YOUTH EMPOWERMENT SERVICES (YES) QUALITY MANAGEMENT IMPROVEMENT AND ACCOUNTABILITY QUARTERLY REPORT

4th Quarter SFY 2017

September 30, 2017

Data and Reports Committee
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YOUTH EMPOWERMENT SERVICES (YES)

Quality Management Improvement and Accountability (QMIA)Quarterly Report

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Quality Management Improvement and Accountability (QMIA)Quarterly Report

September 30, 2017

WHAT IS THE QMIA QUARTERLY?

The Youth Empowerment Services (YES)[1] Data and Reports Committee is pleased to present the Quality Management Improvement and Accountability Quarterly Report (QMIA- Q). The report is a requirement of the Jeff D. Settlement Agreement[2] and is a critical aspect of the YES project. The QMIA-Q report is assembled with information about children, youth, and families in Idaho and from data collected by the Department of Health and Welfare's Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), as well as the Idaho Department of Juvenile Corrections (IDJC), and the Idaho State Department of Education (SDE).

The goal of YES is to develop, implement, and sustain a family-driven, coordinated, and comprehensive children's mental health delivery system. This enhanced system will lead to improved outcomes for children, youth, and families such as:

- Children and youth being safe, in their own homes, and in school.
- Minimization of hospitalizations and out of home placements.
- Reduction in potential risks to families.
- Avoidance of delinquency and commitment to the juvenile justice system to receive mental health services.

A critical aspect of YES is the development of methods to evaluate how effective Idaho is at achieving the goals of the Jeff D. Settlement Agreement and to assure accountability by establishing regular stakeholder reporting. The QMIA-Q report will be delivered to YES workgroups to support decision making related to plans for system improvement by building collaborative systems, developing new services, and creating workforce training plans.

All QMIA-Q reports are published on the yes.idaho.gov website. To navigate from the home screen, select: Project > Reports and Updates > QMIA Quarterly Report.

The initial QMIA-Q reports will focus on statewide and regional level data to provide stakeholder groups baseline information about the child-serving system in Idaho, including:

- Profiles of Idaho's youth
- Access and barriers to care such as gaps in services
- Development of youth and family voice and engagement
- Appropriate use of services including utilization of restrictive levels of care
- Effectiveness of services, based on child, youth, and family outcomes
- Cross-system linkages based on needs and strengths

[1] For more information regarding the YES project you may refer to the following website: yes.idaho.gov.

[2] A copy of the Jeff D Agreement can be located at: http://youthempowermentservices.idaho.gov

As we make progress in implementing YES, the QMIA-Q report will also monitor delivery of care based on five key decision points: Access, Engagement, Appropriateness, Effectiveness and Linkages. These decision points allow us to understand major activities of the system and represent areas of high potential impact in improving children and youth's experience as well as outcomes of care. This methodology for evaluation has been demonstrated to be an effective method to assess complex systems and is the foundation of the Transformational Collaborative Outcomes Management (TCOM) system created by Dr. John Lyons and Dr. Nathaniel Israel and adopted by Idaho.

TCOM

Transformational Collaborative Outcomes Management (TCOM) is a theory based approach to managing human services. This theory focuses on shifting systems away from the traditional idea of services (i.e. spending time with people) to transformational offerings (i.e. helping people change their lives).

Five Key Decision Points:

Diagram provided by Dr. Nathaniel Israel, Chapin Hall, TCOM PowerPoint

The Five Key Decision Points allow us to understand 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.

Access: This decision point represents a youth and family's experience when entering the system of care. This is where the determination regarding the child/ youth's fit for system services is made. The goal is that youth and families experience timely access to system services.

Engagement: The engagement decision point refers to the assessment of strengths and needs and determining how services might fit these through maximum youth and family participation throughout the process. The goal is for youth and families to experience system services as useful and empowering.

Appropriateness: This decision point is present throughout the treatment planning process, where the goal is that routing to services should be focused on individualization regarding both type and intensity. Ongoing youth and family engagement and empowerment is key at this decision point; because service plans will be made based on youth and family needs and strengths.

Effectiveness: The effectiveness decision point refers to ongoing monitoring of services and supports. Continuous evaluation of the effectiveness of services is necessary to make changes based

on how particular programs are helping. The goal is to ensure increasingly effective services that are efficient at supporting youth and families in meeting their goals.

Linkages: Connections should be made to other services and supports that are needed both during care as well as during transitions. The linkages goal is to ensure that gains experienced during care are meaningful, durable, and sustainable.

Throughout the implementation of YES, there will be ongoing improvements in the QMIA -Q reports. The report will become increasingly collaborative, focused, and informative. Input on the report is welcomed. Please contact YES@dhw.idaho.gov with your questions, concerns or suggestions.

YES QMIA QUARTERLY REPORT

This is the fourth of the YES Quality Management Improvement and Accountability Quarterly (QMIA-Q) reports to be published. This quarter, the QMIA-Q report includes data about Idaho youth profiles, potential service gaps and provider shortages that may be a barrier to care, family perception of services and supports, use of restrictive levels of care such as hospital and residential services, and Juvenile Justice data. A narrative description of the Youth Voice project will also be included.

The formatting of this report has been modified to allow the reader to navigate the information through a series of important questions that should be considered by all stakeholders throughout the children's mental health system transformation process. The questions posed in this report will allow us to identify topic areas that we want to gather more data about, as well as prompt new questions to be explored in future reports. One of the main functions of the QMIA report is to provide information to all stakeholders that can be used to identify our needs and strengths which will inform positive system-wide change.

Some of the data used in the 4th quarter QMIA report has been extracted from the Substance Abuse and Mental Health Services Administration's (SAMHSA)'s uniform reporting system's *Idaho 2016 Mental Health National Outcome Measures (NOMs)* report. One benefit to the NOMs report is that it allows us to see Idaho's data next to the national average (external benchmarking). External benchmarking is one way we can gain insight into our system performance before new Youth Empowerment Services (YES) programs launch and we can collect and measure outcomes data. Readers are always cautioned when comparing individual data to the national average, as each entity may have unique factors that influence operations. Additionally, it is important to note that the 2016 NOMs data is only representative of children and youth served by the Division of Behavioral Health (DBH).

The Division of Behavioral Health provides crisis intervention, case management and other supports through the children's mental health program that increase the capacity for children with Serious Emotional Disturbance (SED) and their families to live, work, learn, and participate fully in their communities. Most treatment services are delivered by private sector providers in the community through referrals by the division. The division also administers a psychiatric hospital for children and youth, State Hospital South, and services for court-ordered individuals.

Increasing collaboration among agencies will allow us to create a unified reporting system to streamline information so we can best assess system quality; this is currently a developing project.

Note: Idaho's Division of Behavioral Health regions are referenced throughout this report. A regional map has been provided for reference on page 27, Appendix A.

Profiles of Idaho Youth

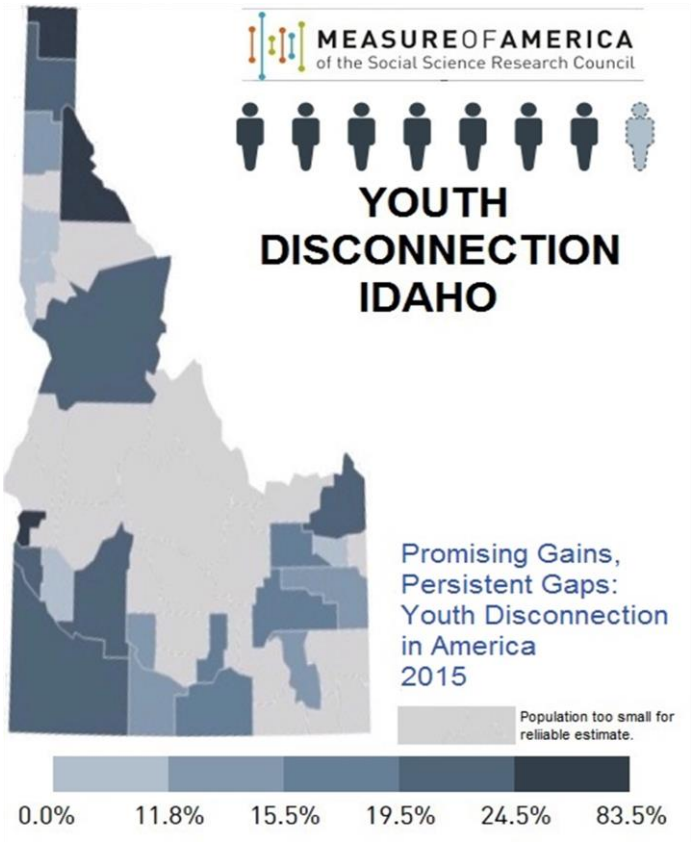
The following profile information provides insight into some factors that may influence be impacted by the mental health of youth in Idaho.

Disconnected Youth

One general measure that can be used to assess the current condition of youth in Idaho is the percentage of disconnected youth. Disconnected youth are defined as young people ages 14-24 who are homeless, in foster care, involved in the justice system, or are neither employed nor enrolled in an educational institution. Measure of America, a program of the Social Science Research Council, published the following data for Idaho in their *Promising Gains, Persistent Gaps: Youth Disconnection in America* 2015 report.

Disconnected Youth: Figure 1 below shows percentages of disconnected youth throughout Idaho (2015).

Figure 1.
Data Source: *Measure of America*



"Disconnected youth are more likely to be poor, to have academic difficulties, to suffer from mental health problems and/or substance abuse, to be involved in violence, and to be teen parents." - *Youth Who are "Disconnected" and Those who then Reconnect: Assessing the Influence of Family, Programs, Peers and Communities.* Hair, E. C. et al. (2009).

State Rankings: Young people are disconnected at rates that range from under 8 percent in some states (New Hampshire, Nebraska, North Dakota, Vermont, Minnesota, and Iowa) to over twice that in others, with New Mexico (17.4 percent), West Virginia (17.0 percent), and Mississippi (16.7 percent) facing the greatest challenges.

11.5% of youth in Idaho were considered disconnected in 2015.

Summary: When compared nationally, Idaho's overall percentage of disconnected youth is fairly average. Idaho areas of highest disconnection (≥83.5%) are Boundary, Shoshone, and Payette counties.

Youth Risk Behavior

Another measure that can be used to assess the current condition of youth in Idaho is youth risk behavior. The Idaho State Department of Education published a report on youth risk behavior as part of the National *Youth Risk Behavior Surveillance System (YRBS)*. The following data on risk behaviors are based on responses from 1,760 students in 48 public Idaho high schools in 2015. The following results are presented alongside the United States averages for comparison.

- Idaho Youth and Bullying, Fig. 2
- Feelings of Hopelessness, Fig. 3
- Idaho Youth and Suicide, Fig. 4

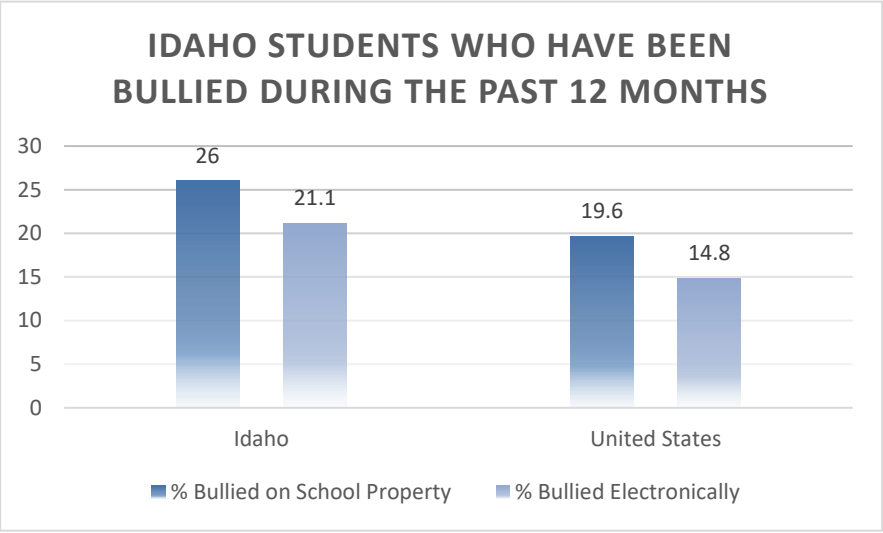
Youth and Bullying: Figure 2 below shows percentages of Idaho youth who had been bullied during the past 12 months (2015).

Figure 2.
Data Source: *National Youth Risk Behavior Surveillance System (YRBS, 2015)*

% Bullied on School Property- Idaho	
Grade	**Total**
9th	30.6%
10th	25.2%
11th	26.1%
12th	21.0%
Overall	26.0%

% Bullied Electronically*- Idaho	
Grade	**Total**
9th	22.1%
10th	19.4%
11th	21.1%
12th	21.4%
Overall	21.1%

** Electronic bullying: e-mail, chat rooms, instant messaging, websites or texting*



Studies have found that victims of bullying show not only elevated levels of social isolation, depression and anxiety but also, especially female bully-victims, an increase in self-harm behaviors and suicidal ideations. - *Arseneault, L.,Bowes, L., and Shakoor, S., Bullying victimization in youths and mental health problems: 'Much ado about nothing'?.(2010)*

Feelings of Hopelessness: Figure 3 below shows percentages of Idaho youth who had feelings of hopelessness in the past 12 months (2015).

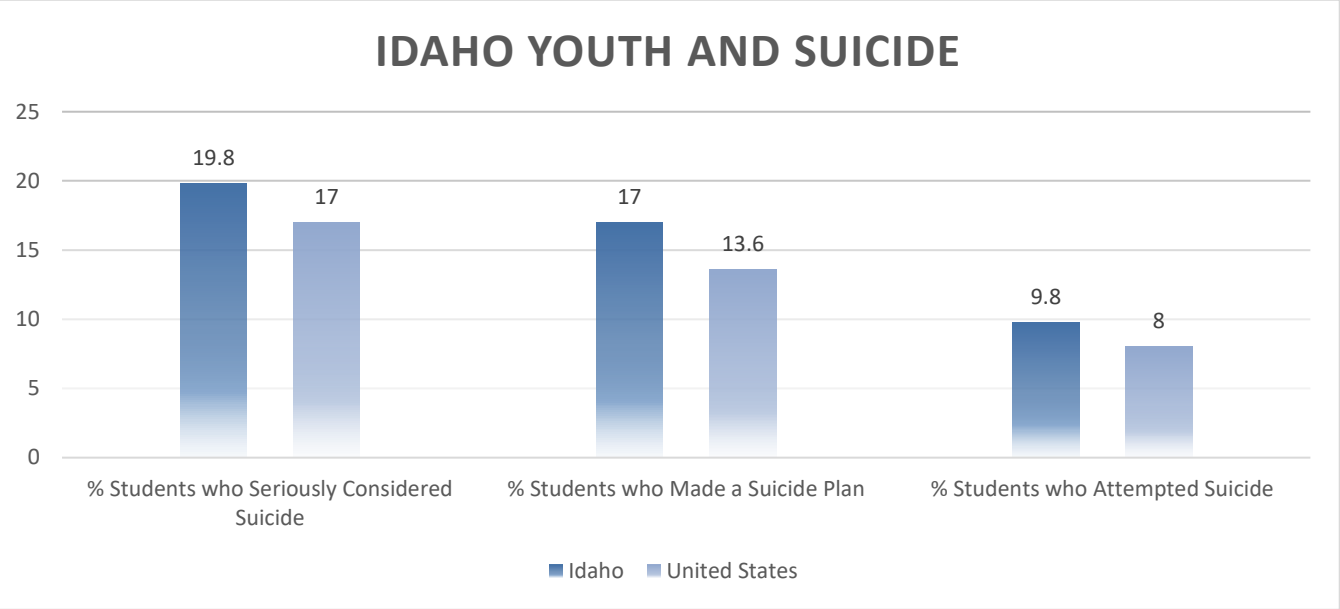
Figure 3.
Data Source: *National Youth Risk Behavior Surveillance System (YRBS, 2015)*

31.6% of Idaho high school students reported that in the previous 12 months they felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities.

Grade	Total	Female	Male
9th	29.7%	39.7%	20.4%
10th	29.7%	42.0%	17.6%
11th	35.3%	46.5%	24.6%
12th	32.3%	42.6%	22.7%
Idaho Overall	**31.6%**	**42.7%**	**21.2%**
U.S. Overall	**29.9%**	**39.1%**	**20.8%**

Suicide: Figure 4 below shows percentages of Idaho youth who considered, had a plan for, or attempted suicide during the past 12 months (2015).

Figure 4.
Data Source: *National Youth Risk Behavior Surveillance System (YRBS, 2015)*



	Grade	Total	Female	Male
Percentage of students who seriously considered attempting suicide during the past 12 months.	9th	19.3%	28.8%	10.5%
	10th	17.9%	24.0%	11.8%
	11th	23.6%	30.4%	17.1%
	12th	18.6%	24.9%	12.7%
	Overall	**19.8%**	**27.2%**	**12.9%**
Percentage of students who made a plan about how they would attempt suicide during the past 12 months.				
	9th	16.4%	24.5%	8.9%
	10th	15.1%	20.1%	9.8%
	11th	21.4%	28.1%	15.0%
	12th	14.8%	19.8%	9.5%
	Overall	**17.0%**	**23.3%**	**10.8%**
Percentage of students who actually attempted suicide one of more times during the past 12 months.				
	9th	10.8%	15.5%	6.4%
	10th	10.1%	14.0%	6.4%
	11th	10.3%	15.7%	4.9%
	12th	7.6%	9.7%	5.4%
	Overall	**9.8%**	**14.0%**	**5.8%**

Idaho Division of Public Health Facts on Youth and Suicide

• Idaho is consistently among the states with the highest suicide rates. In 2015, Idaho had the 5th highest suicide rate, 57% higher than the national average.

• Suicide is the second leading cause of death for Idahoans ages 15-34 and for males age 10-14.

• Between 2011 and 2015, 102 school-age children died by suicide, 24 of whom were 14 or younger, and in that same span of time, 166 college-aged Idahoans (19-24) died by suicide in Idaho.

Youth Risk Behavior Summary: In comparison to the United States average, Idaho youth seem to be experiencing slightly higher rates of bullying, feelings of hopelessness, and suicidal thoughts, plans, and actions.

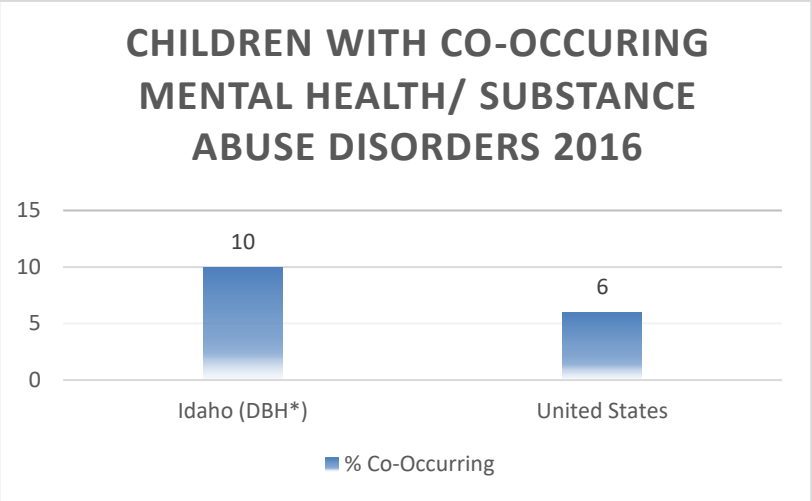
More information about the YRBS can be attained by contacting the State Department of Education at 208-332-6947 or visit www.sde.idaho.gov.

Co-Occurring: Mental Health & Substance Use

The Substance Abuse and Mental Health Services Administration (SAMHSA)'s uniform reporting system will be referenced throughout this report. The *Idaho 2016 Mental Health National Outcome Measures (NOMs)* report provided the following youth profile data:

Co-Occurring: Figure 5 below shows percent of children served who met the Federal definitions of Serious Emotional Disturbance (SED) who also have a substance abuse diagnosis

Figure 5.
Data Source: *SAMHSA- Idaho 2016 Mental Health National Outcome Measures (NOMs)*



"There is always much speculation about what presents first in the youth's life, the substance use or the mental health challenges. It can happen either way and what we do know is that undiagnosed mental health problems can lead to self-medicating with substances."

-Youth.gov

*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

Summary: The above information indicates that prevalence of substance abuse co-occurring with a designation od SED is 4% higher for Idaho youth served by the Division of Behavioral Health when compared to the national average.

While adolescents are generally healthy, the preceding information about Idaho youth highlights the need for ongoing collaborative work to improve the child-serving system.

Who Are We Serving?

Regional information on children and youth served can inform those who are developing plans for system improvement for possible geographical areas throughout Idaho that need to focus on reducing barriers and improving access to care. Information on children and youth served by age can identify age groups that could be underserved.

It is important to note that we do not have the ability to un-duplicate client-served data reported by each division at this time. The reader is cautioned and should keep in mind that there is potential for duplication within the divisional State Fiscal Year (SFY) 2016 data.

The following data from the Division of Medicaid and the Division of Behavioral Health provides information about youth served by region and as age. Division of Medicaid data is from SFY 2016, and Division of Behavioral Health data is from SFY 2017 and provides comparison to youth served in SFY 2016.

Division of Medicaid

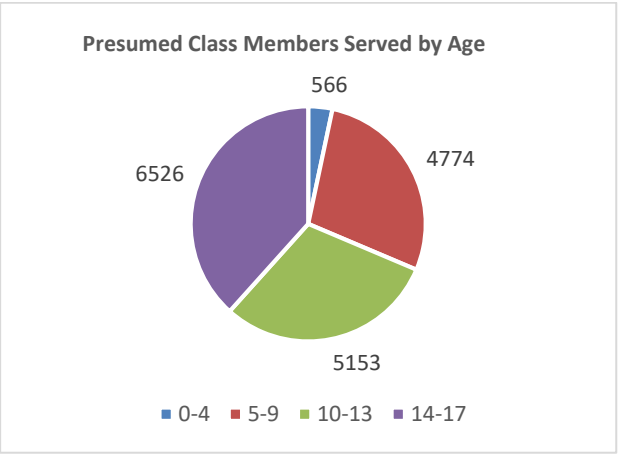
Medicaid Presumed Class Members Served: Figure 6 and 7 below shows information on presumed Class Members served by region and age (SFY 2016).

Figure 6.
Data Source: *Idaho Dept. of Health and Welfare Division of Medicaid, SFY 2016*

Presumed Class Members Served by Region

DBH Regions	# Presumed Class Members served	% of Presumed Class Members served
Region 1	1,592	12.0%
Region 2	437	3.3%
Region 3	2,866	21.6%
Region 4	3,189	24.0%
Region 5	1,365	10.2%
Region 6	1,050	7.9%
Region 7	2,793	21.0%
Statewide Total	13,292	100%

Figure 7.



Division of Behavioral Health

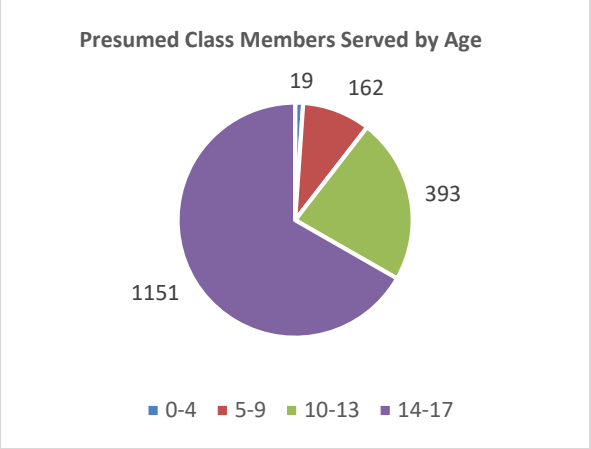
Division of Behavioral Health Presumed Class Members Served: Figures 8 and 9 below shows information on presumed Class Members served by region and age (SFY 2017).

Figure 8.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health, SFY 2017*

Presumed Class Members Served by Region

DBH Regions	# Presumed Class Members served	% of Presumed Class Members served
Region 1	187	10.4%
Region 2	106	5.9%
Region 3	230	12.8%
Region 4	359	20.0%
Region 5	222	12.3%
Region 6	186	10.3%
Region 7	508	28.3%
Statewide Total	1,798	100%

Figure 9.



*Cut off for DBH age data was Jan 1, 2017, therefore service total and age total do not equal

Division of Behavioral Health Presumed Class Members Served Comparison: Figures 10 and 11 below show a comparison of presumed Class Members served for SFY 2016 and SFY 2017.

Figure 10.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health*

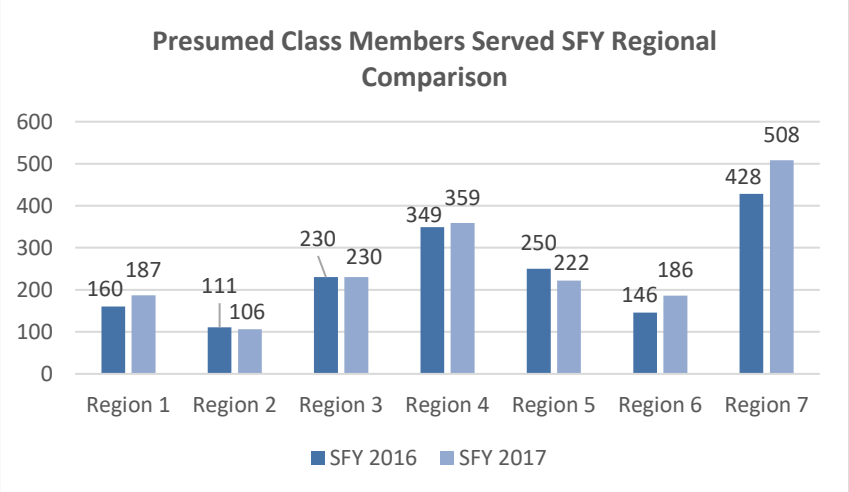
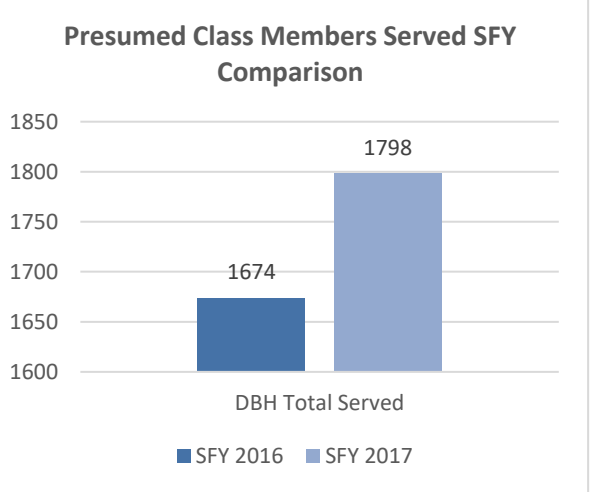


Figure 11.

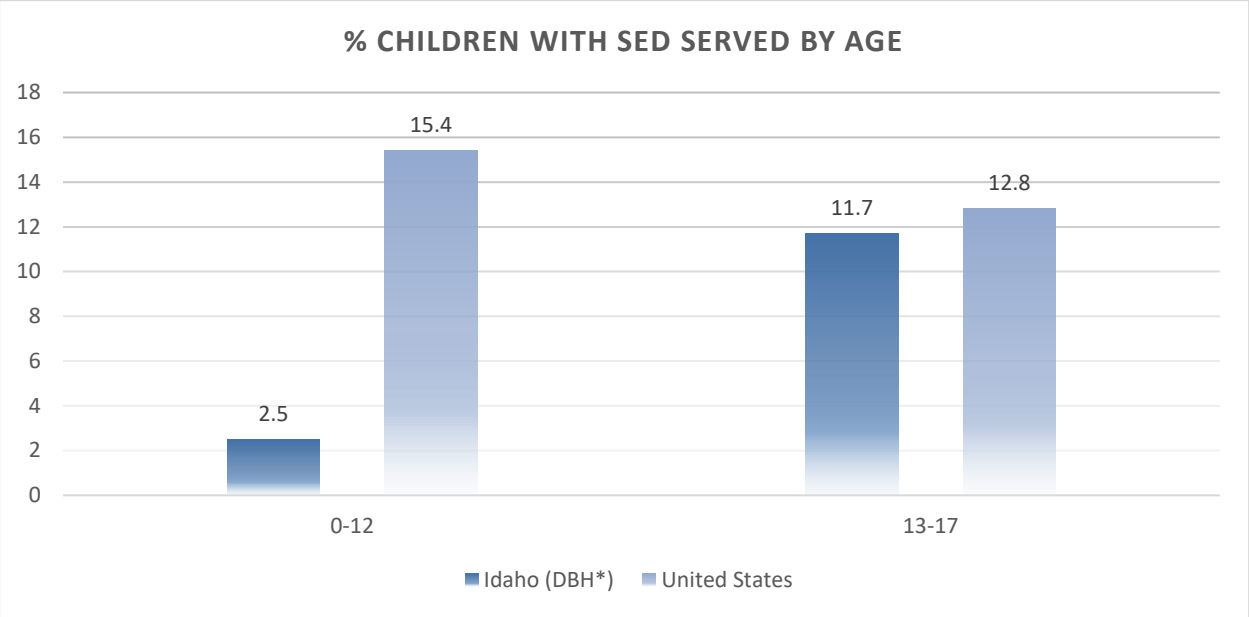


Summary: The Division of Behavioral Health served 124 more youth in State Fiscal Year (SFY) 2017, this increase appears to be largely driven by an increase in youth served in Region 7.

The following information was extracted from the *Idaho 2016 Mental Health National Outcome Measures (NOMs)* by SAMHSA. Depicted in the next figure are percentages of children with Serious Emotional Disturbance (SED) served by age by the Division of Behavioral Health as well as the United States average.

Percent of Children with SED Served: Figure 12 shows percentage of children with SED served by age

Figure 12.
Data Source: *SAMHSA- Idaho 2016 Mental Health National Outcome Measures (NOMs)*



*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

Summary: Compared to the national average, the Division of Behavioral Health appears to be serving significantly fewer children with SED who are in the 0-12 age range. This information demonstrates a need for more comprehensive, state-wide data collection, and monitoring.

Are Children/Youth Provided Services in the Least Restrictive Environment Appropriate for Their Care?

System of Care (SoC) outcomes analysis has shown that youth and family engagement within an SoC model results in children and youth who are less likely to need or receive psychiatric inpatient services, are less likely to visit an emergency room for behavioral and/or emotional issues, and also less likely to be arrested (National Technical Assistance Center for Children's Mental Health; *Return on Investment in Systems of Care for Children with Behavioral Health Challenges*, 2014). As our system transforms, a goal is to see a downshift in service-utilization to less restrictive, more effective and appropriate community-based program environments.

The following tables provide information about the use of hospitalization and the use of residential services (out of home placements) for youth. This data and trends will be tracked over time to assess changes in the utilization of these high-level intensive services.

Again, it is important to note that we do not have the ability to un-duplicate client-served data reported by each division at this time. The reader is cautioned and should keep in mind that there is potential for duplication within Medicaid and Behavioral Health hospitalization data.

Medicaid Inpatient Hospitalization & Residential Placements

Children with SED Served by Medicaid- Inpatient and Residential: Figures 13 and 14 show number of admissions to inpatient hospitalization (SFY 2016) and into psychiatric residential treatment facilities (SFY 2016/2017).

Figure 13.
Data Source: *Idaho Dept. of Health and Welfare Division of Medicaid, SFY 2016*

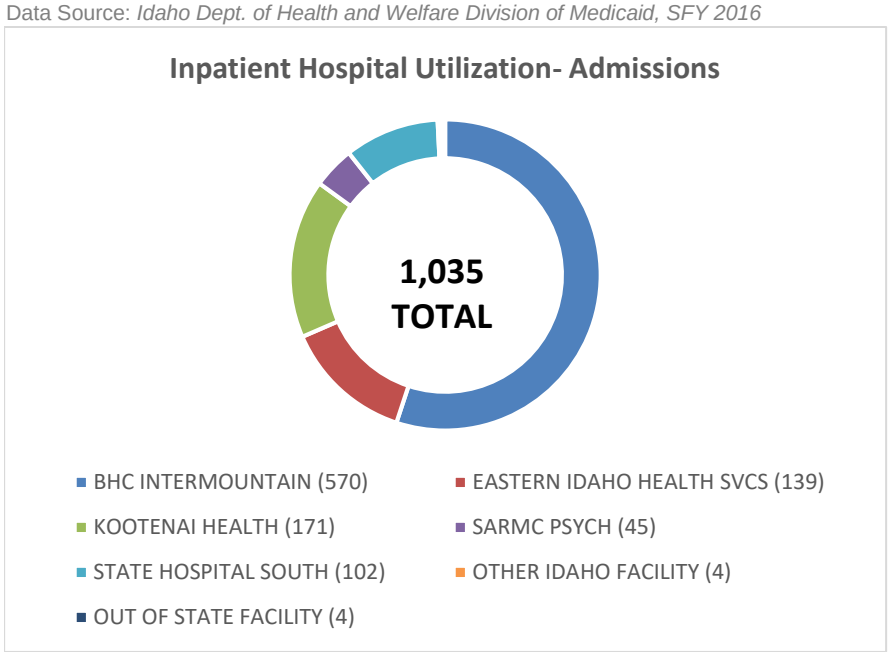
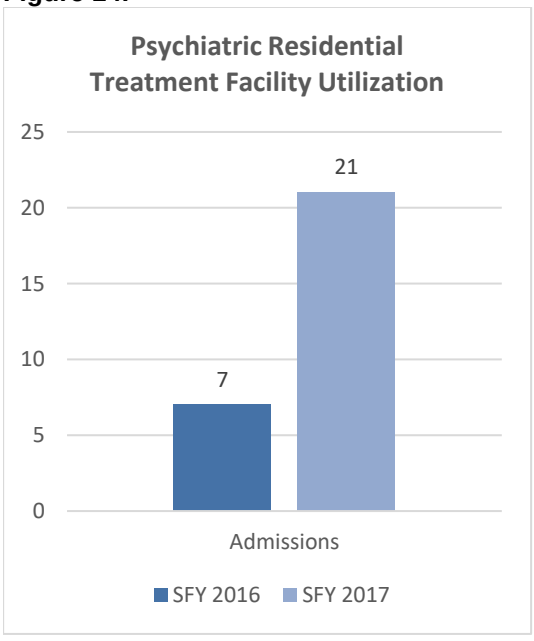
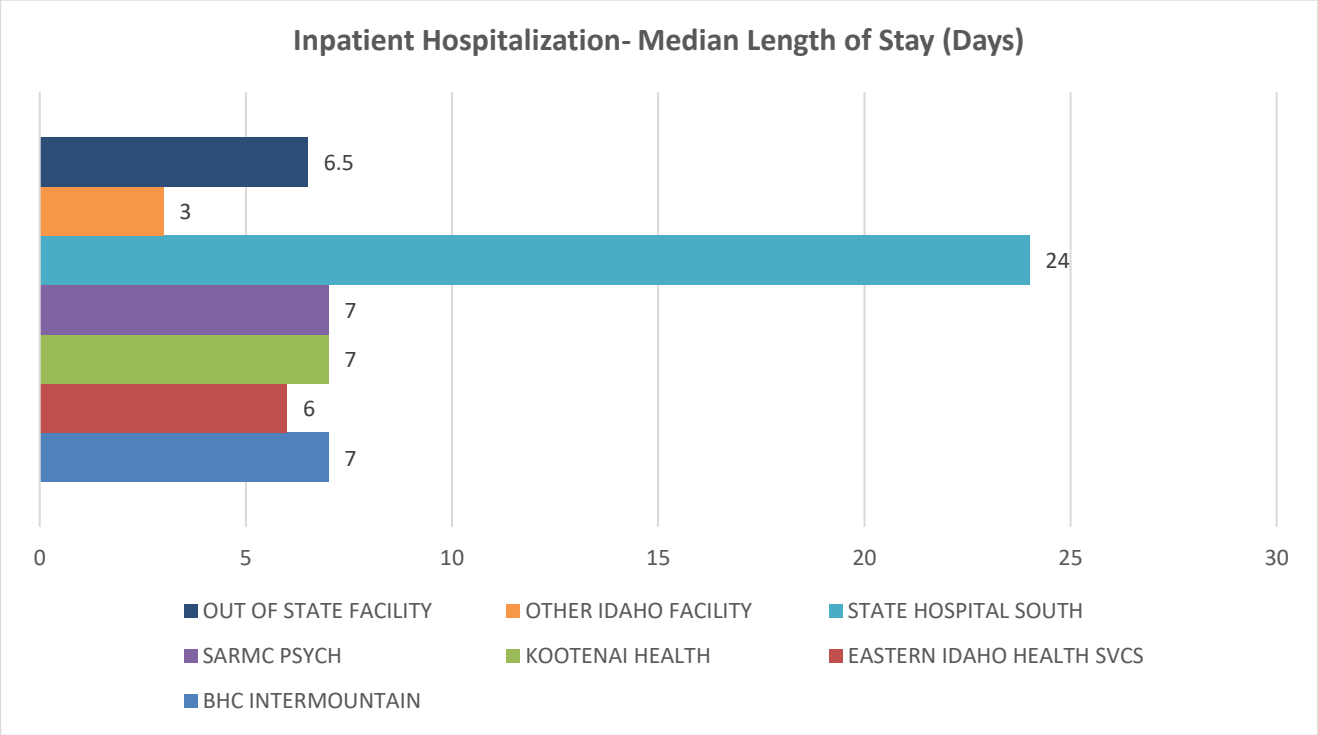


Figure 14.



Children with SED Served by Medicaid- Inpatient Hospitalization Length of Stay: Figure 15 shows median length of stay for children admitted to inpatient hospitalization. (SFY 2016)

Figure 15.
Data Source: *Idaho Dept. of Health and Welfare Division of Medicaid, SFY 2016*



Data from successful system of care implementation has shown reduction in residential treatment as well as shorter length of stay, even though the complexity of children and youth placed has increased. Higher need children and youth are now successfully served in the community because of stronger, more efficient community services (TCOM Conversations; *The Role of the CANS in Reducing Residential Treatment Placement and Length of Stay in New Jersey, December 2016).*

The above information shows a significantly longer length of stay for State Hospital South than reported for other hospitals in Idaho. State Hospital South traditionally provides longer-term treatment, which can account for the longer median length of stay.

It is important to note that within this data, it is possible that youth accounted for in the community hospitals were transferred to and then also served by State Hospital South. The Division of Behavioral Health also reports on youth served at State Hospital South. More information about State Hospital South, including a comparison to other state hospitals nationally, can be found on the following pages of this report.

Behavioral Health Inpatient Hospitalization & Residential Placements

State Hospital South (SHS):
Figure 16 shows Statewide Utilization of State Hospital South- SFY Comparison

Figure 16.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health*

State Fiscal Year (SFY) (July 1- June 30)	SHS Regional Utilization														Statewide Totals	
	1		2		3		4		5		6		7			
	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR
SFY-2015	11	5	4	4	28	10	33	7	18	9	14	11	25	9	**133**	**8**
SFY-2016	13	6	2	2	22	8	38	8	20	10	10	8	19	7	**124**	**7**
SFY-2017	9	4	3	3	25	9	45	9	18	9	3	2	14	5	**117**	**7**

UR= Utilization Rate= Utilization per 100,000 persons (count). Calculated based on 2016 Census population estimates by County.

Figure 16 Summary: Utilization of State Hospital South (SHS) remained fairly consistent in Idaho overall from State Fiscal Year (SFY) 2015 to SFY-2017. Region 6 saw an apparent decrease over the period.

Residential Placements:
Figure 17 shows Statewide utilization of Residential Placements- SFY Comparison

Figure 17.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health*

State Fiscal Year (SFY) (July 1- June 30)	Residential Regional Utilization														Statewide Totals	
	1		2		3		4		5		6		7			
	#	UR	#	**UR**	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR
SFY-2015	3	1	4	4	3	1	29	6	2	1	1	1	0	<1	**42**	**2**
SFY-2016	1	<1	3	3	15	5	33	7	2	1	1	1	1	<1	**56**	**3**
SFY-2017	4	2	4	4	10	4	22	5	3	2	6	5	1	<1	**52**	**3**

UR= Utilization Rate= Utilization per 100,000 persons (count). Calculated based on 2016 Census population estimates by County.

Figure 17 Summary: While residential placement utilization rates remained consistent statewide for the period, Region 6 saw a substantial increase from SFY 2015/16 to SFY-2017. This increase in Region 6 may be linked to the decrease in State Hospital South (SHS) utilization during the same period.

What is Utilization Rate

Calculating utilization rate (utilization per 100,000 people) allows us to more reliably compare usage by region as well as compare regional use to statewide use.

Because each region has vastly different population sizes, comparing actual utilization numbers would not tell us anything of significance.

Rates allow measures to be calculated according to a standard scale. In this case, 100,000 people is used as the standard.

Using this 100,000-person standard scale is essentially like imagining how many residential placements would have been used if each region and the whole state all had the same number of people living in them, which allows for more accurate comparisons to be made. Potential regional differences can be determined and discrepancies to consider evaluating further can be identified.

Although there are other factors that may influence data on individual regional use, this utilization rate calculation allows us to eliminate difference in Regional population size as one of those factors.

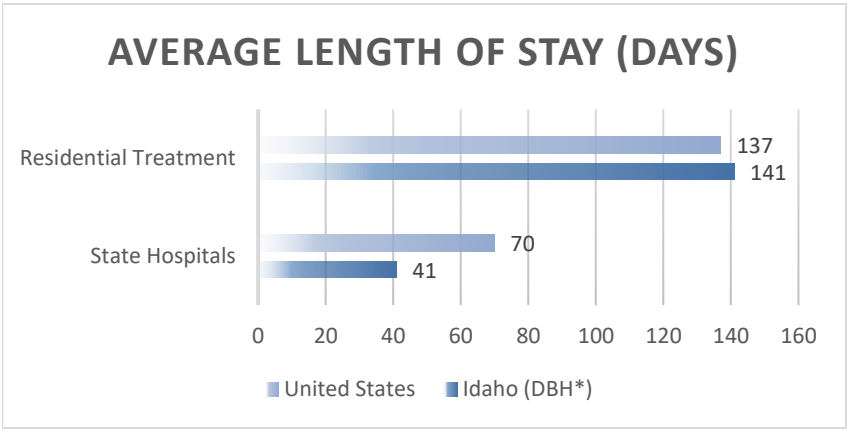
Admission rates for each level of care may offer insight into whether appropriate services are being used. Stronger community-based services and supports and increased admission to these lower levels of care (least restrictive environments whenever appropriate) is the goal. The following figures have been created with data extracted from the 2016 National Outcome Measures (NOMs) report by SAMHSA.

Figure 18 shows the average length of stay for a child or youth served by the Division of Behavioral Health who is enrolled in a higher level of care. Placing children in settings more restrictive than may be necessary is known as 'over-placement'. High level of care admissions will continue to be monitored as the system changes to ensure we are appropriately serving youth and children.

As noted previously, children and youth who entered State Hospital South may have been originally admitted to a community hospital, which would increase their total length of stay (days).

Length of Stay: Figure 18 shows average length of stay for State Hospitals and Residential Treatment programs

Figure 18.
Data Source: *SAMHSA- Idaho 2016 Mental Health National Outcome Measures (NOMs)*

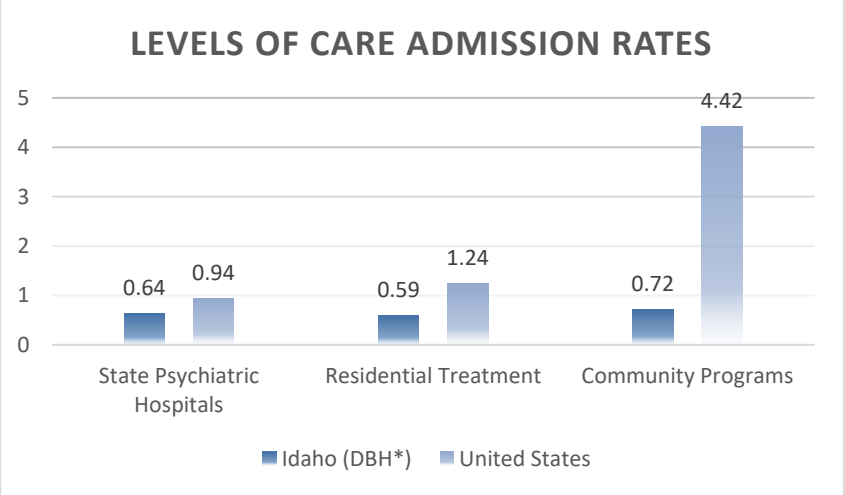


*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

Data on community hospitals is collected by Medicaid and therefore not included in the Division of Behavioral Health (DBH) NOMs report by SAMHSA.

Levels of Care: Figure 19 shows admission rates for State Hospitals, Residential Treatment and Community Programs.

Figure 19.
Data Source: *SAMHSA- Idaho 2016 Mental Health National Outcome Measures (NOMs)*



*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

This data infers that DBH admission rates into state hospitals and residential treatment are below the national average. Idaho's rate of admission into community programs is significantly lower than the United States average. It is also important to note that in Idaho, there is not much variance in admission rates across the three levels of care. The national average data demonstrates an increase in admission rate as levels of care become less restrictive; this is an ideal progression pattern.

The more that children, youth, and families must depend on access to more restrictive levels of care, the more likely it is that the system may not be effectively or efficiently providing less restrictive levels of care. An example of this would be a child or youth who has been placed in a residential facility, but based on their needs, could be living at home if they had appropriate and effective community supports.

Ongoing monitoring of appropriateness of service placement is crucial. It has been determined that hospitalization has significantly better outcomes than community treatment for high-risk children/youth, but is associated with reliable worsening for low-risk children/youth. - (*Communimetrics: A Communication Theory of Measurement in Human Service Settings*; J.S. Lyons, 2009).

Juvenile Justice-Involved Youth

The following figures provide data about the use of Idaho Statute 20-511A which is a rule within the Juvenile Corrections Act whereby a judge can order the Department of Health and Welfare to submit to the court a mental health assessment and a plan of treatment for a youth.

Juvenile Justice: Figures 20 & 21 show Statewide Utilization of 20-511A- State Fiscal Year 2017 Quarterly Comparison

Figure 20.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health*

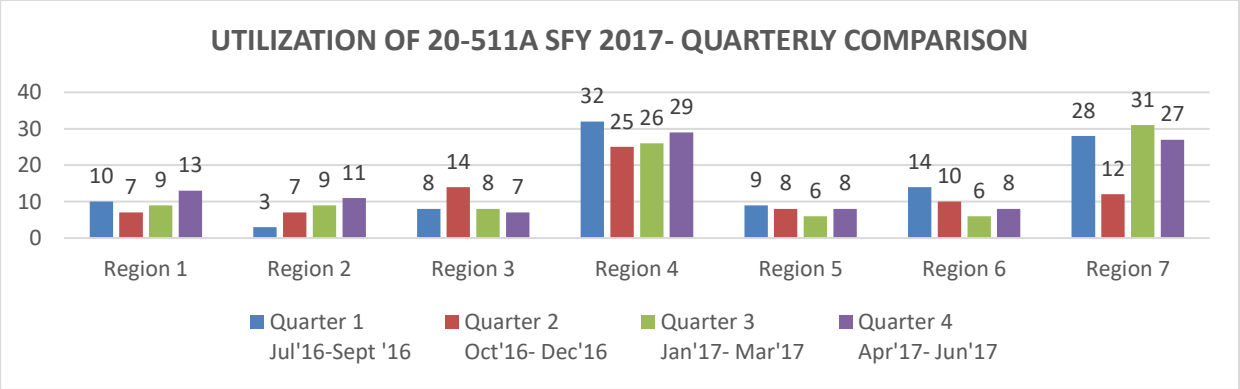
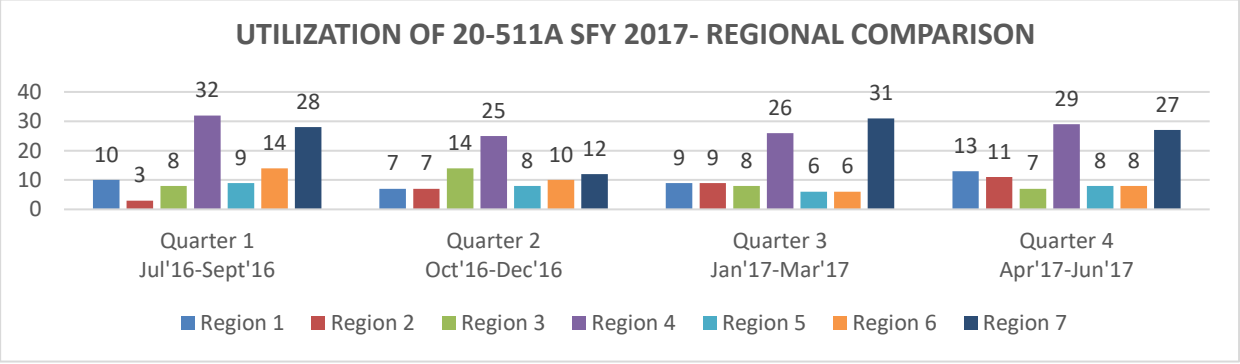


Figure 21.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health*



Figures 20 & 21 Summary: Overall, 20-511A regional utilization throughout 2017 remained fairly consistent for regions 1,3,4,5, and 6. Region 2 saw an increase in referrals as the year progressed (Q1=3, Q4=11). Region 7 saw a 19-referral difference from its lowest quarter (Q2=12) to its highest utilization (Q3=31)

Juvenile Justice: Figure 22 shows Statewide Utilization of 20-511A- SFY Comparison

Figure 22.
Data Source: *Idaho Dept. of Health and Welfare Division of Behavioral Health*

State Fiscal Year (SFY) (July 1- June 30)	20-511A Regional Utilization														Statewide Totals	
	1		2		3		4		5		6		7			
	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR	#	UR
SFY-2015	58	25	30	28	45	16	137	28	103	53	51	42	154	58	**578**	**34**
SFY-2016	57	25	24	22	59	21	131	27	114	59	57	46	156	59	**598**	**36**
SFY-2017	46	20	41	38	47	17	127	26	84	43	38	31	126	48	**509**	**30**

UR= Utilization Rate= Utilization per 100,000 persons (count). Calculated based on 2016 Census population estimates by County.

Figure 22 Summary: From SFY-2015 to SFY-2017, Region 3 had significantly lower rates of utilization of the 20-511A rule compared to Idaho statewide. Regions 5 and 7 had significantly higher utilization rates than Idaho statewide over the same period. While Idaho overall saw a subtle increase in 20-511A utilization from SFY-2015 to SFY-2016, and a modest decrease in SFY-2017; Region 2 saw a decrease from SFY-2015 to SFY-2016, and a substantial increase in SFY-2017.

- Future analysis of 20-511A data may focus on characteristics of those youth using this rule to identify trends as well as possible prevention and diversion practices.

Estimates show that approximately 50 to 75 percent of the 2 million youth (nationally) encountering the juvenile justice system meet criteria for a mental health disorder. Approximately 40 to 80 percent of incarcerated juveniles have at least one diagnosable mental health disorder (International Journal of Environmental Research and Public Health; Mental Illness and Juvenile Offenders, 2016).

The following information from the 2016 National Outcome Measures (NOMs) report by SAMHSA shows a breakdown of known living situations for children and youth served by the Division of Behavioral Health.

Living Situations: Figure 23 shows living situations of youth served by the CMH system.

Figure 23.
Data Source: *SAMHSA- Idaho 2016 Mental Health National Outcome Measures (NOMs)*

Setting	Idaho (DBH*)	U.S.
Private Residence	67.4%	65.4%
Foster Home	1.9%	2.7%
Residential Care	0.9%	0.9%
Crisis Residence	0.1%	0.1%
Residential Treatment Center	0.2%	0.4%
Institutional Setting	0.5%	0.4%
Jail (Correctional Facility)	3.5%	0.5%
Homeless (Shelter)	0.2%	0.3%
Other	0.8%	1.9%
Not Available	24.3%	27.4%
Total	**100%**	**100%**

*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

Idaho appears to have more youth in jail or correctional facilities served by the children's mental health system than the U.S. average. From this information, we can hypothesize that either Idaho does a better job of identifying and treating youth with mental health concerns while they are involved in the justice system, or, that we need to improve our approach to identifying and offering preventative services to youth with mental health concerns who are at risk of being involved in the justice system. More information must be collected about Idaho's justice-involved youth to better understand them and their use of mental health services.

Tracking utilization of high-level, restrictive services and living situations associated with those services allows us to monitor progress toward the goal of keeping as many children and youth at home, in school, and in their communities, wherever appropriate and possible.

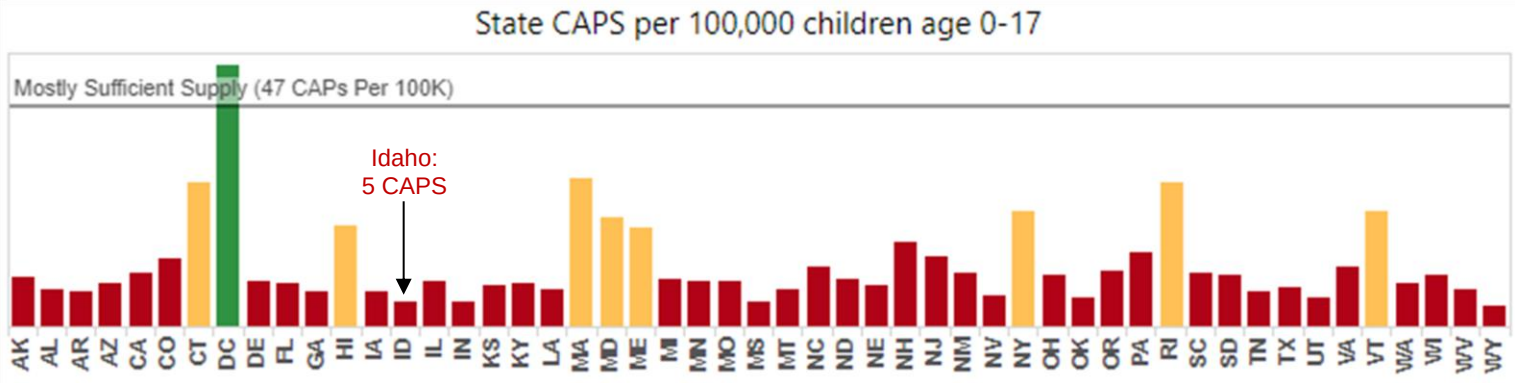
Do Children, Youth and Families Have Access to the Services That They Need?

Mental Health Professional Shortage in Idaho

The Health Resources & Services Administration (HRSA) has deemed Idaho a Geographic Health Professional Shortage Area (HPSA) for mental health professionals. HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. As of December 2016, **HRSA declared Idaho as meeting 55.16% of population mental health care geographic needs.** The following provider shortage information has been provided by the American Academy of Child and Adolescent Psychiatry- *Practicing Child and Adolescent Psychiatrists 2015* report.

Provider Shortage: Figure 24 shows a shortage of practicing Child and Adolescent Psychiatrists (CAPS) in Idaho, 2015.

Figure 24.
Data Source: *American Academy of Child and Adolescent Psychiatry*



Key: **GREEN** Mostly Sufficient Supply (>47), **YELLOW** High Shortage (18-46), **RED** Severe Shortage (1-17)

Figure 24 Summary: 42 States are considered in severe provider shortage; Wyoming ranking as most severe (4 CAPS), with **Idaho**, Indiana and Mississippi following (5 CAPS).

We Need more Information:

- Subsequent data collection is needed to further investigate Idaho's mental health Provider shortage and pinpoint areas of need throughout the state.

How is the Children's Mental Health System Experienced by Children, Youth and Families?

The Division of Behavioral Health (DBH) administers an annual satisfaction survey to families of children and youth receiving its services. This survey, named the Youth Satisfaction Survey-Family Version (YSS-F) is part of the 2016 National Outcomes Measures (NOMs) report by SAMHSA. Results on several items related to family engagement, access to services and service effectiveness/outcomes are noted and compared to the national average,

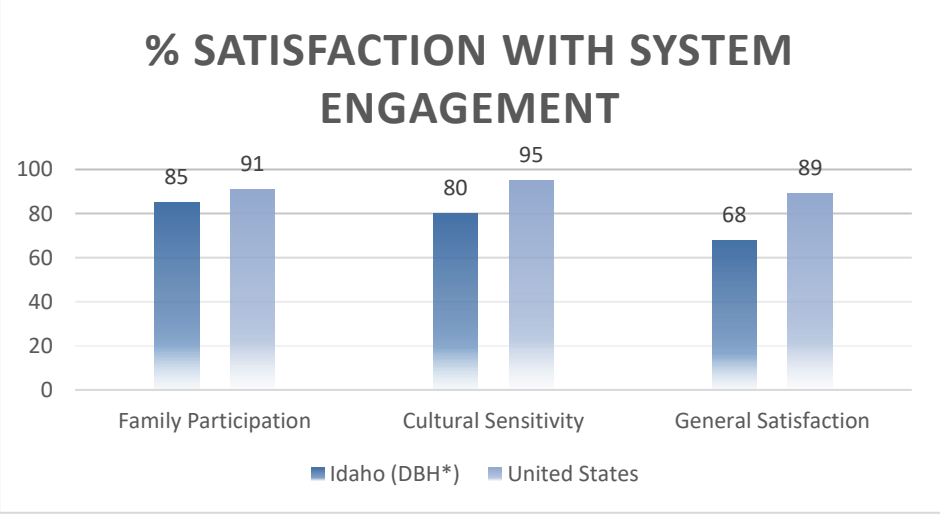
YSS-F response rate for Idaho was 7.5% (544 families were sent surveys; 41 responses were received). To be able to truly center the children's mental health system around the voices and choices of youth and their families, we encourage all youth and families to participate in as many feedback opportunities as possible.

How Well are we Engaging with Families?

Youth and family engagement is one of the foundations for the transformation planned in the Youth Empowerment Services (YES) system of care. One way to assess the progress in this area is to review client feedback on core engagement practices. This feedback can lead to identification of and need for training on engagement practices.

Family Satisfaction with System Engagement: Figure 25 shows family perception about engagement.

Figure 25.
Data Source: *SAMHSA- Idaho 2016 NOMs- Youth Satisfaction Survey- Family Version (YSS-F)*



YSS-F Survey: Engagement
I helped to choose my child's services.
I helped to choose my child's treatment goals.
I was given the opportunity to participate in my child's treatment.
Staff respected my family's religious/spiritual beliefs.
Staff members were sensitive to my family's cultural and ethnic background.

*YSS-F response rate for Idaho was 7.5% (544 families were sent surveys; 41 responses were received).
*Data included in the NOMS report is representative only of Idaho children and youth served by the Division of Behavioral Health.

The above YSS-F information shows that Idaho is below the national average for youth and family satisfaction with system engagement overall. There is a significant difference in families reporting general satisfaction with care.

How do Idaho Families feel about Access to Services?

The following figure is an excerpt from the Youth Satisfaction Survey- Family (YSS-F) portion of the National Outcome Measures (NOMs) report that demonstrates family perception of access to services.

Survey items within the Access domain included:

- The location of services was convenient.
- Services were available at times that were good for me.

Family Satisfaction with Access to Services: Figure 26 shows family perception about access to services.

Figure 26.
Data Source: *SAMHSA- Idaho 2016 NOMs- Youth Satisfaction Survey- Family Version (YSS-F)*

YSS-F Indicator	Idaho (DBH*)	U.S. Average
Reporting Positively about Access	68.3%	85.2%

*YSS-F response rate for Idaho was 7.5% (544 families were sent surveys; 41 responses were received)
*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

How do Idaho Families feel about Service Effectiveness?

The following figure is an excerpt from the Youth Satisfaction Survey- Family (YSS-F) portion of the 2016 National Outcome Measures (NOMs) report by SAMHSA regarding family perception of service effectiveness.

Survey items within the Functioning domain included:

- My child is better able to do things he or she wants to do.
- My child is better at handling daily life.
- My child gets along better with family members.
- My child gets along better with friends and other people.
- My child is doing better in school and/or work.
- My child is better able to cope when things go wrong.

Service Effectiveness: Figure 27 shows family perception of functioning resulting from services.

Figure 27.
Data Source: *SAMHSA- Idaho 2016 NOMs- Youth Satisfaction Survey- Family Version (YSS-F)*

YSS-F Indicator	Idaho (DBH*)	U.S. Average
Reporting Improved Functioning from Services	61.5%	73.4%

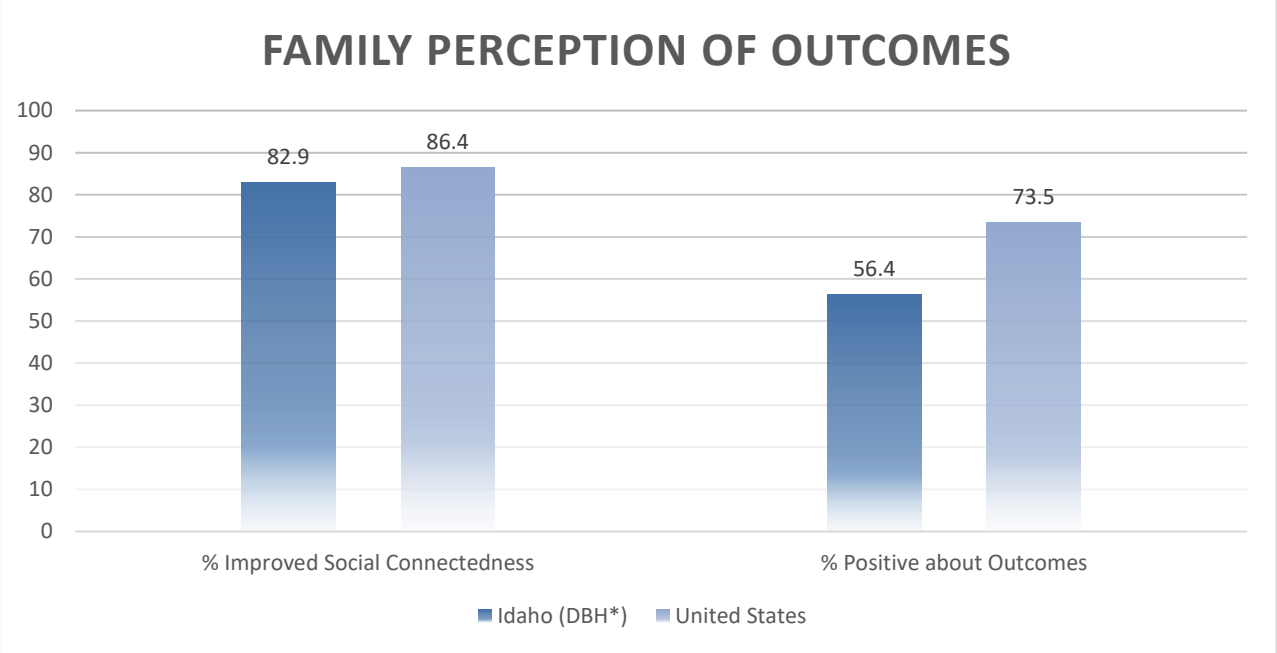
*YSS-F response rate for Idaho was 7.5% (544 families were sent surveys; 41 responses were received).
*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

How do Idaho Families feel about Treatment Outcomes?

Improving youth and family experience is the driving force behind the Youth Empowerment Services (YES) project. The below information from the Youth Satisfaction Survey- Family (YSS-F) portion of the National Outcome Measures (NOMs) report demonstrates family perception of service outcomes; improved social connectedness, and positivity about outcomes.

Outcomes: Figure 28 shows family perception of transition and linkage outcomes.

Figure 28.
Data Source: *SAMHSA- Idaho 2016 NOMs- Youth Satisfaction Survey- Family Version (YSS-F)*



*YSS-F response rate for Idaho was 7.5% (544 families were sent surveys; 41 responses were received).
*Data included in the NOMs report is representative only of Idaho children and youth served by the Division of Behavioral Health.

Measuring youth and family experiences and gathering feedback and input will be an ongoing theme throughout this system transition. It is important to reiterate that to be able to truly center the children's mental health system around youth and family voice and choice, we encourage all youth and families to participate in as many feedback opportunities as possible.

How Well are Children, Youth and Families Prepared for Care Transitions?

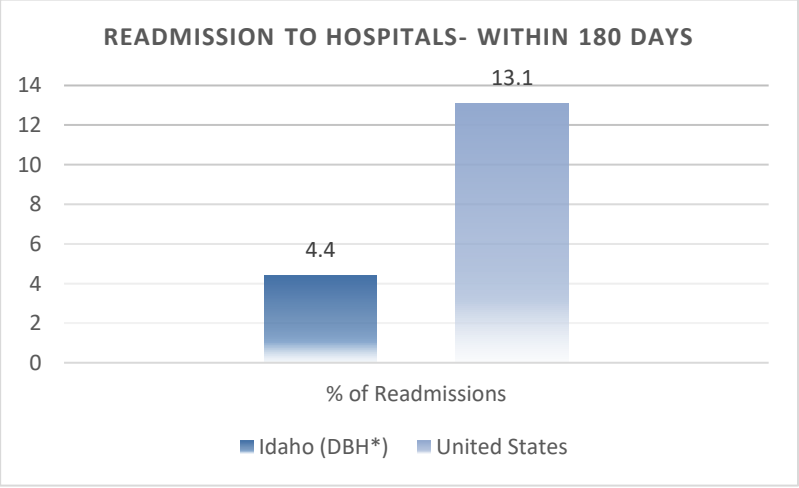
Are Treatment Gains Maintained Post-Treatment?

The final category of data for this Quality Management Improvement and Accountability (QMIA) quarterly report is associated with linkages and transitions. Here we are looking at indicators of how the youth and family felt about the effectiveness of the transition support they received throughout their system involvement. Linkage support should allow youth and families to feel prepared at discharge and transitions and to experience gains that are meaningful in their communities.

The below figure captures psychiatric hospital readmissions within a 180-day period. Information is from the 2016 National Outcomes Measures (NOMs) report by SAMHSA. It is important to note that this data represents state hospitalization only. Re-admissions to the community hospitals do not get tracked and recorded in the NOMs report. Additionally, State Hospital South provides longer-term treatment and may keep children and youth longer than a typical forensic hospital, which may also contribute to a lower re-admission rate.

State Psychiatric Hospital Readmissions: Figure 29 shows hospital readmissions within 180 days for children and youth aged 0-17.

Figure 29.
Data Source: *SAMHSA- Idaho 2016 NOMS- Youth Satisfaction Survey-Family Version (YSS-F)*



*Data included in the NOMS report is representative only of Idaho children and youth served by the Division of Behavioral Health.

"Potentially preventable causes of overall hospital readmission include failure to adequately stabilize patients before release; overly brief stays/premature discharge; failure to coordinate and reconcile medications after discharge; inadequate communication among hospital personnel, patients, caregivers and community-based clinicians; and poor planning for care transitions."
- Medicare's Readmissions Reduction Program: A Positive Alternative

How is Youth Involvement at the System/ Policy Level Being Enhanced?

Youth Voice Project

The vision for the Youth Voice Project is to be able to connect to and collaborate with as many Idaho youth who may be impacted by the children's mental health system transformation as possible. The Youth Voice Project plan will allow us to receive diverse, feedback from youth statewide and promote continuous youth involvement. The Youth Voice Project plan will be twofold:

1) Partnering with existing Idaho youth groups; We will begin working directly with established youth groups throughout the state such as Idaho Youth MOVE. Youth MOVE is a youth-driven organization dedicated to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education and child welfare. The Boise Youth MOVE chapter will assist with the development and leadership of the Youth Voice Project initiative. We are excited to begin reaching out to other MOVE chapters as well as other youth groups around the state to build our Youth Voice network.

2) We feel that all youth should have the opportunity to have their voice and opinions heard; even those who cannot, or do not want to attend traditional community meetings. The YES QMIA team is working on a proposal to create a 'Youth Action Center' as an extension of the YES website. Draft project ideas, informational materials, project content, language, design and display will be posted to the Youth Action Center for feedback and discussion. Additionally, youth opinions, ideas and feedback will be requested about specific system programs and components. Finally, there will also be a 'general discussion' option where youth can inform the YES team of their experiences with the system, or of any other ideas or feedback they may have. There will also be a section of the Youth Action Center which provides information about self-advocacy and participation in service planning. The "I want to do more!" section of the Action Center will inform youth of current YES workgroups and subcommittees they may consider joining. Other Youth MOVE chapters and local youth groups will also be promoted here.

The goal of the Youth Voice Project is to empower Idaho's youth to help drive their own system transformation. We hope to grow this initiative, to identify and support youth leaders, and to promote youth voice and choice throughout the children's mental health system transformation and beyond.

Glossary

- **Child and Adolescent Needs and Strengths (CANS):** A tool used in the assessment process that provides a measure of a child's or youth's needs and strengths.

- **Class Member**: Idaho residents with a serious emotional disturbance (SED) who are under the age of 18, have a diagnosable mental health condition, and have a substantial functional impairment.

- **ED:** ED is an acronym for an emotional disturbance used by schools. An IDEA disability category in which a student has a condition exhibiting one or more of five behavioral or emotional characteristics over a long period of time, and to a marked degree, that adversely affects educational performance. The term *does not* include students who are socially maladjusted unless it is determined they have an emotional disturbance. The term emotional disturbance *does* include students who are diagnosed with schizophrenia.

- **IEP:** The Individualized Education Plan (IEP) is a written document that spells out a child or youth learning needs, the services the school will provide and how progress will be measured.

- **Jeff D. Class Action Lawsuit:** The Settlement Agreement that ultimately will lead to a public children's mental health system of care (SoC) that is community-based, easily accessed and family-driven and operates other features consistent with the System of Care Values and Principles.

- **Parties:** The litigants in the Jeff D Lawsuit.

- **Presumed Class Member (PCM):** A presumed Class Member is a child, or youth who is currently receiving publicly funded mental health services and who may meet the criteria to be a Jeff D class member based on proxy indicators.

- **QMIA:** A quality management, improvement, and accountability program.

- **Penetration Rate:** The degree to which a defined population is served, calculated by dividing those served by the total population which matches the defined population.

- **Plaintiffs**: Representatives of those children, youth, and families who brought the Jeff D. legal action and their counsel.

- **Serious Emotional Disturbance (SED)**: The mental, behavioral, or emotional disorder that causes functional impairment and limits the child's functioning in family, school, or community activities. This impairment interferes with how the youth or child needs to grow and change on the path to adulthood, including the ability to achieve or maintain age-appropriate social, behavioral, cognitive, or communication skills.

- **Settlement Agreement (Jeff D. Settlement Agreement):** The contractual agreement agreed to between the parties to the Jeff D. class action lawsuit for a resolution to the underlying dispute.

- **SFY**- The acronym for State Fiscal Year which is July 1 to June 30 of each year. The noted year indicates the year at the end of June.

- **System of Care:** An organizational philosophy and framework that involves collaboration across agencies, families, and youth for improving services and access, and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children.

- **TCOM**: The Transformational Collaborative Outcomes Management (TCOM) approach is grounded in the concept that the different agencies that serve children all have their own perspectives and these different perspectives create conflicts. The tensions that result from these conflicts are best managed by keeping a focus on common objectives — a shared vision. In human service enterprises, the shared vision is the person (or people served). In health care, the shared vision is the patient; in the child serving system, it is the child and family, and so forth. By creating systems that all return to this shared vision, it is easier to create and manage effective and equitable systems.

- **Youth Empowerment Services (YES)**: The name chosen by youth groups in Idaho for the new System of Care that will result from the Children's Mental Health Reform Project.

- Other definitions can be found at http://youthempowermentservices.idaho.gov/Portals/105/Documents/YESWebglossary.pdf

Of special note:

Comparison for SED and ED

These two terms are similar but are not synonymous.

- SED is an acronym for a serious emotional disturbance used by the child-serving mental health system. SED refers to a level of emotional disturbance that causes functional impairment and limits the child's functioning in family, school, or community activities. This impairment interferes with how the youth the child needs to grow and change on the path to adulthood, including the ability to achieve or maintain age-appropriate social, behavioral, cognitive, or communication skills. SED in Idaho is defined in state rule 16.03.09.852.01.A.
- ED is an acronym for an emotional disturbance used by schools. An IDEA disability category in which a student has a condition exhibiting one or more of five behavioral or emotional characteristics over a long period of time, and to a marked degree, that adversely affects educational performance. The term *does not* include students who are socially maladjusted unless it is determined they have an emotional disturbance. The term emotional disturbance *does* include students who are diagnosed with schizophrenia.

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Youth.gov

Appendix A

Idaho Division of Behavioral Health Regional Map