APPENDIX G

Family and Youth Involvement and Support Contract

To build a program that supports and sustains family and youth involvement at all levels of the Youth Empowerment Services (YES) program, the Department of Health and Welfare's Division of Behavioral Health is developing a *Family Youth Involvement and Support* contract. The Department will be seeking a contractor to assist in establishing family and youth voice as a permanent feature of the YES system of care. The expectation is that the successful contractor identifies, recruits, educates and supports family members and youth for involvement and engagement in system improvements, as well as provide support to families navigating the YES system. A single successful contractor shall provide orientation to family members who participate in the YES system of care process. The contractor shall also provide community awareness activities, a strategic plan for building family and youth involvement into the system, and a website and other materials that educate and support families of children with serious emotional disturbance (SED). This will be a statewide contract in which family and youth involvement methods shall be available to the public for the targeted population in each of the seven (7) regions, which includes rural and frontier areas throughout the State.

The Department hopes to contract with an organization who will provide the following activities to parents/caregivers and to youth utilizing methods that meet their needs and incorporating the YES Principles of Care. Input from Department staff, workgroup participants, parents/caregivers and youth contributed to the development of activities that are being considered for inclusion within the RFP.

Potential areas for inclusion:

- Engagement – identify and recruit family members with lived experience to be a part of the system of care
- Education – orientation of the YES system of care and education about mental health issues, how to access the system, where to find support, and what's needed in transitioning to the adult mental health system
- Involvement – opportunities to be involved in the system from workgroups, advocacy, trainings and community leadership
- Support – provide support to families needing information and resources, as well as support from others who have "been there"
- Advocacy – provide learning opportunities regarding how to advocate for their child (parents/caregivers) or for themselves (youth) on a local, state and federal level

It is expected that the *Family Youth Involvement and Support* contract will be in place by late summer- early fall of 2018.