
Quality Management Improvement & Accountability

Quality Management Improvement & Accountability (QMIA)

# Quarterly Report

Issue # 8 – January 1, 2019

**QMIA Council Data & Reports Subcommittee**
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Youth Empowerment Services

# QMIA Quarterly Report - Issue # 8 - January 1, 2019

## About this Report & Table of Contents

July 1- September 30, 2018

**About This Report:** The Youth Empowerment Services (YES) 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 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; this quarterly report is one tool being used to monitor and evaluate progress toward achieving these goals.

The QMIA-Q reports will focus on statewide and regional-level data and information to provide stakeholder groups insight into the child-serving system in Idaho, including: Profiles of Idaho's youth, workforce development, access and barriers to care such as gaps in services, youth and family experience and engagement, appropriate use of services, effectiveness of services and quality improvement projects.

The QMIA-Q report is available to all stakeholders and 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. If information provided within this report evokes questions or an interest in further data collection, please contact **YES@dhw.idaho.gov** with your questions, concerns or suggestions. For Medicaid-specific questions or concerns, please contact MedicaidSEDProgram@dhw.idaho.gov.

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# QMIA Quarterly Report - Issue # 8 - January 1, 2019

## Who is Accessing YES: The Independent Assessment Process

July 1- September 30, 2018

**The Independent Assessment**: To increase access to services, the division of Medicaid developed and submitted a 1915(i)-state plan option application to the Centers for Medicare and Medicaid Services that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level. A youth who does not have Medicaid coverage, or has Medicaid coverage and would like to access Agency Respite services will be referred to the Independent Assessment Provider (IAP), Liberty Healthcare. The Independent Assessment Provider will complete a Comprehensive Diagnostic Assessment as well as use the Child Adolescent Needs and Strengths (CANS) tool to determine Youth Empowerment Services eligibility.

**Between July and September, a total of 407 CANS assessments were administered by the IAP for 392 youth.** *Of the 407 CANS, 397 were labeled as initial, and 10 were labeled as update CANS.*

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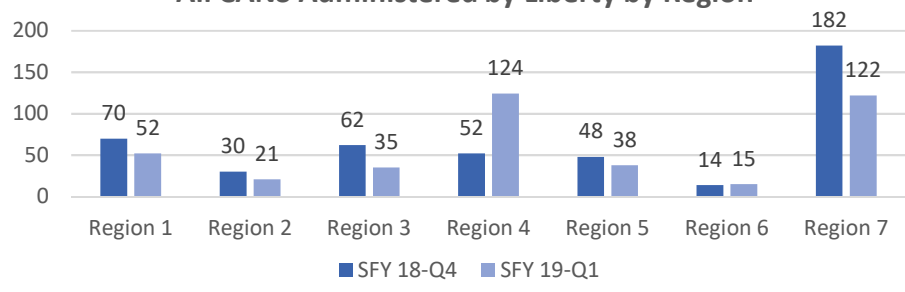


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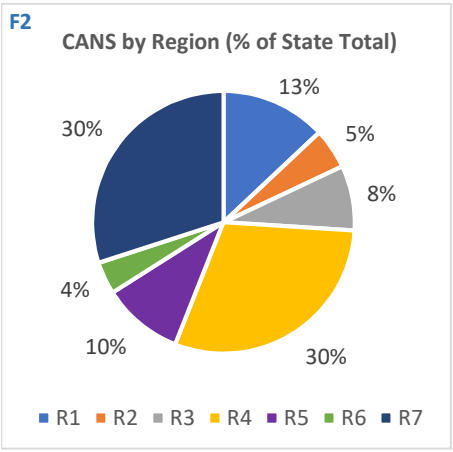


Overall, the IAP served slightly less youth than in the previous quarter (-51). A decrease was seen within most regions, most notably region 7 saw a 33% decrease. Conversely, Region 4 had a 138% increase in number of youth assessed.

The IAP in Regions 4 and 7 were responsible for 60% of the total assessments this quarter. The most significant changes from last quarter were again in Region 4 where the IAP served 11% of the total last quarter, and Region 7 where the IAP served 40% last quarter.

## DEMOGRAPHICS:

Figure 3 shows that there is some significant variation between the regions regarding ages of youth served between the ages of five and seventeen. Most notably is Region 2 (5% of total youth served were age 14-17). The IAP appears to have served very few children aged 0-4 statewide as well as 18-year-old youth.

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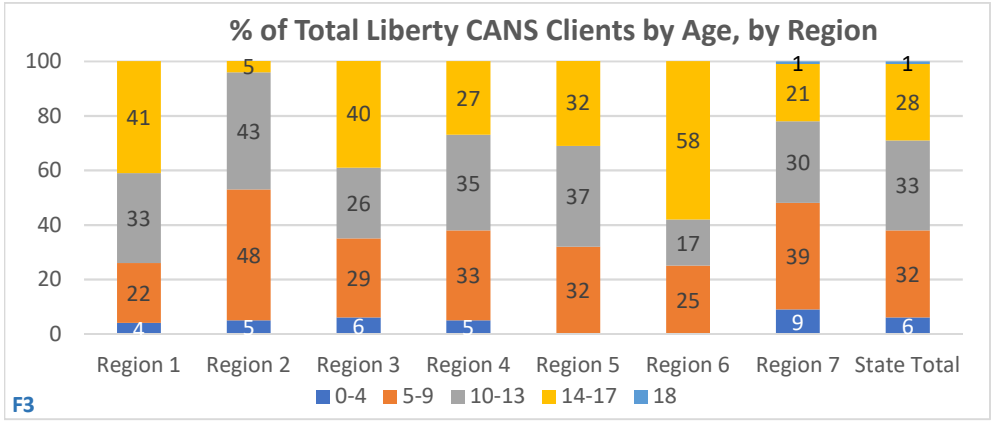
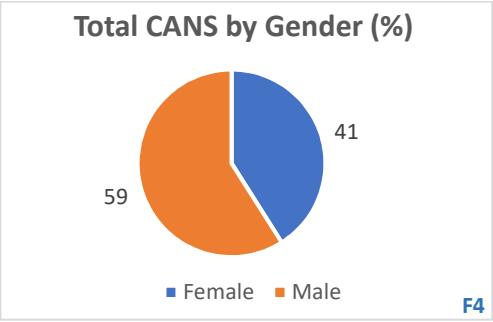



Regarding youth served by **gender**, the IAP statewide appears to be serving almost 20% more males than females. All regions, with exception of Region 1 appear to have served more males than females during this reporting period. Regions 2, 5 and 7 most closely align with the overall state representation.

| Region | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Female | 53% | 43% | 29% | 36% | 42% | 33% | 43% |
| Male | 47% | 57% | 71% | 64% | 58% | 67% | 57% |

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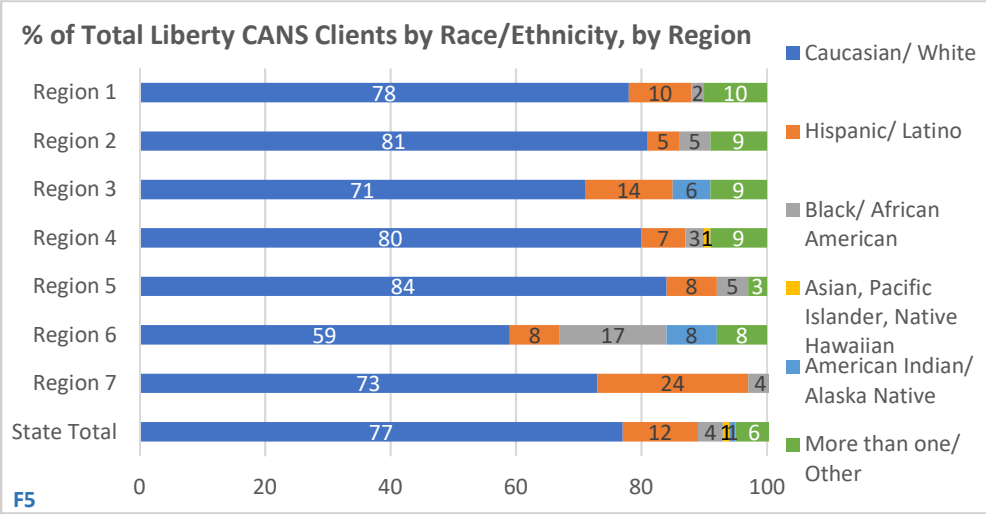
CANS Clients for Figures 3-6 (#): *Region 1: 51, Region 2: 21, Region 3: 35, Region 4: 116, Region 5: 38, Region 6: 12, Region 7: 119, State total: 392*

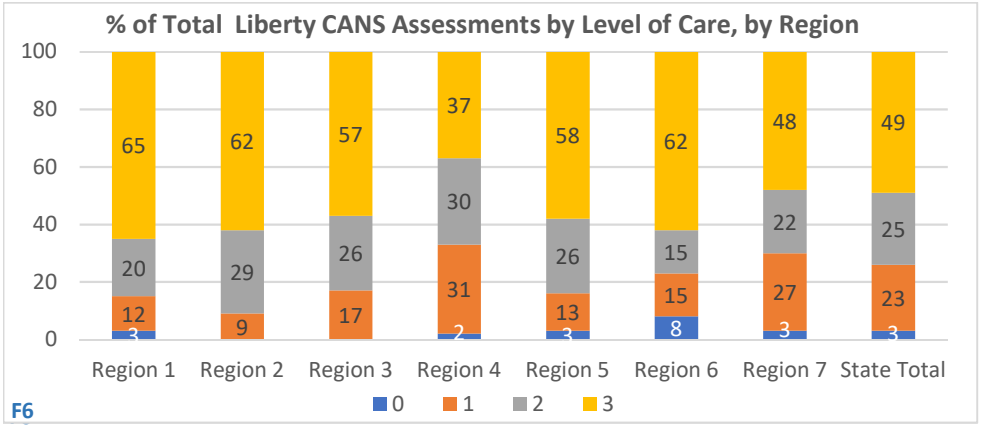
# DEMOGRAPHICS CONTINUED: Race & Ethnicity




Across the state, the IAP appears to have seen a majority of youth who identified as Caucasian/ White. Regions 7 and 4 assessed the highest percentages of youth who identified as Hispanic/ Latino, while Region 6 saw a high percentage of youth identifying as Black/ African American. Regions 3 and 6 were the only regions who saw youth who identified as American Indian or Alaska Native; similarly, Region 4 was the only region to see youth identifying as Asian, Pacific Islander or Native Hawaiian.

**Levels of Care (LOC)** recommended by the IAP by region and statewide for this reporting period are displayed below. Much like last quarter, there is a consistently higher amount of youth who are assigned a LOC of '3' than any other LOC. There is not much variation seen among the regions regarding LOC '2'. Region 4 appears to have the most unique LOC pattern overall.

| Recommended Levels of Care | |
|---|---|
| 0 | YES eligibility criteria not met |
| 1 | SED identified. Services should be coordinated, but functioning is stable |
| 2 | SED identified. Youth may be involved in multiple systems and require extensive service collaboration |
| 3 | SED identified. Youth is considered to have high treatment needs and is at risk of out-of-home placement |




**Youth Newly Eligible for Medicaid Coverage:** Youth who are determined to be eligible for YES (LOC 1-3 in Figure 6) and who do not already have Medicaid coverage will be referred to the state's Self Reliance program to apply for Medicaid coverage. Medicaid eligibility for YES program participants will be granted to youth with family incomes from 150-300% of the federal poverty level (FPL). This is referred to below as the 'YES aid code.' From January 1- December 15, 2018: a total of 1,051 youth were approved for Medicaid as part of the YES program. Of the total, 356 youth were approved under the YES aid code. The remaining 695 approvals were for youth already receiving Medicaid through a different aid code. There were 306 Medicaid-eligibility denials during this period.

All youth who have been found to be YES eligible through the Independent Assessment process, are newly YES Medicaid eligible and/or would like to access Agency Respite services will have a **person-centered service plan**.

| Region | New Referrals | % of Total | # Completed during period | % of Total | Med. Time to Complete |
|---|---|---|---|---|---|
| **1** | 45 | 13% | 56 | 19% | 49 days |
| **2** | 18 | 5% | 23 | 8% | 53 days |
| **3** | 34 | 10% | 37 | 12% | 58 days |
| **4** | 103 | 30% | 53 | 18% | 69 days |
| **5** | 38 | 11% | 44 | 15% | 46 days |
| **6** | 17 | 5% | 13 | 4% | 65 days |
| **7** | 90 | 26% | 74 | 25% | 69 days |
| **State** | 345 | 100% | 300 | 100% | 60 days |

As expected, the percent distribution of person-centered service plan referrals was similar to that of the percent of youth seen by the IAP per region. The median amount of days to complete person-centered service plans during this period varied by region, with Region 3 being similar the state median, Regions 4, 6 and 7 higher, and Regions 1, 2 and 6 lower than the state median number of days to complete.

**The number of plans completed during period does not necessarily have a direct correlation to the number of new referrals, as some referrals included in this number were received before the reporting period began, and some were received right before it ended.*

# QMIA Quarterly Report - Issue # 8 - January 1, 2019

## Who is Accessing YES: CANS Administered by DBH & Community Providers

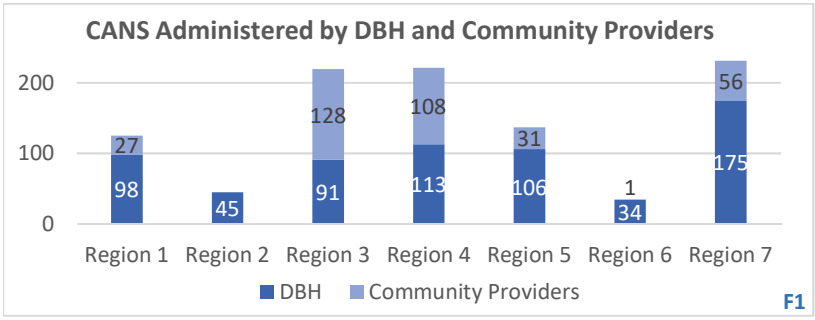
July 1- September 30, 2018

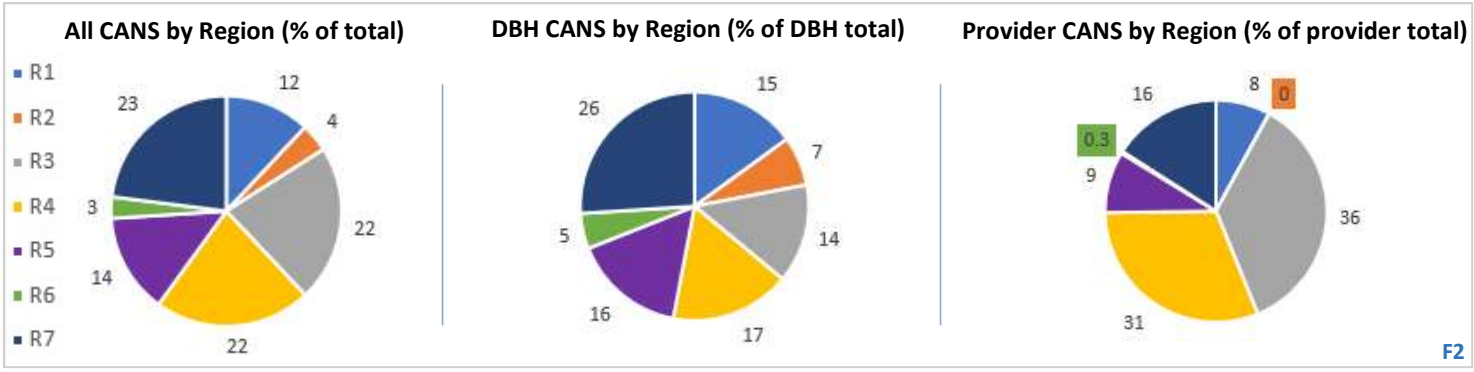
Between July 1 and September 30, a total of **1,013** Child Adolescent Needs and Strengths (CANS) assessments were administered for **960** youth by a Division of Behavioral Health (DBH) Regional Clinician or a Community Provider. Community Providers began using the CANS in July 2018, however is it important to note that use of the tool is not mandatory until July 2019. These CANS were administered for youth in one of the following situations: 1) Initial CANS for a new or existing client who did not go through the Independent Assessment process, 2) CANS update: 90 days following initial assessment or as otherwise appropriate, 3) CANS at discharge.

| Agency | Division of Behavioral Health | Community Providers | Total |
|---|---|---|---|
| Initial | 238 | 349 | 587 |
| Update | 357 | 2 | 359 |
| Discharge | 67 | - | 67 |
| Total | 662 | 351 | 1013 |

**DBH assessed a total of 623 youth during this reporting period. Community providers saw a total of 349 youth. 12 youth received a CANS from both entities.**

According to **Figure 1**, which shows the total number of CANS completed by both DBH and Community Providers, regions 3, 4, and 5 administered a similar total amount and the highest number of CANS during this reporting period. **Figure 2** below shows percentages of total CANS completed per region for the total number of CANS, CANS administered by DBH and CANS completed by Community Providers.



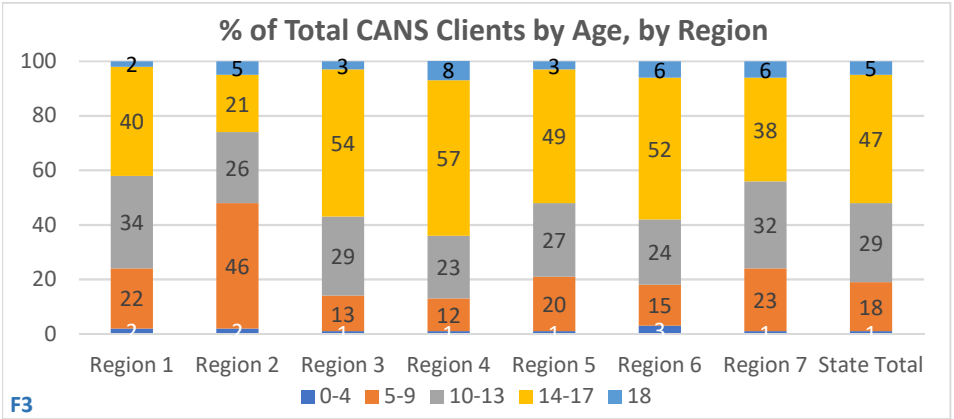




*Total # of CANS: Region 1: 125, Region 2: 45, Region 3: 219, Region 4: 221, Region 5: 137, Region 6: 35, Region 7: 231*

Overall, there are significant differences between regional percent of total when comparing DBH-completed CANS to those completed by Community Providers. This difference may be attributed to the fact that DBH has been completing the CANS consistently since January, and Community Providers just begun using the tool at the start of this reporting period. Patterns in this data will continue to be monitored as more community providers begin to use the CANS tool.

# DEMOGRAPHICS:

**Figure 3** demonstrates that there is some variation between the regions regarding ages of youth served. Most notably is Region 2 (21% of total youth served were age 14-17, 46% of youth were age 5-9). It is important to note that Region 2 data consisted only of DBH CANS. All regions appear to have served very few children aged 0-4 as well as 18-year-old youth.




CANS Clients for Figures 3-5 (#): *Region 1: 122, Region 2: 42, Region 3: 209, Region 4: 210, Region 5: 132, Region 6: 33, Region 7: 224, State total: 960*

Regarding youth served by **gender**, DBH and Community Providers combined appear to have assessed almost 15% more males than females. The most significant differences from the statewide percentages are seen in Regions 5-7.

| Region | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| Female | 43% | 50% | 51% | 43% | 35% | 36% | 37% |
| Male | 56% | 50% | 47% | 57% | 64% | 60% | 62% |
| Transgender | 1% | - | 2% | - | 1% | 3% | - |
| Unknown | - | - | - | - | - | 1% | 1% |

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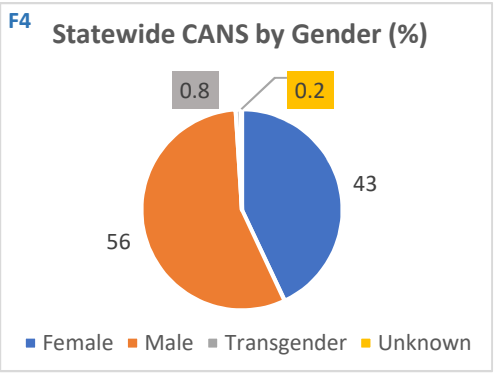
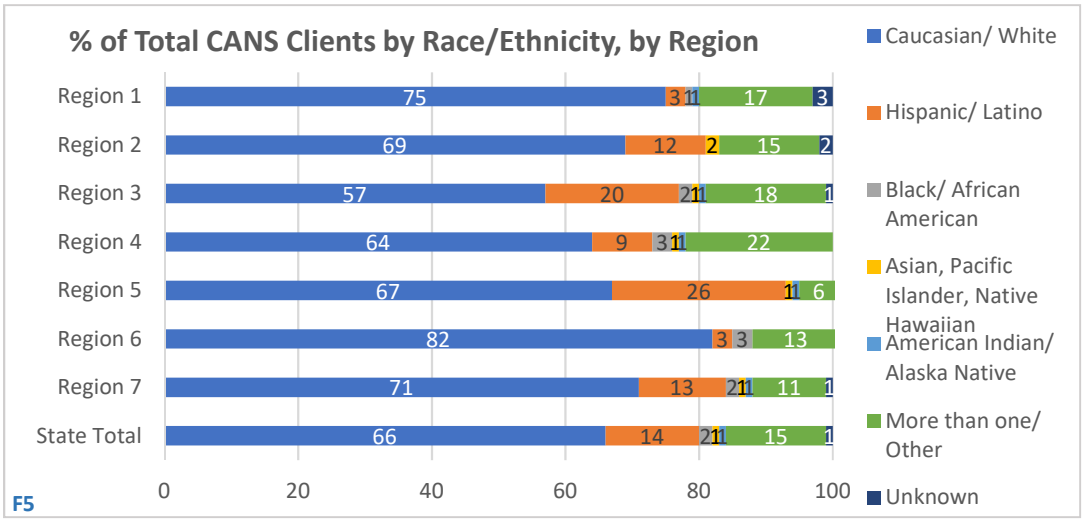



Regions across the state appear to have assessed a majority of youth who identified as Caucasian/ White. Regions 3 and 5 assessed the highest percentages of youth who identified as Hispanic/ Latino. Most regions, with exception of 2 and 5 assessed youth who identified as Black/ African American, however these percentages were small. Small percentages of youth identifying as Asian, Pacific Islander, or Native Hawaiian were seen in Regions 2, 3, 4, 5 and 7, and Regions 1, 3, 4, and 7 assessed a small number of youth who identified as American Indian/ Alaska Native.

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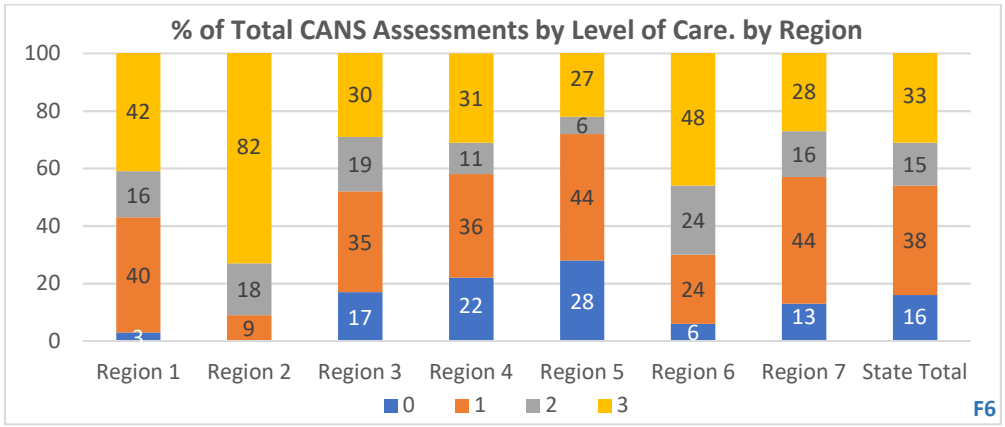
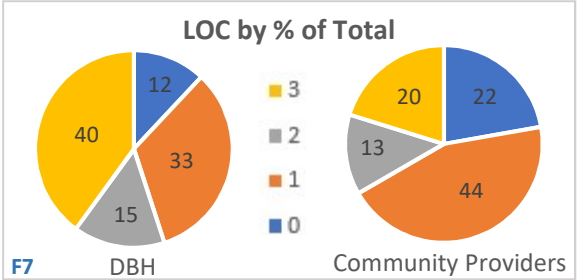
**Levels of Care (LOC)** recommended by DBH and Community Providers by region and statewide for this reporting period are displayed below. If a youth had more than one CANS on file, the most recent CANS was considered for this data set. Incomplete CANS were removed from this analysis. Overall, LOC '1' was the most frequently recommended level of care in most regions, followed by LOC '3'. Regions 2 and 6 appear to deviate from this pattern most significantly. Region 2 data demonstrates the most unique LOC pattern overall. *Reminder: Region 2 data consisted of CANS administered by DBH only.*

| Recommended Levels of Care | |
|---|---|
| 0 | YES eligibility criteria not met |
| 1 | SED identified. Services should be coordinated, but functioning is stable |
| 2 | SED identified. Youth may be involved in multiple systems and require extensive service collaboration |
| 3 | SED identified. Youth is considered to have high treatment needs and is at risk of out-of-home placement |




F6

CANS Clients for Figure 6 (#): *Region 1: 113, Region 2: 34, Region 3: 207, Region 4: 201, Region 5: 127, Region 6: 33, Region 7: 218, State total: 921*




F7

**Figure 7** shows the individual percentage distribution breakouts for CANS completed by DBH and CANS completed by Community Providers. The majority of CANS completed by DBH appear to have been given a recommended LOC of '3', while most CANS completed by Community Providers were given a recommended LOC of '1'. LOCs will continue to be monitored as time goes on and more providers begin using the CANS tool.

*DBH N= 617, Community Provider N= 334 (Incomplete CANS removed)*

# Who We're Serving: Youth Needs and Strengths

July 1- September 30, 2018

Collecting data on the most commonly identified treatment needs and useful strengths can inform the system of the direction in which practice needs to go to best support those it's serving. Identifying the most prevalent system-wide needs could indicate that the addition of services and supports targeted to address these needs should be explored or help determine which evidence- based practices may be a valuable investment. Clinicians who administer the CANS have the opportunity to view this type of report at the individual client or caseload level, allowing for individualization of treatment and approach. *The information below has been pulled from initial CANS only and includes all assessing agencies (Independent Assessment Provider (IAP), Division of Behavioral Health (DBH), and Community Providers). This allows us to understand the needs and strengths of youth as they are receiving their first CANS assessment within the YES system of care.*

*CANS Records (#) for Figures 1-4: Region 1: 160, Region 2: 56, Region 3: 240, Region 4: 308, Region 5: 154, Region 6: 45, Region 7: 331, State total: 1294. If a youth had more than 1 'initial CANS' on file, the most recent record was used.*

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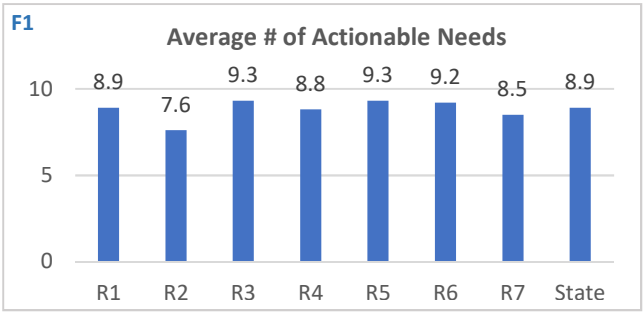


**Figure 1** shows the average number of actionable needs identified within the Behavioral/Emotional, Life Functioning, and Risk Behavior domains of the CANS, displayed per region and statewide. The number of actionable needs identified for a youth can be an indication of case complexity. Overall, there doesn't appear to be significant variation between the regions. Region 2 had the most variation from the state average. Statewide, the average number of actionable needs identified from these core domains is around 9.

| | |
|---|---|
| **Actionable NEED** | An item rated '2' or '3' on the CANS. A rating of '2' indicates that the need is interfering with functioning and requires action or intervention to ensure that the need is addressed. A rating of '3' indicates that the need is dangerous or disabling and requires immediate and/or intensive action. |
| **Useful STRENGTH** | An item rated as '0' or '1' on the CANS. A rating of '0' indicates a well-developed strength that may be used as a centerpiece of a strength-based plan. A rating of '1' indicates that a strength is evident, but some effort is needed to maximize the strength; this may be built upon in treatment. |

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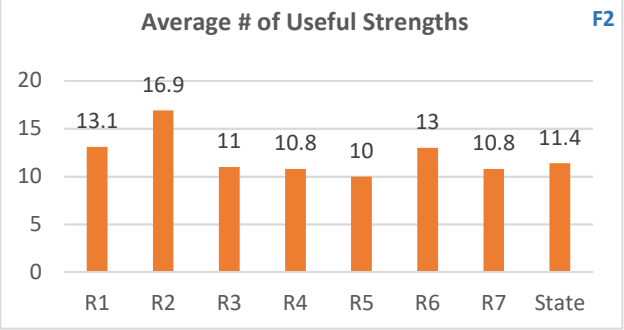


**Figure 2** shows the average number of useful strengths identified within the strengths domain of the CANS. Overall, there is more variation between the regions seen here than with actionable needs. Once again, Region 2 is showing the most variation from the state average. Statewide, the average number of useful strengths identified in initial CANS is about 11.

## What Needs and Strengths are youth and families identifying most often?

**Statewide:** **66%** of youth identified **Emotional/ Physical Regulation** as an actionable need, **60%** of youth identified **Anger Control** and **Family**, **59%** identified **Impulsivity**, and **56%** **Social Functioning**.

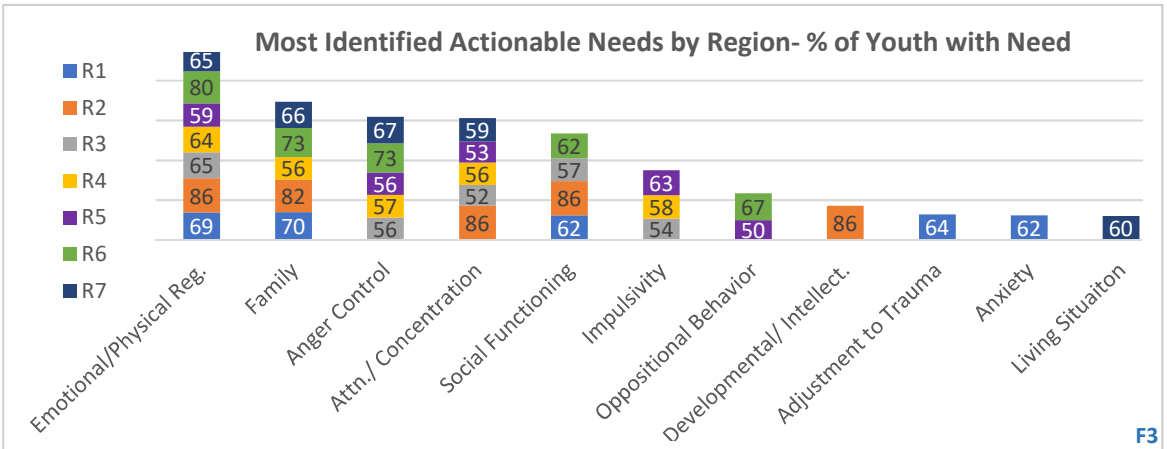


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**Figure 3** is showing the top 5 most identified actionable needs within each region. Each colored box represents a region, and the number inside the box represents the percent of total youth with a CANS completed within that region that identified the corresponding need as actionable. Although this is a limited view, there are still some notable variations between regions and as compared to the state.

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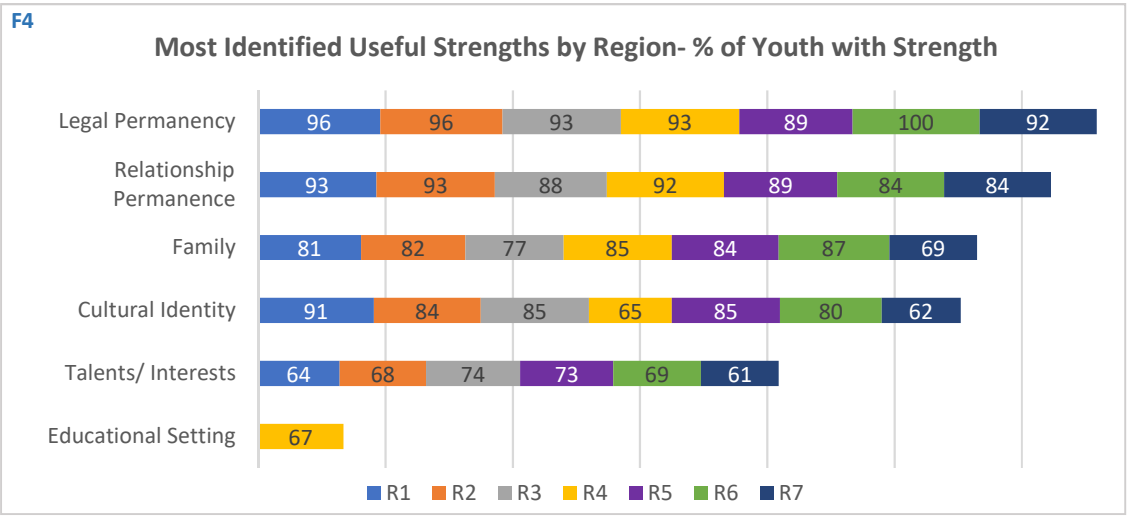



**Statewide: 93%** of youth identified **Legal Permanency** as a useful strength, **89%** of youth identified **Relationship Permanence**, **79%** of youth identified **Family**, **75%** identified **Cultural Identity**, and **66%** identified **Talents/ Interests**.

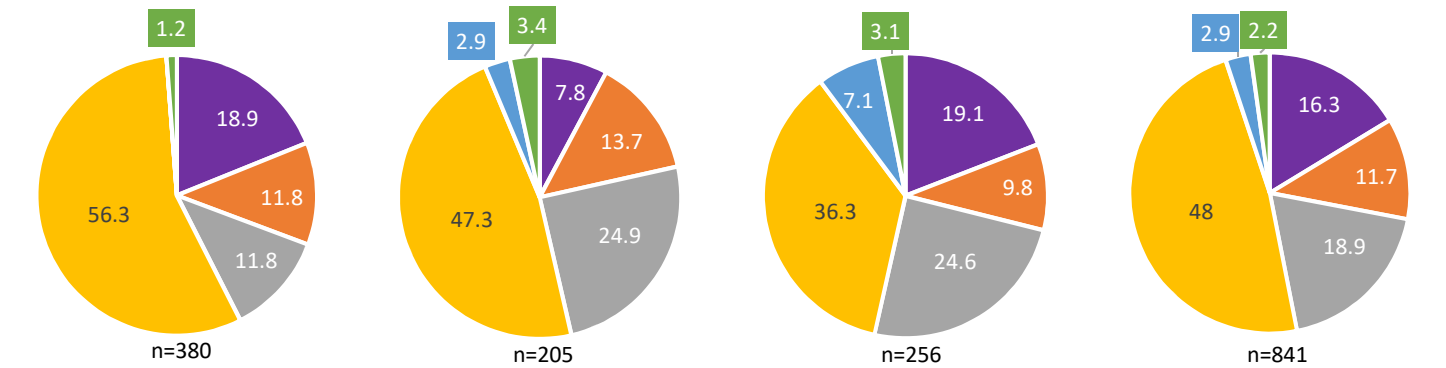
According to **Figure 4**, Legal Permanency was the most frequently endorsed strength by all regions, with very high percentages ranging from 89 to 100%. Relationship Permanence was also endorsed by a high percentage of youth regionally and statewide. Notable variances begin when looking at Family, Cultural Identity and Talents and Interests. A solitary outlier is seen in Region 4, with 67% of youth assessed identifying Educational Setting as a useful strength.

## Presenting Concerns- Primary Diagnoses

The following figure and table shows presenting concern categories based on primary diagnosis for all youth who were administered an initial CMH CANS between July and September. There are several percentage variations between regions as well as between assessing agencies. The most notable variations are the percentage of stress and trauma-related diagnoses for youth in Region 1, the percentage of mood-related diagnoses for youth assessed by Liberty, the percent of anxiety-related concerns for youth assessed by DBH, and the percentage of youth with externalizing-related and mood-related diagnoses in Region 2. More information about the presenting concern categories can be found in Appendix B (full report).

| Presenting Concern Categories by Region- All Assessing Agencies Combined | | | | | | |
|---|---|---|---|---|---|---|
| **Region** | Anxiety | Stress/Trauma | Mood | Externalizing | Neurological | Other |
| 1 (n=96) | 16.7% | 33.3% | 15.6% | 29.2% | 3.1% | 2.1% |
| 2 (n=30) | 13.3% | 6.7% | 6.7% | 73.3% | 0% | 0% |
| 3 (n=154) | 14.3% | 11.1% | 20.1% | 45.5% | 5.8% | 3.2% |
| 4 (n=231) | 16.5% | 10% | 21.2% | 48.1% | 2.6% | 1.6% |
| 5 (n=82) | 12.2% | 7.3% | 18.3% | 57.3% | 1.2% | 3.7% |
| 6 (n=22) | 13.6% | 9.1% | 27.3% | 45.5% | 0% | 4.5% |
| 7 (n=226) | 19.5% | 7.1% | 18.1% | 51.3% | 2.2% | 1.8% |

F5




***Initial CANS designation**: it is important to note that all youth will receive an 'Initial CANS', regardless if they are a new or existing client to DBH or a Community Provider. This designation indicates a youth's first CMH CANS assessment, not necessarily that they are a new client or new to receiving services.*

## Services & Supports: **Wraparound**

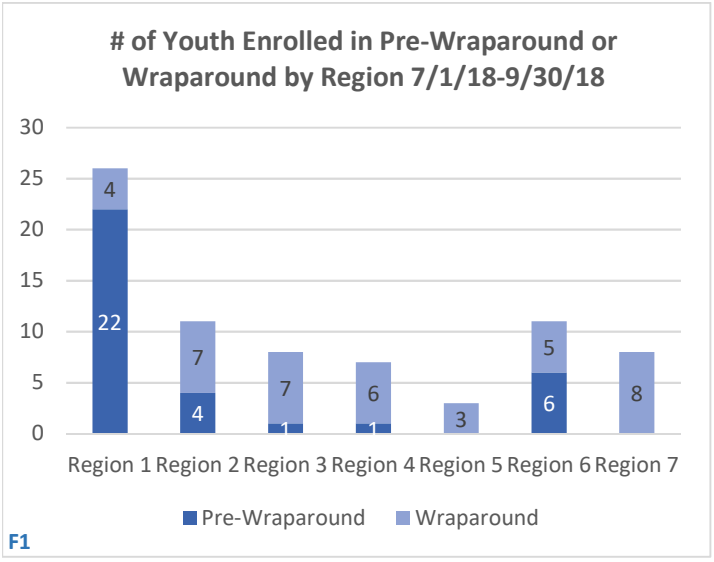
July 1- September 30, 2018

A Wraparound utilization report was recently completed by Boise State University (BSU) School of Social Work to estimate the number of youth who are likely to need/use Intensive Care Coordination (ICC). BSU's report suggested that 1,350 Idaho youth would have benefitted from Intensive Care Coordination in 2016. For an emerging program, in a pilot phase or in the early stages of implementation, it was estimated that Idaho may serve around 65 youth per year. BSU's findings were summarized in detail in the QMIA Quarterly report #5, and the full report, entitled Estimated Need for Intensive Care Coordination among Idaho Youth can be found on the YES Website (link). *The 'emerging program' utilization goal for the YES Wraparound program is that all seven Division of Behavioral Health Regional Program Specialists will have an initial caseload of 4 families.*

**Presently, there are 35 Care Coordinators trained in Wraparound throughout the state. Two of which have the designation of supervisor and are not carrying a caseload.**

| | |
|---|---|
| Region 1 | 4 |
| Region 2 | 4 |
| Region 3 | 4 |
| Region 4 | 4 |
| Region 5 | 5 |
| Region 6 | 3 |
| Region 7 | 5 |
| FACS DD Program | 6 |

The Pre-Wraparound program designation is used when families are considering Wraparound or have agreed to Wraparound but have not started yet. To remove duplication, youth who had both a Pre-wraparound and then a Wraparound enrollment during the reporting period were counted under Wraparound.

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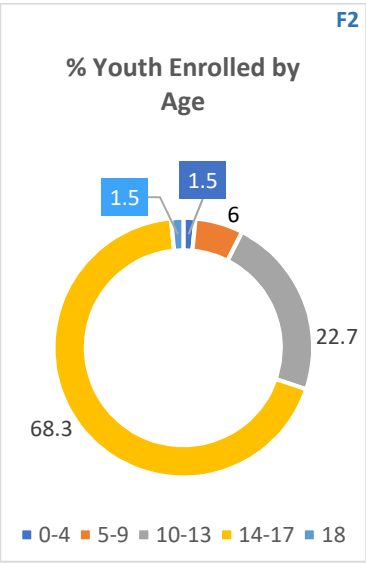
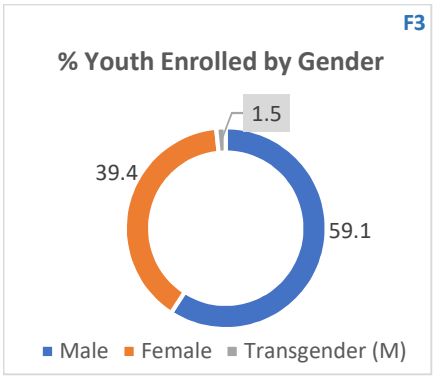
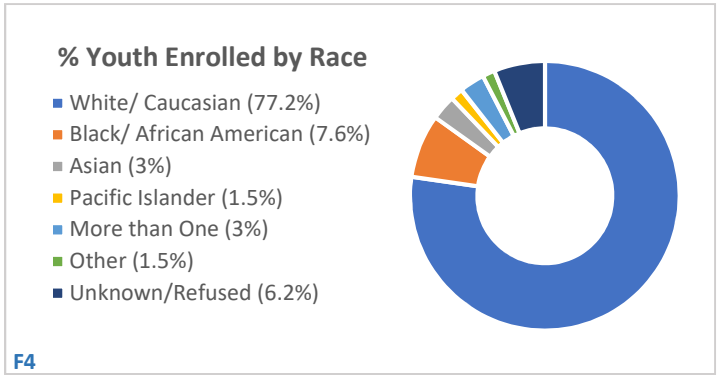



F4

**88%** of youth enrolled were not of Hispanic or Latino origin. 2 youth, or **3%** reported to be Hispanic or Latino. The race of the remaining **9%** was either unknown or the family/ youth chose not to disclose.

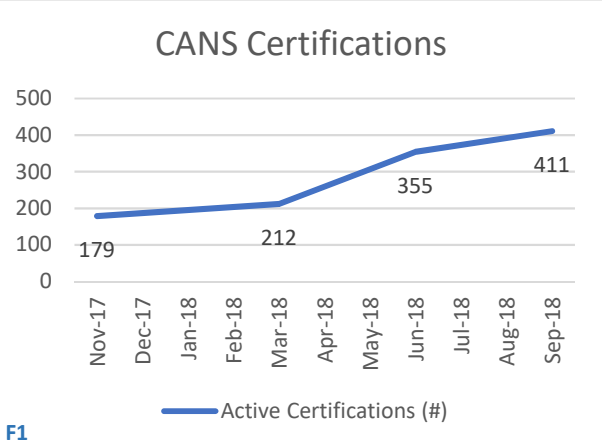
The Division of Behavioral Health began enrolling currently served youth into Wraparound programs in February of 2018. From February to June 30th, 2018, there were 32 youth enrolled in Wraparound or Pre-Wraparound. From July to September 30th, 2018, there was a total 74 youth enrolled in either program (34 in Pre-Wraparound and 40 in Wraparound). Regional enrollment breakdowns for these 74 youths have been provided in **Figure 1**. Although there was a total of 74 youth enrolled in the Wraparound program during the reporting period, 8 of these youths have exited. As of September 30th, 66 youth were being served in Wraparound or Pre-wraparound. The demographic information provided in **Figures 2-4** is representative of the 66 youth still enrolled in a Wraparound program as of the end of the reporting period.

*Data source: Division of Behavioral Health, WITS*

## Supporting the Workforce: CANS Certifications & Trainings

July 1- September 30, 2018

The CANS tool is designed to facilitate an engaging and collaborative partnership between the provider, youth and family to inform planning, support decisions and monitor outcomes. When a provider becomes CANS certified, they are trained on the TCOM Fundamental Tenets: 1) A required focus of a shared vision of the children and families receiving services, 2) Collaboration of multiple partners, 3) Communication facilitation among partners, including youth and families, 4) Shared commitment to serving youth and families despite differences, 5) Collective accountability to the youth and family. *The number of providers and key individuals who are CANS certified represents system progress toward improved youth and family engagement practices and meaningful change.*




F1

**ICANS Trainings:** During the reporting period, the Division of Behavioral Health (DBH) hosted **50** ICANS training webinars for their own staff (46) as well as community partners and providers (52), the Department of Juvenile Corrections (11), the Division of Family and Community Services (183), agency administrators (46), and the Independent Assessment Provider (6). An additional 3 ICANS users participated on the ICANS User Coaching call.

**Coaching & Support:** *Wraparound Care Coordinators and DBH staff working with families to complete person-centered service plans participate in weekly support calls:*

| | | |
|---|---|---|
| Wraparound | 8 calls during report period | Average 25 attendees |
| Person-centered service planning | 12 calls during report period | Average 40 attendees |

In addition to the weekly support calls, an In-person Wraparound Supervisors and Coaching Training was held in September for 18 Wraparound staff.

The Division of Behavioral Health helped support the following learning opportunities for family members during the reporting period: *Principles of Care and Practice Model*, *Coordination of Care Planning*, and *Being the Parent of a Kid with SED*. These trainings were delivered via webinar and had a total of 115 attendees.

**Medicaid supported 4 trainings in July where providers were taught how to use CANS data and interpret reports. These trainings were held in Boise, Pocatello and Moscow and 47 providers were in attendance.**

YES Navigation Series: Medicaid supported YES Navigation series trainings for providers: Part 1 in July and Part 2 in September. Part 1 was offered across the state while Part 2 was available via live webinar and is since available on demand. A total of 134 providers attended Part 1 and 43 attended Part 2.

| State Department of Education | | | | |
|---|---|---|---|---|
| Training | Date | Audience | # Reached | Mode |
| YES Checklist- how and where to distribute | 9/18 | Regional Special Education Directors | 150 | In-person presentation |
| YES and the role of Community Partnerships | 9/18 | School staff, family members, and community partners | 355 | In-person presentation |

**Juvenile Justice:** In September, DBH presented at the Idaho Juvenile Justice Association conference, reaching 40 association members as well as the Idaho Judicial Conference, reaching 40 Judges and court-system staff. The **Idaho Department of Juvenile Corrections (IDJC)** has been working to ensure that their regional staff have training, certification, and access to the CANS assessment and ICANS system as needed. **26** IDJC staff have completed CANS certification and **27** have completed ICANS training.

## Supporting the Workforce: **Capacity & Gaps Analysis**

July 1- September 30, 2018

The Department of Health and Welfare contracted with Boise State University School of Social Work (BSU) to conduct a survey and compose a report to complete a workforce capacity and gaps analysis. The survey results were utilized by BSU to estimate the number of Medicaid providers who are currently delivering mental health services and supports to youth and their families. This estimate was then used to determine if there are any gaps between what is currently available and what is needed to support the mission of Youth Empowerment Services. This analysis has been used to inform the YES Workforce Development Plan. *A review of the survey findings was included in the previous QMIA Quarterly report. A summary of the subsequent report completed by BSU entitled 'Idaho Youth Empowerment Services (YES) Workforce Capacity and Gaps Analysis' has been provided below. The full document can be found here.*

**About the Analysis:** Population estimates of Medicaid workforce capacity were developed using weighted data collected from providers who completed the above-mentioned workforce survey. The weighting incorporated information on geographic location, practice type, and practice size. This estimate included the following survey data: 1) the number of mental health professionals who serve youth by role, 2) the number of mental health professionals with specialized training in wraparound and other select evidence-based practices (EBPs), and 3) the number of youth who received EBPs as part of their treatment. Estimates of the number of youth in need of services were derived from Department of Health and Welfare projections and analysis of Medicaid claims data. This capacity and gaps analysis provided estimates for two different scenarios: one using the estimated number of youth who are likely to need and/or use YES services (18,750), and the other using the estimated number of all youth in Idaho with a Serious Emotional Disturbance (37,500).

**Results:** It was estimated that in 2016, about 3,603 providers delivered community-based mental health services and supports to approximately 27,411 youth through the Medicaid system. This analysis indicated that Medicaid's youth mental health workforce needed to be 15.9% (scenario 1) to 29.5% (scenario 2) larger in order to provide the needed YES services and supports to youth with a Serious Emotional Disturbance. In addition, significant deficits were found in the areas of training and preparedness to deliver evidence-based practices and new services such as wraparound and respite. Results also indicated a consistent pattern where Region 5 had the largest deficit in mental health providers relative to youth need.

**Recommendations:** BSU concluded their report with 16 recommendations for improving capacity, increasing the number of providers delivering YES services, and improving data collection for ongoing workforce analysis. A snapshot of these recommendations is provided below.

1. Support the Idaho mental health provider network in developing competencies to deliver YES services by providing training within a sustainable, value-added approach built around credentialing.
2. Make YES training efforts sustainable by partnering with institutions of higher education to develop curriculum materials and certificate programs that meet the State's needs.
3. Support providers in delivering new YES services by providing training in practice management and billing and by ensuring that all aspects of YES services are reimbursable.
4. Provide frequent, low-cost training to providers in EBPs across the State with an emphasis on areas of low penetration.
5. Reduce the geographic maldistribution of mental health service providers for youth.
6. Leverage federal workforce development funds to increase the supply of mental health providers for youth in Idaho.
7. Create an Idaho state behavioral workforce incentive program that provides stipends, loan repayment and/or tax credits to professionals who deliver YES services in targeted areas of the State for a specified period of time.
8. Incentivize clinical training sites in targeted areas to train graduate student interns and trainees in YES service delivery models.
9. Increase the non-profit behavioral health workforce by obtaining federal grants and contracts that directly deliver community-based services to youth.

**Recommendations Continued:**

10. Expand the mental health workforce for youth by increasing funds for family peer support training and supervision and by exploring service integration with schools and other service systems.
11. Confirm the competitiveness of reimbursement rates for services so that mental health providers for youth can earn competitive salaries relative to other professions.
12. Work with licensing boards to allow telehealth for clinical supervision in remote areas and craft similar guidelines for supervision of YES services at all levels.
13. Implement a robust, standardized workforce data-collection process that ensures timely, useful data is available for planning.
14. Develop sustainable methods of assessing youth need/ demand for mental health professionals that serve youth.
15. Develop an estimate of projected changes in the supply and demand for YES services to further aid workforce planning.
16. Partner with other Idaho state agencies, such as the Idaho Bureau of Labor to inform workforce development.

Statement of limitation: The data contained in this analysis may not be generalizable to all providers in the whole state. For example, the organizational respondents report that 14 communities with populations of 100 and over receive no services. In fact, these communities may be served by organizations that did not respond to the survey. It is also important to note that these estimates serve as a point-in-time view and do not account for future population growth or potential changes in provider supply over time.

The QMIA Council has requested that YES system partners review the noted recommendations and determine which items they may consider adopting. Identified items will be recorded by the Council and progress toward implementing these recommendations will be monitored.

# QMIA Quarterly Report - Issue # 8 - January 1, 2019

## Youth and Family Experiences: **Complaints and Appeals**

July 1- September 30, 2018

As part of the Quality Management, Improvement and Accountability Plan, described in paragraph 52 of the Settlement Agreement, QMIA is working toward the collection of and reporting data on written notices of action, complaints, and fair hearings requests and outcomes. Provided below is youth-specific complaints and appeals data from the Division of Medicaid, complaints data from the Division of Behavioral Health (DBH), and complaints data from the Department of Juvenile Corrections (DJC), State Department of Education (SDE) and Family and Community Services (FACS). Complaints reported by FACS and SDE are not necessarily complaints that are related to mental health, as these systems are not currently set up to filter these types of complaints for reporting purposes.

**The Division of Behavioral Health received 11 complaints and 0 appeals between July 1 and September 30.**

| Complaints by Location | | | | | |
|---|---|---|---|---|---|
| Region 1: **2** | Region 2: **1** | Region 3: **1** | Region 4: **4** | State Hospital: **1** | Central Office: **2** |
| **Complaints by Complainant** | | | | | |
| Family: **5** | Client: **1** | Stakeholder: **1** | Provider: **1** | Advocate: **3** | |
| **Complaints by Service** | | | | | |
| Residential Treatment: **4** | Therapy: **4** | Person-centered Service Plan: **1** | Respite: **2** | | |
| **Complaints by Type of Concern** | | | | | |
| Access to Service: **6** | Quality: **3** | Interpersonal Interaction: **2** | | | |
| **Complaints by Status** | | | | | |
| Resolved: **2** | In Progress: **9** | | | | |

The Division of Family and Community Services had **7** formal complaints reported to the Director's office 7/1-9/30.

| **Optum Complaints** | | |
|---|---|---|
| Complaint Type | Number | Average Days to Resolve |
| Quality of Service | 4 | 8.25 |
| Quality of Care | 4 | 10.5 |

**Optum Appeals:** Optum received **3** Non-Urgent appeals during the reporting period; all 3 were upheld with an average resolution time of **14.67** days. There were no urgent appeals filed during this time.

**Independent Assessment Provider (IAP):** *Complaints data from the IAP, Liberty Healthcare is also being collected and reported. There were no complaints to report during the period of July 1- September 30.*

### The State Department of Education received a total of 6 complaints during the reporting period:

| Region | # Complaints | # Denied | # Cases Closed | Time to Close | # Allegations | # Founded | # Pending |
|---|---|---|---|---|---|---|---|
| Region 2 | 1 | 0 | 1 | 42 days | 3 | 0 | 0 |
| Region 3 | 3 | 1 | 0 | - | 13 | 7 | 0 |
| Region 4 | 1 | 0 | 0 | - | 6 | 0 | 6 |
| Region 6 | 1 | 0 | 0 | - | 5 | 5 | 0 |
| Total | 6 | 1 | 0 | - | 27 | 12 | 6 |

| **Idaho Department of Juvenile Corrections Complaints/Grievances (YES Class Juveniles/ Families)** | | | | |
|---|---|---|---|---|
| Region | Complainant | Concern Type | Status (as of 9/30) | **Average Time to Resolution:** |
| 2 | Family member | Release of information (medical) | Resolved | 2.25 days |
| 2 | Juvenile | Staff interaction | Resolved | |
| 2 | Juvenile | Staff interaction | Resolved | |
| 3 | Juvenile | Staff interaction | Resolved | |

**Family Experience Snapshot:** A parent called the YES Complaints line to report an issue that they had obtaining information on eligibility requirements. The parent was referred to several entities before finding out that their child did not quality for services. In response to this, the regional office has done outreach to clarify the eligibility and referral process for stakeholders.

***Regional Reporting Differences****: The Department of Juvenile Corrections categorizes geographic location using three regions- Region 1: Lewiston, Region 2: Nampa, Region 3: St. Anthony. The State Department of Education's geographic regions also differs from that of the Department of Health and Welfare. The State Department of Education's regional map has been provided in Appendix A (full report).*

Quality Improvement: **Early Periodic Screening Diagnostic & Treatment --- Transitioning Home from Residential Care**

July 1- September 30, 2018

## Early Periodic Screening Diagnostic & Treatment (EPSDT):

| Period | 2016 | 2017 |
|---|---|---|
| Total Applications | 56 | 96 |
| Total Placements | 11 | 35 |
| Average time to Determination | 60-90 days | 27 days |

In the sixth QMIA quarterly report, quality improvement projects that the agency partners are working on were introduced. One quality improvement project that Medicaid has successfully implemented is improving the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) process. Medicaid focused on reviewing and improving the EPSDT 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. Our primary focus was decreasing the time between receipt of the completed application, approval of the request, and completed placement. Medicaid has successfully decreased the average turn-around time of 60-90 days in 2016 to 27 days in 2017. This is particularly impressive based on the exponential increase in PRTF application requests.

As Medicaid continues to make progress with this initiative, the YES QMIA team will collect and report the data:

| Period | Total Applications | Approved | Denied | In Process/ Awaiting Completed Application | | Withdrawn/ Closed | | Average Time to Determination[1] |
|---|---|---|---|---|---|---|---|---|
| 1/1-3/31/18 | 34 | 7 | 5 | 18 | 1 | 2 | 1 | 45 days |
| 4/1-6/30/18 | 44 | 10 | 11 | - | - | 15 | 8 | 54 days |
| **7/1-9/30/18** | **35** | **21** | **7** | **-** | **1** | **3** | **1** | **28 days** |

*[1]Since the 2017 report, Medicaid has begun calculating 'average time to determination' using calendar days instead of business days*

## Transition home from Residential Care: Family Experience Survey

The following is a summary of responses received from the 2018 'Transition from Psychiatric Residential Treatment Facility to Home' survey. This survey was requested by the QMIA Council in an effort to better understand a family's experience when a child is transitioning home from a residential treatment facility. Survey responses will help to inform the QMIA Council's quality improvement work. The survey was offered to parents/family members who have had experience with a child transitioning home from a residential facility. The survey was distributed in April of 2018 at a Parent Network event. Although the response was minimal (5), it was expected as this is a targeted experience survey where qualitative responses were more meaningful than the quantitative results.

### SURVEY QUESTIONS

1. When was your child discharged from a psychiatric residential treatment facility?
2. Do you feel that you and your child received adequate support/ resources to assist with their transition back to living at home?
3. If you answered 'no' to question 2, please provide some examples of what the issues were that made the transition difficult.
4. What would have improved the experience for your child as he/she was returning home?
5. What would have improved the experience for you and other family members as your child was returning home?
6. If there were no difficulties transitioning back to living at home, what do you think was done well to prepare for the transition?

Discharge dates for survey respondents ranged from July of 2016 to November of 2017, with two respondents indicating that their child/ youth was in the middle of a transition home. One youth was transitioning from children's services to adult, the other was receiving treatment at a 'step-down' out-of-home placement.

**Question 2:** All respondents indicated that they did not feel that they/ their child received adequate support/ resources to assist with their transition. Responses about transition difficulties have been summarized below.

| | |
|---|---|
| **Services** | Intensive Outpatient groups not available |
| | Respite not available |
| | No peer services available |
| | In need of transition-aged-youth services/ facility/ life coaching |
| | Mid-level services are not available |
| | Lack of 'step-down' services/ facilities |
| | 45-day wait for individual therapy |
| | 90-day wait for family therapy |
| **Non-therapeutic Supports** | No one available to watch other children when attending appointments |
| **Residential Facility** | Facility owner did not start transition process even though it was requested, family was criticized for beginning it on their own |
| | Child experienced trauma at facility |
| | Once transition was requested, staff tone changed from united with family to possessive of child- ex. denying family right to phone meetings |
| **Transition Support** | Lack of communication re: service options and finding/ scheduling providers (resulted in family/Optum duplication of efforts) |
| | Family struggling to receive information from Medicaid about what kinds of services and supports are available |
| | Feeling like because child will soon be aging out of system, 'no one wants to deal with her situation'. No one is providing help planning for and putting resources in place before child returns home |
| | Transition unknowns: child is struggling with not knowing when she will be discharged, what services and supports she will be receiving next; has resulted in suicidal ideation |

## Family Recommendations for Improvement

| Child/Youth Experience | Family Experience |
|---|---|
| • More time in residential care- not being sent home just because insurance refused to pay and CMH wouldn't cover<br>• Skype visits with facility therapist while at home<br>• Youth need to be prepared for transition/ informed of what's next<br>• Collaboration between Medicaid, DBH, the facility, school and medical team to verify that all identified needs were going to be met<br>• Services should have been lined up before transition so there aren't huge gaps in between returning home and receiving services<br>• Services: Respite care, Group therapy<br>• Step-down intensive services<br>• Look into 'out of the box', non-traditional solutions to help with transition, such as someone to provide text support for youth | • Services/ Supports: Respite care, Babysitting<br>• Need guidance/ direction/ advice that is clear, help finding the right resources<br>• State professionals should have the willingness to help and resources available to them to assist families navigate services and supports not only in Idaho but neighboring states<br>• State departments should be collaborating with each other, so families do not have to call multiple places themselves and continue to walk through the wrong doors<br>• Write processes and instructions for families and train employees on how to help, not just pass on to another agency<br>• Facility staff should be trained in trauma-informed practices/ Facility needs to be adequately staffed to provide the level of service that is needed<br>• Step-down facility within each region or Immediate engagement in services after transition home |

## POSITIVE EXPERIENCES:

**1)** Transportation home: this was contracted through the residential facility.

**2)** Following residential placement, youth has learned to state his needs and feelings and behave appropriately. Youth has been able to reintegrate into a community setting and has acquired life skills.

The QMIA Council plans to review the results of this survey in detail and determine how identified issues and recommendations can be utilized to inform next steps toward improving the family experience in this specific situation as well as others.

# QMIA Quarterly Report - Issue # 8 - January 1, 2019

## SFY 2018 Annual Summary: July 1, 2017[1]- June 30, 2018

[1]YES Activities within this summary did not commence until 1/1/18

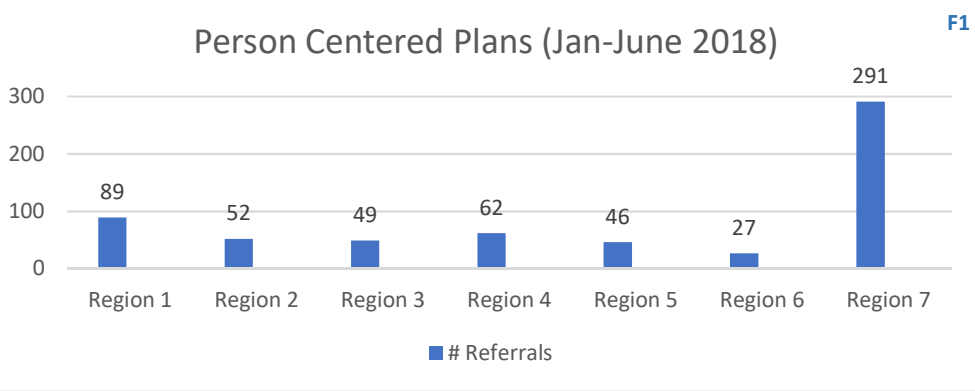
The **Child Adolescent Needs and Strengths (CANS)** tool was utilized by the Independent Assessment Provider (IAP) and the Division of Behavioral Health (DBH) during this reporting period. Between January and June of 2018, approximately 1,216 total youth had been administered a CANS. Of these youth, 1,131 received a CANS recommended level of care rating of 1-3, indicating the presence of a Serious Emotional Disturbance (SED) and need for services. For the remaining 85 youth, a SED was not identified.

## The Independent Assessment Process

Independent Assessment Providers began administering the CANS in January of 2018. From January 1 to June 30th, a total of 810 CANS were completed for 790 youth through the Independent Assessment Process. It is important to note that the CANS 50, a subset to the Children's Mental Health (CMH) CANS, was used during a portion of this reporting period to determine YES Class Membership and subsequent Medicaid eligibility. Today, all Independent Assessments are being completed using the CMH CANS and the CANS 50 is no longer in use. The last CANS 50 was completed in June.

| CANS ASSESSMENTS COMPLETED BY THE IAP SFY 2018 | | | |
|---|---|---|---|
| CANS 50 | | CMH CANS | |
| # CANS | # Youth | # CANS | # Youth |
| 698 | 683 | 112 | 107 |

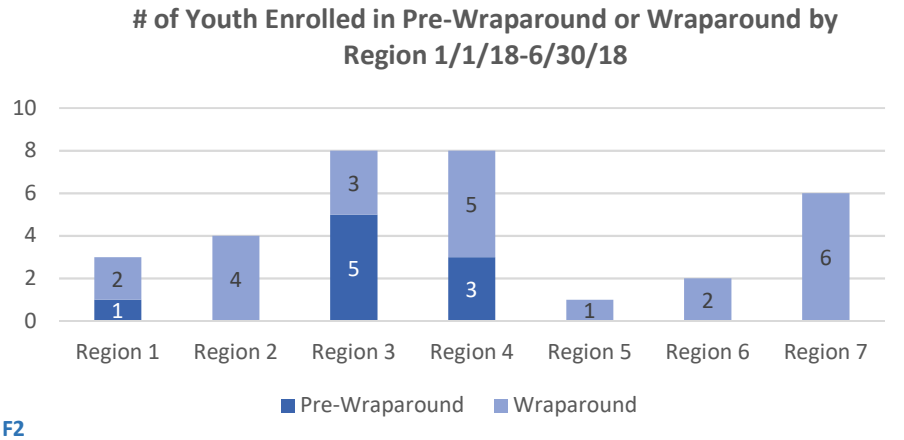
The YES Person-centered service planning process launched in January of 2018. All youth who have been found to be YES eligible through the Independent Assessment process, are newly YES Medicaid eligible and/or would like to access Agency Respite services will have a person-centered service plan.




## CANS Administered by DBH:

DBH completed a total of 1093 CANS for 858 youth in SFY 2018. It is important to note that the totals may not add up for unique 'total youth' counts. This is because there are a handful of clients who completed assessments in multiple regions.

| Children's Mental Health CANS Assessments Administered by DBH | | | | | |
|---|---|---|---|---|---|
| Region | Initial CANS | Update | Discharge | Total CANS | Total Youth |
| 1 | 91 | 12 | 0 | 103 | 93 |
| 2 | 44 | 18 | 0 | 62 | 46 |
| 3 | 102 | 41 | 23 | 166 | 109 |
| 4 | 147 | 38 | 10 | 195 | 156 |
| 5 | 122 | 38 | 0 | 160 | 131 |
| 6 | 37 | 20 | 0 | 57 | 41 |
| 7 | 280 | 59 | 11 | 350 | 286 |
| State | 823 | 226 | 44 | 1093 | 858 |




### WRAPAROUND

The Division of Behavioral Health began enrolling currently served youth into Wraparound programs in February of 2018. From February to June 30th, 2018, there were 32 youth enrolled in Wraparound or Pre-Wraparound. Although there have been 32 youth enrolled in the Wraparound program, 5 of these youths have exited. As of June 30th, 27 youth were being served in Wraparound or Pre-Wraparound.

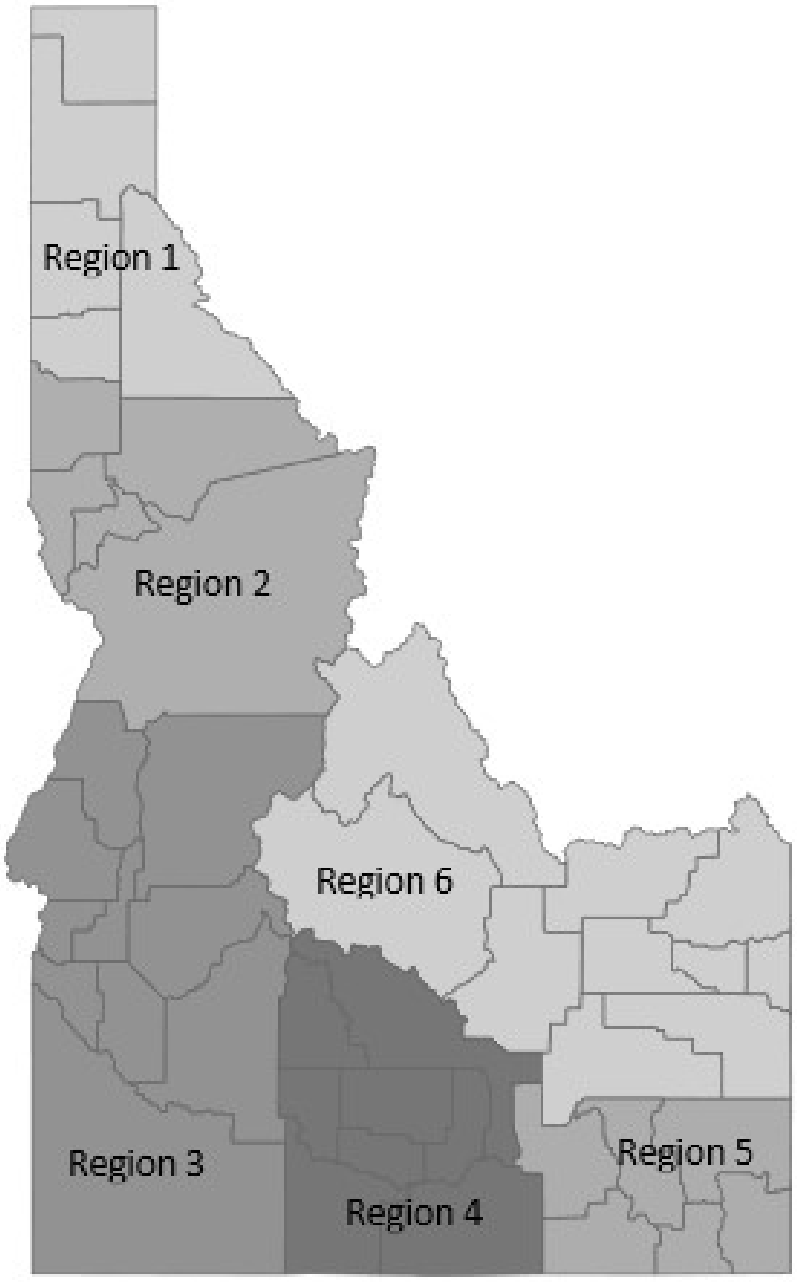
# Glossary

| | |
|---|---|
| **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. |
| **Emotional Disturbance (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. |
| **EPSDT** | Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. (Medicaid.gov). |
| **IEP** | The Individualized Education Plan (IEP) is a written document that spells out a child or youth's learning needs, the services the school will provide and how progress will be measured. |
| **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. |
| **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. |
| **QMIA** | A quality management, improvement, and accountability program. |
| **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. |
| **SFY** | The acronym for State Fiscal Year which is July 1 to June 30 of each year. |
| **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 YES Definitions** | YES Terms to Know |

# Appendix A

## Idaho Division of Behavioral Health Regional Map

# Idaho State Department of Education Regional Map



# Appendix B

## Actionable Needs and Useful Strengths most frequently identified Statewide on the CANS tool 7/1-9/30/18

| Idaho CMH CANS- Needs | |
|---|---|
| **Item** | **Description** |
| Emotional/Physical Regulation | This item describes the individual's difficulties with arousal regulation or expressing emotions and be rated in the context of what is normative for an individual's age and developmental stage. |
| Family | This item rates the individual's relationships with those who are in their family. It is recommended that the description of family should come from the individual's perspective (i.e. who the individual describes as their family). In the absence of this information, consider biological and adoptive relatives and their significant others with whom the individual is still in contact. Foster families should only be considered if they have made a significant commitment to the individual. For children/ youth involved with child welfare, family refers to the person(s) fulfilling the permanency plan. When rating this item, take into account the relationship the individual has with their family as well as the relationship of the family as a whole. |
| Anger Control | This item captures the individual's ability to identify and manage their anger when frustrated. |
| Impulsivity | Problems with impulse control and impulsive behaviors, including motoric disruptions. Children with impulse problems tend to engage in behavior without thinking, regardless of the consequences. |
| Social Functioning | This item rates social skills and relationships. It includes age appropriate behavior and the ability to make and sustain relationships. Social functioning is different from Interpersonal (Strengths) in that functioning is a description of how the Individual is doing currently. Strengths are longer-term assets. |
| **Idaho CMH CANS- Strengths** | |
| **Item** | **Description** |
| Legal Permanency | This item refers to the likelihood that the individual who is currently in legal custody of the state will achieve legal permanency through adoption, guardianship or reunification with birth parent(s). |
| Relationship Permanence | This item refers to a mutual, emotional connection between the individual and one or more adults characterized by lifelong commitment. |
| Family | This item refers to the presence of a sense of family identity as well as love and communication among family members. Even families who are struggling often have a firm foundation that consists of a positive sense of family and strong underlying love and commitment to each other. These are the constructs this strength is intended to identify. As with Family Functioning, the definition of family comes from the individual's perspective (i.e., who the individual describes as their family). If this information is not known, then we recommend a definition of family that includes biological/adoptive relatives and their significant others with whom the child/ youth is still in contact. |
| Cultural Identity | Cultural identify refers to the individual's view of self as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography, sexual orientation or gender identity and expression (SOGIE). |
| Talents/Interests | This item refers to hobbies, skills, artistic interests, and talents that are positive ways that young people can spend their time, and also give them pleasure and a positive sense of self. |

For more information about all CMH CANS items, please visit The Praed Foundation website.

## Presenting Concern Categories

| Presenting Concern Categories Assigned based on Primary Diagnosis of Youth entered into CANS Tool | |
|---|---|
| **Category** | **Concern** |
| Anxiety | Anxiety/Generalized Anxiety |
| | Panic |
| | Phobia |
| | Adjustment |
| Stress or Trauma | Post-Traumatic Stress |
| | Trauma/Loss |
| | Reactive Attachment |
| Mood | Mood Disturbance |
| | Dysthymia |
| | Depression |
| | Bi-polar Disorder |
| Externalizing | Attention-Deficit Hyperactivity Disorder (ADHD) |
| | Conduct Disorder |
| | Intermittent Explosive Disorder |
| | Disruptive Mood Dysregulation |
| | Oppositional Defiant Disorder |
| Neurological Concerns | Psychotic Features of Disorder |
| | Autism Spectrum |
| | Intellectual Disability |
| | Neurological Disorder NOS |
| Other | Disorders of Eating |
| | Gender Identity Disorder |
| | Personality Disorders |

Presenting Concern Categories provided by Dr. Nathaniel Israel of Union Point Group, LLC.