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

7th Quarterly Report

October 1, 2018

Data and Reports Committee
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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: About YES > Project Information > Reports and Updates > QMIA Quarterly Reports.

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
- 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
- System of Care implementation
- Quality Management Improvement and Accountability projects

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.

[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 here.

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.

YES QMIA QUARTERLY REPORT

This is the seventh of the Youth Empowerment Services (YES) Quality Management Improvement and Accountability Quarterly (QMIA-Q) reports to be published. The reporting period for this QMIA-Q is April through June of 2018. As the system has begun statewide implementation of the CANS tool, a large focus within QMIA has been collecting initial CANS data and planning for future, more complex CANS reporting. QMIA has also been monitoring system process indicators, identifying gaps and barriers to care and working to promote TCOM culture and practice throughout the system.

This QMIA report contains the following information:

- Independent Assessment Process
- CANS 50 and CMH CANS Data
- Wraparound Utilization
- Training Information
- Measuring Client Satisfaction
- Complaints and Appeals
- Quality Improvement Projects

This report has been formatted to allow the reader to navigate the data and information provided through a series of important questions that should be considered by all stakeholders throughout the children's mental health system transformation. 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.

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. Data collection and reporting should be a collective and interactive process and all stakeholders and interested individuals are encouraged to participate.

"Create a learning loop whereby data feeds a conversation leading to action, which generates new data, new conversation, and new action." – Transformational Collaborative Outcomes Management

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.

Note: Idaho's Division of Behavioral Health and State Department of Education regions are referenced in this report. Regional maps have been provided for reference beginning on page 45, Appendix A.

Who are we serving?

The first section of this report provides information about the youth that have gone through the YES assessment process by completing a Child Adolescent Needs and Strengths (CANS) either with the Independent Assessment Provider (IAP) or through the Division of Behavioral Health (DBH). Since January, 790 youth have gone through the Independent Assessment Process and 858 youth have received an assessment from one of the Division of Behavioral Health's seven regional offices. Because some youth were assessed by both the IAP and DBH depending on the initial assessment tool used, an analysis was done to determine the number of youth who have received a CANS, regardless of assessing agency and regardless of the CANS tool used. Determining the number of youth who have completed a CANS will allow us to estimate the number of youth who have been assessed for YES Class Membership and services thus far. Between January and June of 2018 approximately 1,216[1] 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 and need for services. For the remaining 85 youth, a serious emotional disturbance was not identified.

For this reporting period, the CANS was exclusively being administered by Division of Behavioral Health regional clinicians and the Independent Assessment Provider, Liberty Healthcare. CANS expansion to the Idaho Behavioral Health Provider network began in July of 2018.

[1]*This unique youth count has been produced using our current client record matching method (Soundex last name/ date of birth/ Unique Client Number). Although this is our best matching method, there may be some duplication as this method is not without flaw. The QMIA Data team continues to work toward the establishment of a Unique Client Identifier (UCI) which will enable more accurate data matching.*

Independent Assessment Process

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 (CMS) that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level (FPL). 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). The Independent Assessment Provider will complete a Comprehensive Diagnostic Assessment (CDA) as well as use the CANS tool to determine Youth Empowerment Services Class Membership.

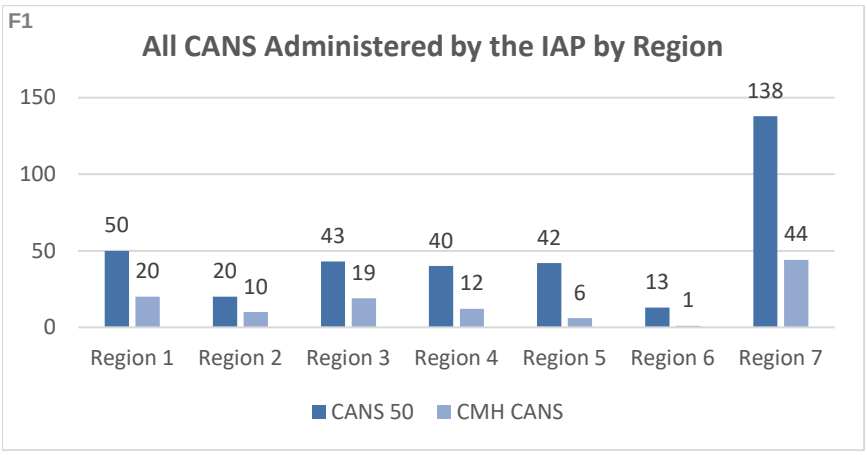
It is important to note that the CANS 50, a subset to the Children's Mental Health (CMH) CANS, was used during a portion of this reporting period to determine YES Class Membership and subsequent Medicaid eligibility. Today, all Independent Assessments are being completed using the CMH CANS and the CANS 50 is no longer in use. The last CANS 50 was completed in June.

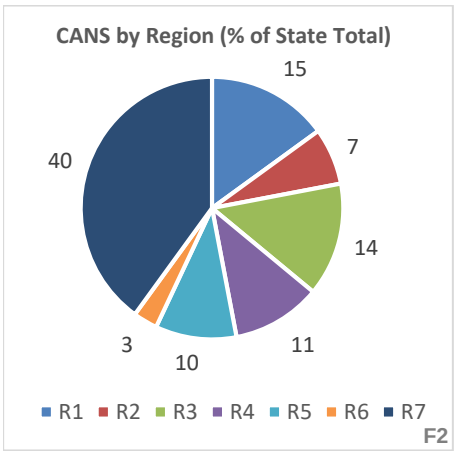
From January through June, 698 CANS 50 assessments were administered by the IAP for 683 youth. An additional 112 CMH CANS assessments were administered by the IAP for 107 youth. Since January, a total of 810 CANS assessments were completed for 790 youth through the Independent Assessment process. It is important to note that distinct youth counts have been determined by their unique client number (UCN); this is the best guess we have at distinguishing clients at this time but is not guaranteed to be perfectly unique.

Details regarding assessments administered during the reporting period of April through June have been provided below:

Figures 1-2.
Data Source: *YES ICANS System (April-June 2018)*

From April 1 to June 30, 2018, 346 CANS 50 assessments were administered for 344 youth, and 112 CMH CANS assessments were administered for 107 youth. A total of 458 CANS were completed for 451 youth.

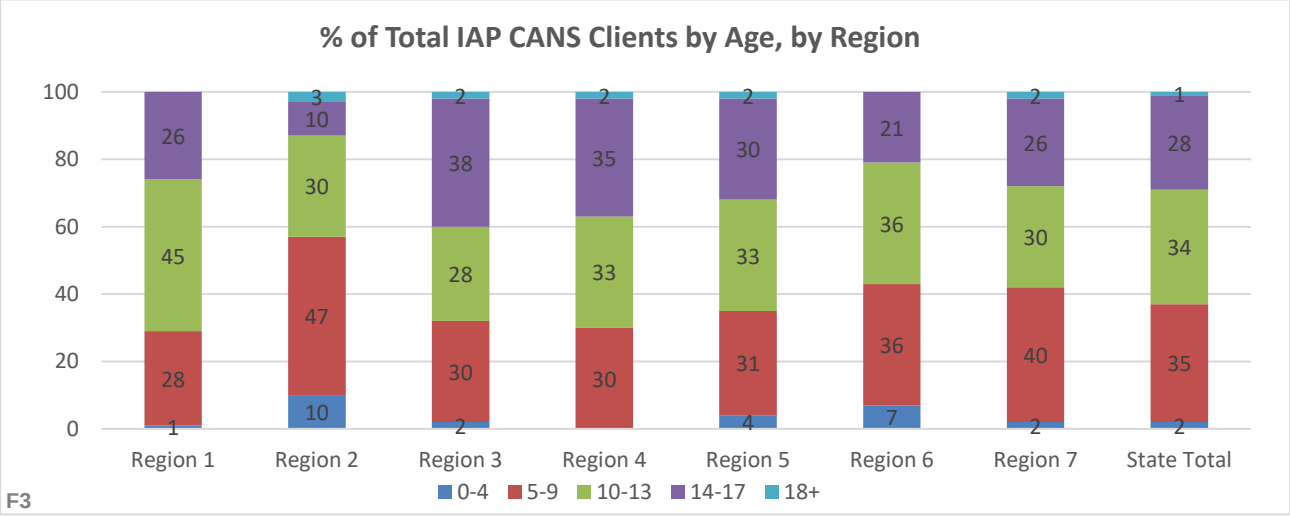




According to the above figures, 40% of the CANS administered by the IAP within this reporting period were for youth in region 7. Following is region 1 (15%), region 3 (14%), region 4 (11%), region 5 (10%), region 2 (7%) and region 6 (3%). A utilization comparison to data collected from the CANS administered by Division of Behavioral Health regional offices can be found on page 12.

Demographic information about the 451 youth who have received a CANS from the IAP are demonstrated in the following figures. This data has been displayed using stacked columns that calculate the percentage of each demographic variable against the region or state's own total. Data is displayed this way, so comparisons can easily be made between regional patterns and then to the statewide presentation. *It is important to note that some regions had significantly smaller population samples than others, therefore percentages and comparisons should be interpreted with this in mind.*

Figure 3.
Data Source: *YES ICANS System (April-June 2018)*



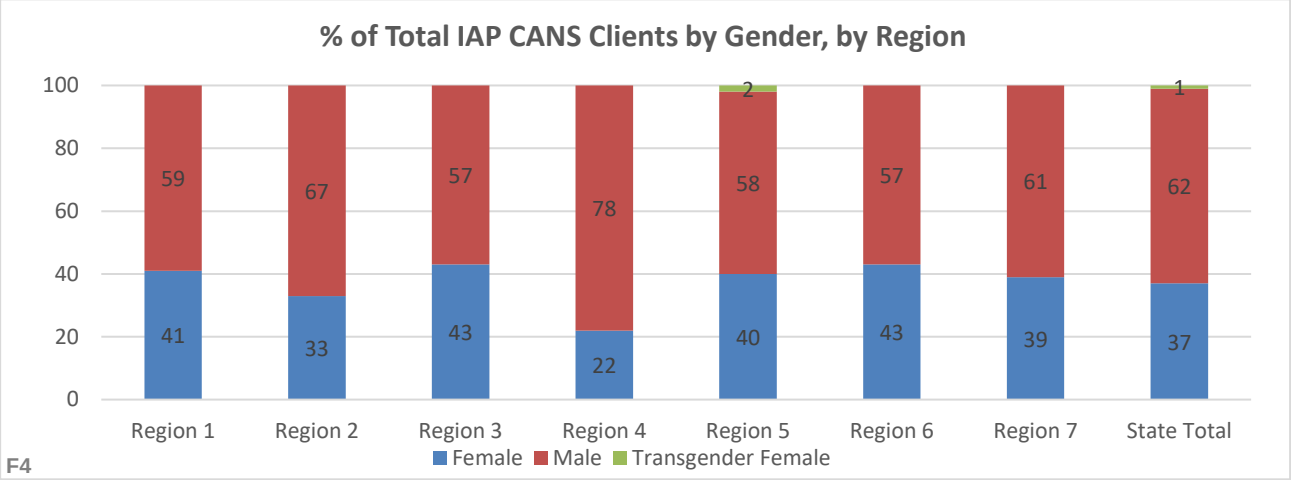
CANS Clients (#): *Region 1: 69, Region 2: 30, Region 3: 60, Region 4: 51, Region 5: 48, Region 6: 14, Region 7: 180, State total: 451*

Between the months of April and June, the highest percentages of youth receiving a CANS from the IAP statewide were within the age groups of 5-9 and 10-13. Regions 1, 2, 5, 6 and 7 share this same pattern. Regions 3 and 4 saw the highest percentage of youth within the age group of 14-17. Region 2

saw a significantly higher percentage of youth between ages 5-9 than any other region, or statewide. For the youngest age group, region 2 saw the highest percentage (10%), followed by region 6 (7%), while region 4 did not see any youth within this age group during this period. Regions 2-5 and 7 saw a very small percentage of youth who were 18+ during this period, while the IAP in regions 1 and 6 did not see any youth within this age group.

Figure 4.

Data Source: *YES ICANS System (April-June 2018)*

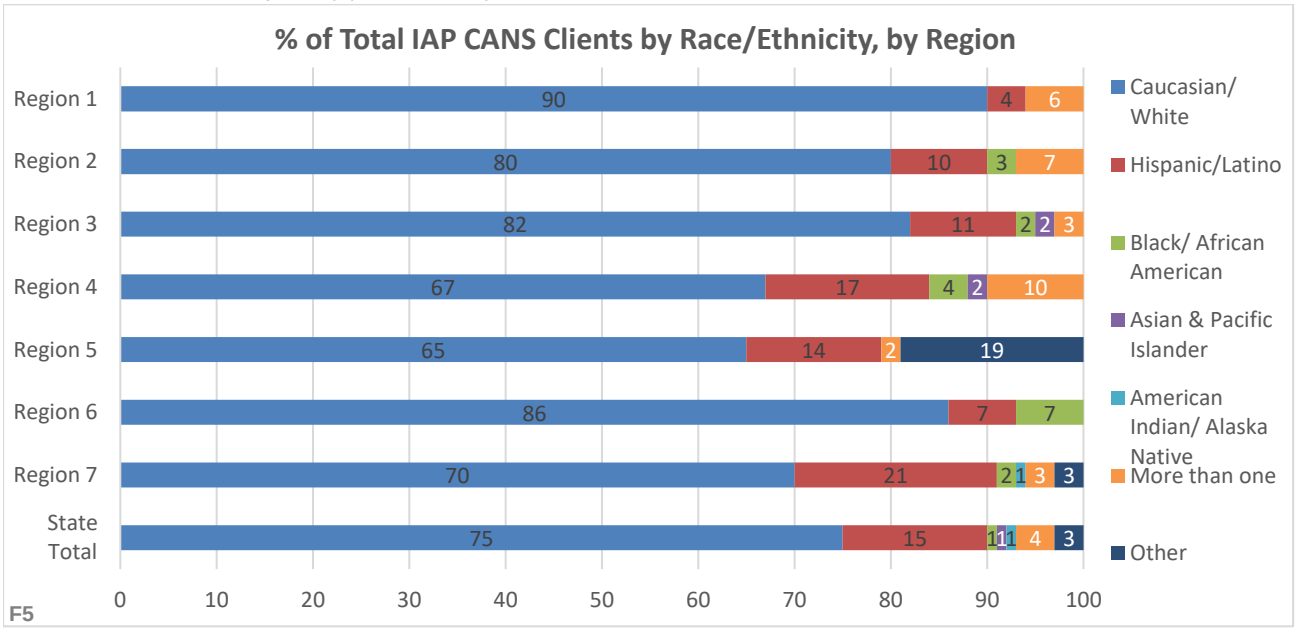


CANS Clients (#): *Region 1: 69, Region 2: 30, Region 3: 60, Region 4: 51, Region 5: 48, Region 6: 14, Region 7: 180, State total: 451*

According to the above figure, the IAP consistently saw more males than females statewide during this reporting period. Region 5 appears to be the only region who assessed a youth who identified as transgender. Region 4 and region 2 saw a significantly higher percentage of males than females with 78% and 67% respectively.

Figure 5.

Data Source: *YES ICANS System (April-June 2018)*



CANS Clients (#): *Region 1: 69, Region 2: 30, Region 3: 60, Region 4: 51, Region 5: 48, Region 6: 14, Region 7: 180, State total: 451*

Figure 5 above shows that the highest percentage of youth served by the IAP statewide identified as Caucasian/White and non-Hispanic (75%). The percentage of each region's total youth served

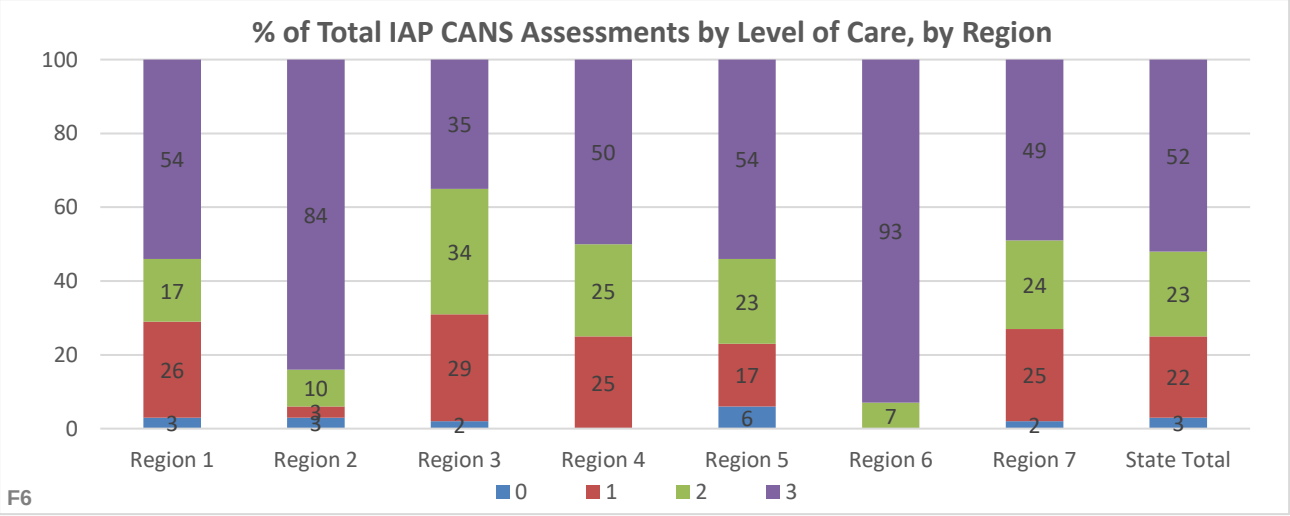
identifying as Caucasian/White ranged from 90% in region 1 to 65% in region 5. The IAP in Region 5 also appears to have assessed the highest percentage of youth identifying as Hispanic/Latino (21% of the total number of youth they served). Regions 2-4 and 7 served a very small percentage of youth who identified as Black/African American, while region 6 served the highest percentage (7% of those assessed). Regions 1 and 5 did not serve any youth who identified as Black/ African American during this reporting period. Youth who identified as Asian, Pacific Islander, American Indian and Alaska Native were represented minimally statewide. *It is important to note that factors such as race and ethnicity are not solely responsible for differences in health outcomes or whether a population is underserved/ underrepresented or overrepresented. There are additional factors such as poverty, trauma, other environmental factors and complex societal issues that perpetuate differences in access and outcomes.*

Recommended Level of Care: CANS Completed by the Independent Assessment Provider

When a CANS is completed, a total CANS recommended level of care (LOC) score of 0-3 is determined:

- **0**: Serious Emotional Disturbance (SED) has not been identified, the child or youth does not meet criteria for YES services at this time
- **1**: SED identified, services should be coordinated but functioning is stable
- **2**: SED identified, child/youth generally involved in multiple systems and require extensive service collaboration
- **3**: SED identified, child/youth is considered to have high treatment needs and is at risk of out of home placement

Figure 6.
Data Source: *YES ICANS System (April-June 2018)*



CANS Records (#): *Region 1: 69, Region 2: 30, Region 3: 62, Region 4: 51, Region 5: 48, Region 6: 14, Region 7: 182, State total: 456*

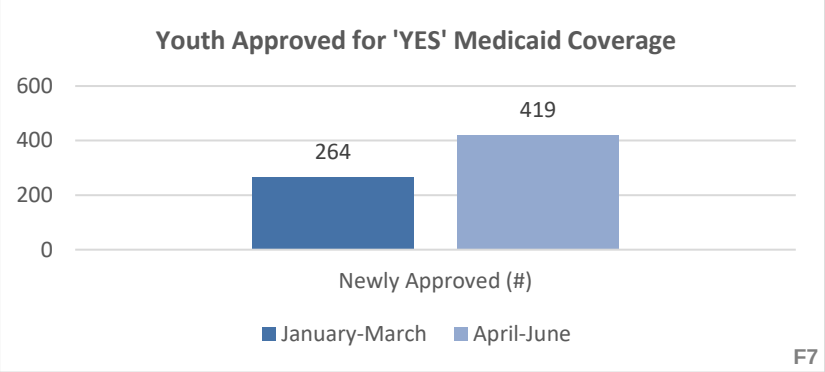
Between April and June, only 3% of youth assessed by the IAP statewide received a recommended CANS LOC of '0'. The highest percentage of youth assessed statewide received a LOC score of '3' (52%). Youth who received a LOC score of '1' represented 22% of those assessed statewide, and similarly those who received a '2' represented 23% of total youth assessed during this reporting period. This statewide pattern is similar to the previous reporting period for CANS assessments completed by the IAP January through March: LOC '0' 2%, LOC '1' 29%. LOC '2' 22%, LOC '3' 47%.

Regionally, there are some differences to note regarding recommended level of care. Regions 2 and 6 have the highest percentage of youth assessed who received a recommended LOC of '3' with 84% and 93% respectively. In addition, region 6 did not have any youth assessed by the IAP during this period who received a recommended LOC of '0' or '1'. Region 3 had the lowest percentage of youth assessed who received a recommended LOC of '3' (35%). *Again, it is important to note that some regions had significantly smaller population samples than others, therefore percentages and comparisons should be interpreted with this in mind.*

Youth Newly Eligible for Medicaid Coverage

Youth who are determined to be Class Members 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 Class Members will be granted to youth with family incomes from 150-300% of the federal poverty level (FPL).

Figure 7.
Data Source: *Department of Health and Welfare- Self Reliance (April-June 2018)*



As of March 31st, 264 youth had received YES Medicaid coverage. As of June 30th, 419 youth were approved for Medicaid through the YES Program. Youth with family incomes over 300% of the federal poverty limit (FPL) who are eligible for the YES Program are referred to community providers and DBH regional offices for access to services.

Person Centered Planning

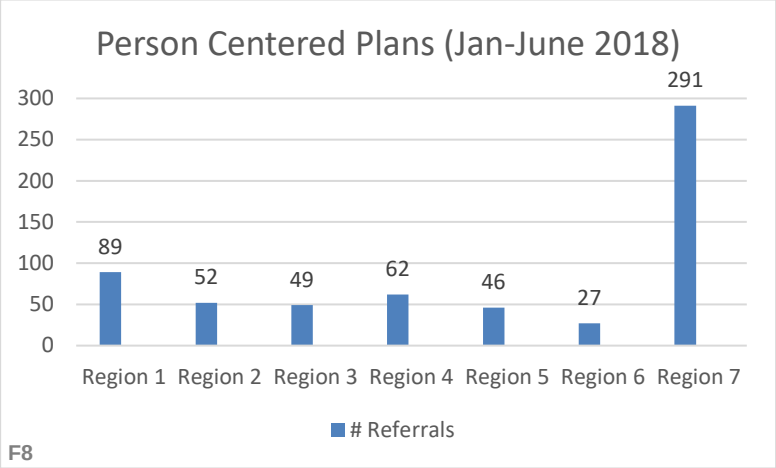
The YES Person-Centered Planning process launched in January of 2018. All youth who have been found to be YES eligible through the Independent Assessment process, are newly YES Medicaid eligible and/or would like to access Agency Respite services will have a Person-Centered Plan. This is a mandatory requirement when utilizing the 1915(i), and it also ensures that there is collaboration, treatment plans are aligned and there is no duplication of services.

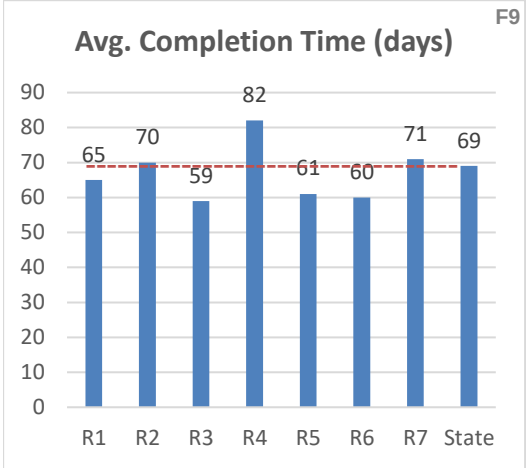
Person-Centered Planning is a process, directed by the family, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or youth directs the Person-Centered Planning process. The process includes participants freely chosen by the family or youth who can serve as important contributors. The family or participants in the Person-Centered Planning process enable and assist the youth to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her achieve personally-defined outcomes in the most inclusive community setting. The youth and family identify planning goals to achieve these personal outcomes. The identified personally-defined outcomes and the training supports, therapies,

treatments, and or other services the youth is to receive to achieve those outcomes becomes part of the plan of care.

Figures 8-10.

Data Source: *Division of Behavioral Health (January-June 2018)*





Period	January 1- March 31[1]			April 1- June 30[1]		
Agency	# Referred	# Completed	Avg. Time to Complete	# Referred	# Completed	Avg. Time to Complete
Region 1	42	36	83 days	47	38	54 days
Region 2	24	21	82 days	28	18	55 days
Region 3	23	20	60 days	26	22	57 days
Region 4	27	17	98 days	35	19	71 days
Region 5	10	8	76 days	36	28	60 days
Region 6	10	8	50 days	17	10	69 days
Region 7	142	104	77 days	149	66	65 days
Dual Eligible*	4	2	92 days	70	26	90 days
State Total	**282**	**216**	**79 days**	**408**	**227**	**61 days**

[1]*Based on first reviewed month* F10

**Dual Eligible refers to youth who are also being served through the Developmental Disabilities program*

Between April 1st and June 30th, Region 7 had received around 37% of the referrals to complete a Person-Centered Plan. This is a direct reflection of the amount of youth who were seen by the Independent Assessment Provider (IAP) for a CANS in Region 7 (around 40% of all youth seen by the IAP). Since January, region 7 has received 42% of the total Person-Centered Plan referrals, followed by region 1 (13%), region 4 (9%), region 2 (8%), regions 3 and 5 (7%), and region 6 (4%). An additional 10% of the referrals were for youth who are also being served by the Developmental Disabilities program through the Division of Family and Community Services.

The QMIA team will continue to monitor the Person-Centered Planning process, which includes determining a timeliness performance goal for plan completion. Until a goal for timeliness is established, some regional comparisons can be made using the statewide average. According to figure 9, for the period of January to June, regions 4, 2 and 7 had average Person-Centered Plan completion times that exceeded the statewide average, with regions 2 and 7 taking only slightly longer. Regions 1, 3, 5 and 6 had average completion times that were shorter than the state average. Figure 10 is showing a comparison of each region's average Person-Centered Plan completion time from the previous reporting period to the current reporting period. The data from this figure shows that all regions, with the exception of region 6, have shown a decrease in 'average time to complete' from the previous reporting period.

Children's Mental Health (CMH) CANS- Division of Behavioral Health

Children's Mental Health (CMH) CANS

The CMH CANS:

- Assesses a youth's individual and family strengths and needs
  - If a CANS 50 was completed prior, this information will be used as a foundation for the CMH CANS
- Supports clinical decision-making and practice including treatment plans and level of care decisions
- Measures and communicates outcomes at the individual level, the program level and the system level
- Improves service coordination and quality

Between January and June, 1,093 CMH CANS were administered by the Division of Behavioral Health (DBH) for 858 youth. These CMH CANS assessments were administered for youth in one of the following situations:

- Following positive YES Class Membership determination through the Independent Assessment Provider (for youth who were initially assessed using the CANS 50)
- Initial CMH CANS for an existing Division of Behavioral Health youth client who did not go through the Independent Assessment Provider
- CMH CANS update- 90 days following initial assesment or as otherwise appropriate
- CMH CANS at discharge from services

Figure 11.
Data Source: *YES ICANS System (January-June 2018)*

F11

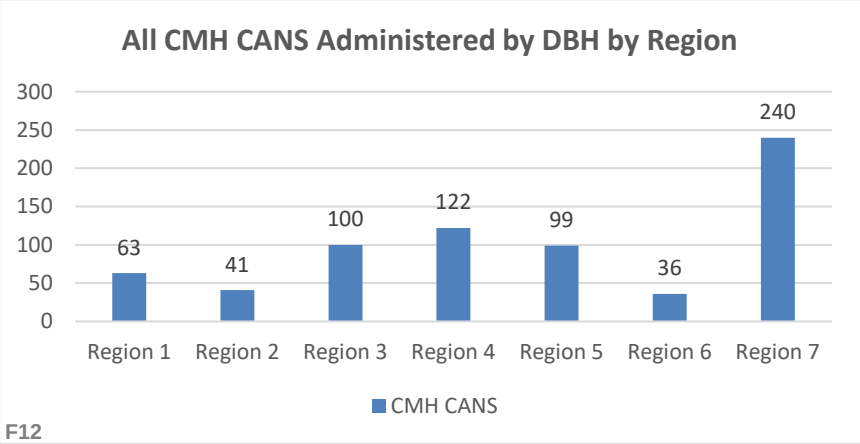
Children's Mental Health CANS Assessments Administered by DBH January 1-June 30, 2018					
Region	Initial CANS	Update CANS	Discharge CANS	Total CANS	Total Youth[1]
1	91	12	0	103	93
2	44	18	0	62	46
3	102	41	23	166	109
4	147	38	10	195	156
5	122	38	0	160	131
6	37	20	0	57	41
7	280	59	11	350	286
State	823	226	44	1093	858

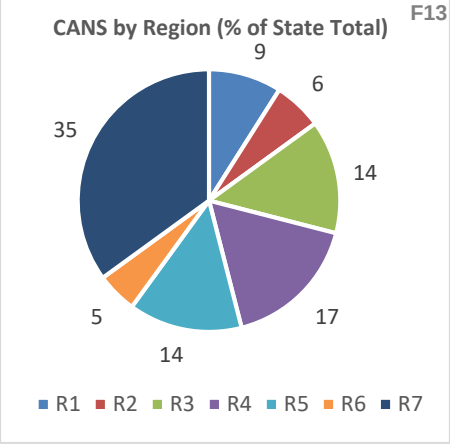
[1]Please note that the totals may not add up for unique 'total youth' counts. This is because there are a handful of clients who completed assessments in multiple regions.

Details regarding assessments administered during the reporting period of April through June have been provided below:

Figures 12-13.
Data Source: *YES ICANS System (April-June 2018)*

From April 1 to June 30, 2018, 701 CMH CANS assessments were administered for 661 youth.

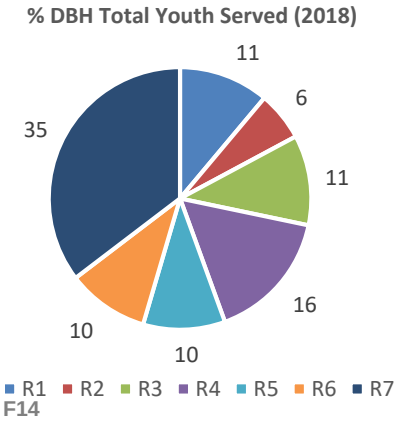


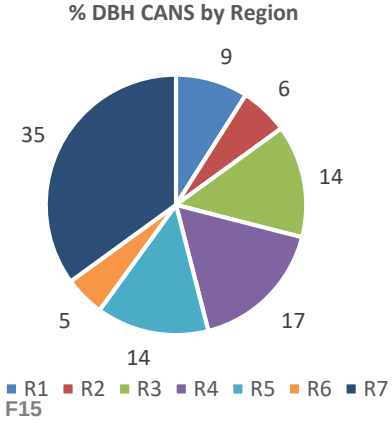


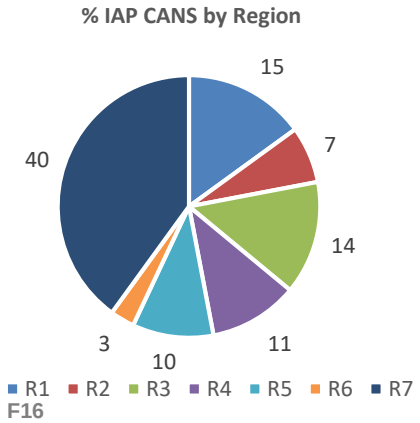
According to the above figures, 35% of the CANS administered by DBH within this reporting period were for youth in region 7. Following is region 4 (17%), regions 3 and 5 (14%), region 1 (9%), region 2 (6%), and region 6 (5%).

For comparative purposes, the percent of youth served by each of the Division of Behavioral Health regional offices for state fiscal year 2018 has been displayed below. The Independent Assessment Provider (IAP) utilization data provided earlier in this report has also been repeated for additional comparison.

Figures 14-16.
Data Sources: *YES ICANS System (April-June 2018), DBH WITS (June 2018)*







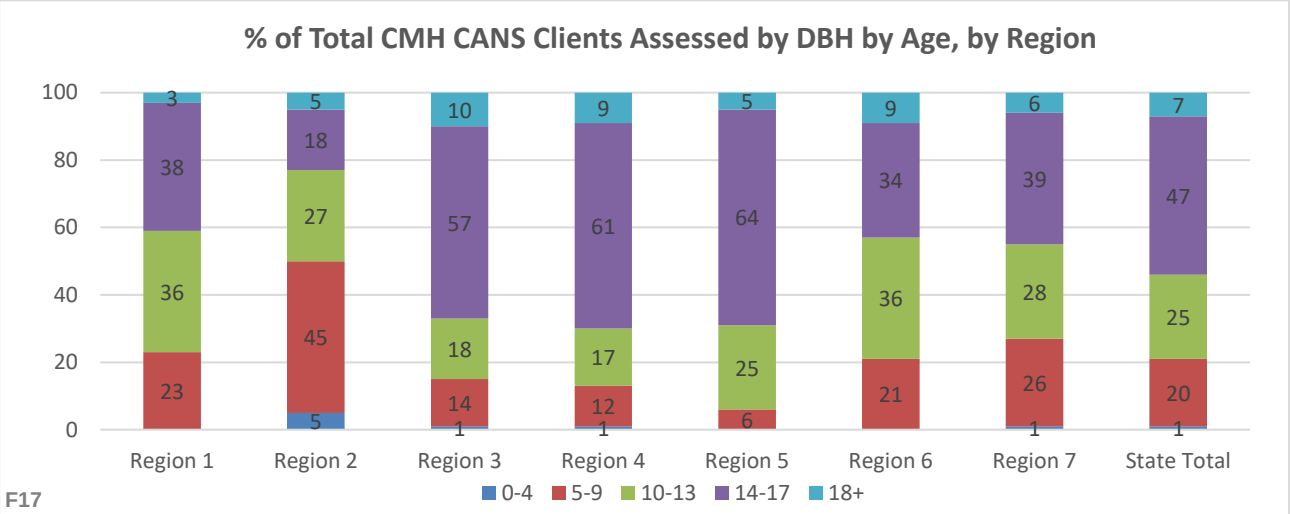
Figures 14 and 15 show a notable difference in the percentage of youth served by DBH and the percentage of CANS administered in regions 3 (3% increase), 5 (4% increase) and 6 (5% decrease). There is a significant increase in the percent of total CANS completed by the IAP as compared to figures 14 and 15 in region 7 and region 1. There is a notable decrease in percentage of total CANS completed by the IAP as compared to the percentages in figures 14 and 15 for regions 4 and 6.

Demographic information about the 661 youth who have received a CANS from DBH are displayed in the following figures. This data has been displayed using stacked columns that calculate the

percentage of each demographic variable against the region or state's own total. Data is displayed this way, so comparisons can easily be made between regional patterns and then to the statewide presentation. *It is important to note that some regions had significantly smaller population samples than others, therefore percentages and comparisons should be interpreted with this in mind.*

Figure 17.

Data Source: *YES ICANS System (April-June 2018)*



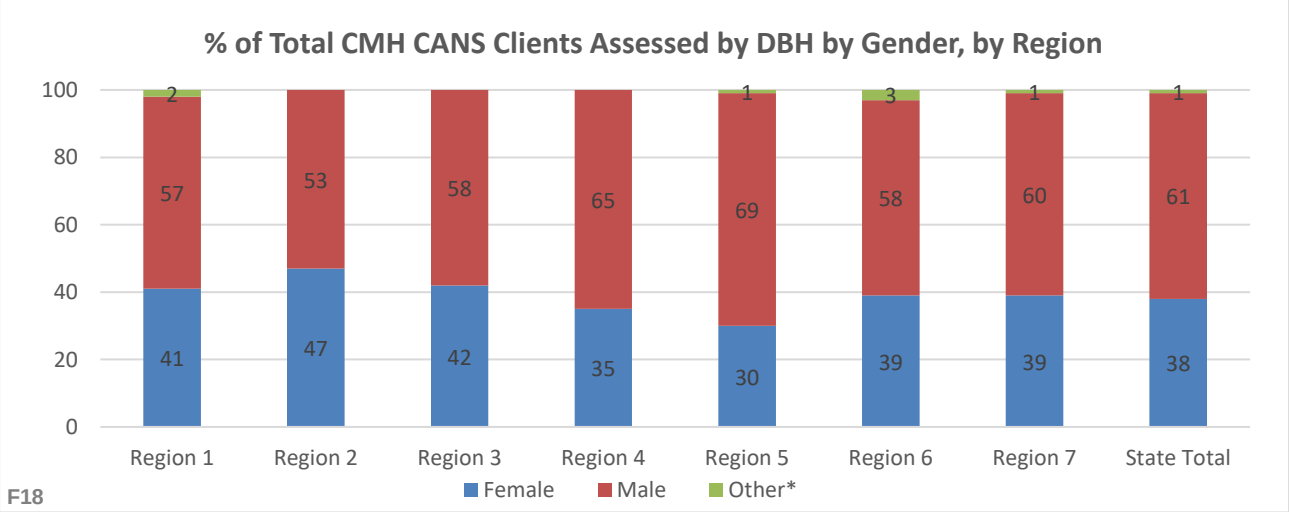
CANS Clients (#): *Region 1: 61, Region 2: 38, Region 3: 90, Region 4: 115, Region 5: 94, Region 6: 33, Region 7: 232, State total: 661* [1]

[1]*Total equals 663 as 2 youth received a CANS in multiple regions.*

Between the months of April and June, the highest percentages of youth receiving a CANS from DBH statewide were within the age groups of 14-17 (47%) and 10-13 (25%). This differs from the IAP data provided earlier in this report, where the majority of youth who received a CANS were within the age group of 5-9. This variance may be explained by the DBH children's mental health program primarily completing CANS for existing clients, who are typically older youth. Regions 1, 3, 4, 5 and 7 share this same pattern to varying degrees. Region 6 administered the CANS to a slightly higher percentage of youth aged 10-13 (36%) than to the 14-17 age group (34%). Region 2 saw significantly more youth aged 5-9 than any other age group, this was also seen in the IAP data provided earlier in this report.

Figure 18.

Data Source: *YES ICANS System (April-June 2018)*



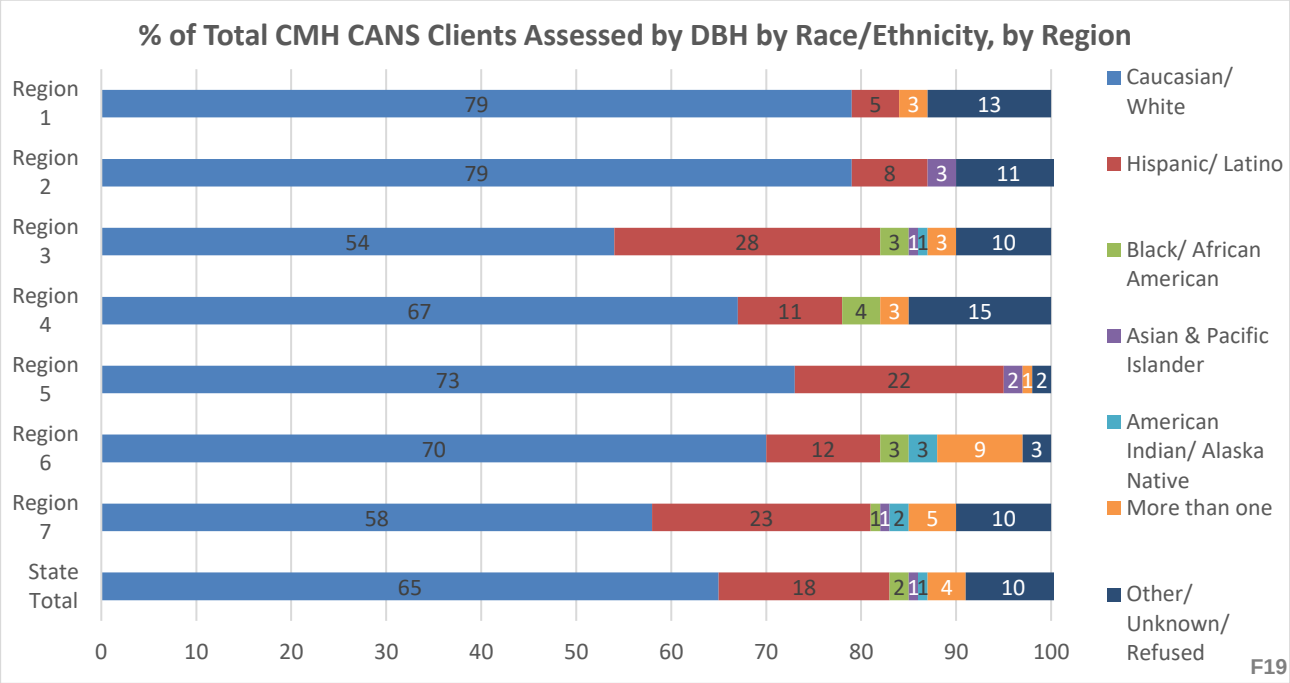
CANS Clients (#): *Region 1: 61, Region 2: 38, Region 3: 90, Region 4: 115, Region 5: 94, Region 6: 33, Region 7: 232, State total: 661* [1]

[1]*Total equals 663 as 2 youth received a CANS in multiple regions.* [*]*Other: Transgender or Unknown/Refused*

According to the above figure, DBH consistently saw more males than females statewide during this reporting period. This gender distribution pattern was also demonstrated within the IAP data. Region 5 and Region 4 administered a CANS to a notably higher percentage of males than females with 69% and 65% respectively.

Figure 19.

Data Source: *YES ICANS System (April-June 2018)*



CANS Clients (#): *Region 1: 61, Region 2: 38, Region 3: 90, Region 4: 115, Region 5: 94, Region 6: 33, Region 7: 232, State total: 661* [1]

[1]*Total equals 663 as 2 youth received a CANS in multiple regions.*

Figure 19 above shows that the highest percentage of youth served by DBH statewide identified as Caucasian/White and non-Hispanic (65%). The percentage of each region's total youth administered a CANS identifying as Caucasian/White ranged from 79% in regions 1 and 2, to 54% in region 3. Region 5 administered a CANS to the highest percentage of youth identifying as Hispanic/Latino (28% of the total number of youth). Regions 3, 4, 6 and 7 served a small percentage of youth who identified as Black/African American, while regions 1, 2 and 5 did not serve any youth who identified as Black/ African American during this reporting period. Youth who identified as Asian, Pacific Islander, American Indian and Alaska Native were represented minimally statewide. *It is important to note that factors such as race and ethnicity are not solely responsible for differences in health outcomes or whether a population is underserved/ underrepresented or overrepresented. There are additional factors such as poverty, trauma, other environmental factors and complex societal issues that perpetuate differences in access and outcomes.*

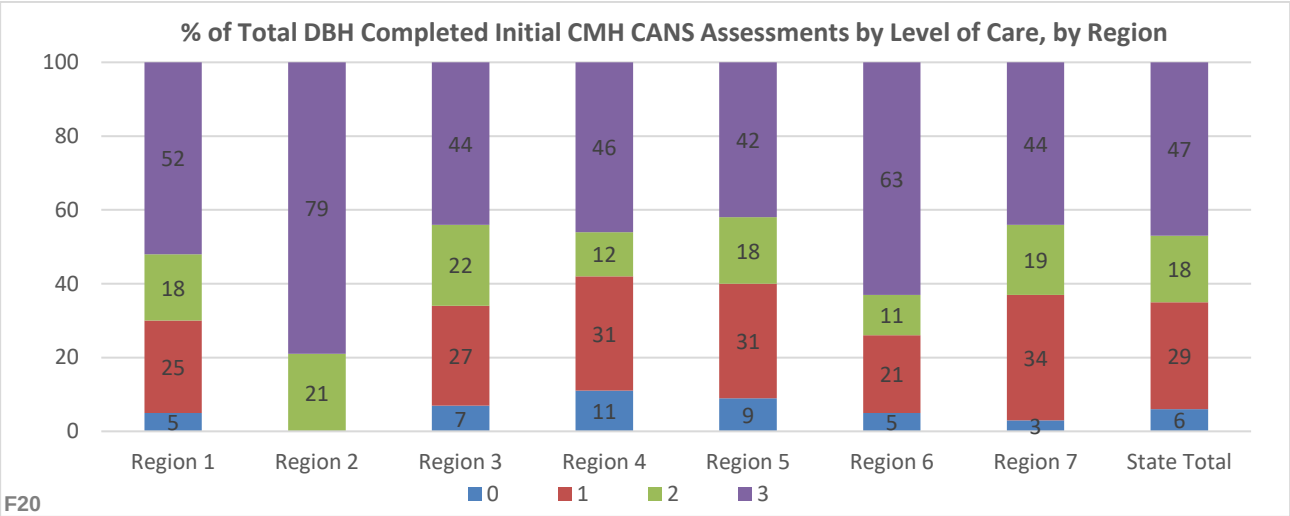
Recommended Level of Care: CANS Completed by the Division of Behavioral Health

Reminder: When a CANS is completed, a total CANS recommended level of care score of 0-3 is determined:

- **0**: Serious Emotional Disturbance (SED) has not been identified, the child or youth does not meet criteria for YES services at this time
- **1**: SED identified, services should be coordinated but functioning is stable

- **2**: SED identified, child/youth generally involved in multiple systems and require extensive service collaboration
- **3**: SED identified, child/youth is considered to have high treatment needs and is at risk of out of home placement

Figure 20.
Data Source: *YES ICANS System (April-June 2018)*



CANS Records (#): *Region 1: 56, Region 2: 19, Region 3: 45, Region 4: 74, Region 5: 65, Region 6: 19, Region 7: 167, State total: 445*
**24 CANS records with a status of 'in progress/ incomplete' were not included in this analysis [total records: 469]*

Between April and June, 6% of the 445 youth statewide who completed an initial CMH CANS from DBH received a recommended CANS LOC of '0'. The highest percentage of youth assessed statewide received an initial LOC score of '3' (47%). Youth who received an initial LOC score of '1' represented 29% of those assessed statewide, and those who received a '2' represented 18% of total youth assessed during this reporting period. This statewide pattern is similar to the CANS assessments completed by the IAP for this reporting period. QMIA will continue to monitor recommended LOC outputs for youth receiving their first CANS assessment in an effort to gain baseline understanding about youth being served, evaluate trends as well as identify system needs and potential gaps.

Regionally, there are some differences to note regarding recommended level of care. Regions 2 and 6 have the highest percentage of youth assessed who received an initial recommended LOC of '3' with 79% and 63% respectively. A similar pattern was noted for these regions regarding CANS completed by the IAP. In addition, region 2 did not have any youth assessed by DBH during this period who received an initial recommended LOC of '0' or '1'. Region 4 had the highest percentage of youth assessed who received an initial recommended LOC of '0' (11%). *Again, it is important to note that some regions had significantly smaller population samples than others, therefore percentages and comparisons should be interpreted with this in mind.*

Children's Mental Health (CMH) CANS- All Initial Assessments

This section of the report reviews all initial CMH CANS assessments completed within the reporting period, regardless of the assessing agency. The following information allows us to understand the needs and strengths of youth as they are receiving their first CANS assessment and entering into the YES system of care.

Primary Diagnoses

The following table identifies the most prevalent primary diagnoses for the 551 youth who were administered an initial CMH CANS between April and June. For youth who had more than one initial CMH CANS on file, the identified diagnosis from their most recent CANS were reported.

Figure 21.

Data Source: *YES ICANS System (April-June 2018)*

F21

Most Prevalent Diagnoses per Region and Statewide						
State	Attention-deficit hyperactivity disorder, combined type	17%	Oppositional defiant disorder	14%	Generalized anxiety disorder	9%
Region 1	Attention-deficit hyperactivity disorder, combined type	21%	Post-traumatic stress disorder, unspecified	11%	Generalized anxiety disorder	9%
Region 2	Attention-deficit hyperactivity disorder, combined type	34%	Attention-deficit hyperactivity disorder, inattentive type	10%	Generalized anxiety disorder	9%
Region 3	Attention-deficit hyperactivity disorder, unspecified type	13%	Anxiety disorder, unspecified	11%	Major depressive disorder, recurrent severe without psychotic features	8%
Region 4	Attention-deficit hyperactivity disorder, unspecified type	12%	Major depressive disorder, recurrent severe without psychotic features	10%	Oppositional defiant disorder	10%
Region 5	Oppositional defiant disorder	24%	Generalized anxiety disorder	11%	Disruptive mood dysregulation disorder	7%
Region 6	Attention-deficit hyperactivity disorder, combined type	26%	Oppositional defiant disorder	16%	Major depressive disorder, recurrent severe without psychotic features	11%
Region 7	Attention-deficit hyperactivity disorder, combined type	23%	Oppositional defiant disorder	18%	Generalized anxiety disorder	11%

CANS Records (#): *Region 1: 75, Region 2: 29, Region 3: 62, Region 4: 86, Region 5: 71, Region 6: 19, Region 7: 209, State total: 551*

Almost exclusively, the most prevalent diagnosis for youth who were administered an initial CMH CANS assessment regionally was Attention-deficit hyperactivity disorder, with varying specification types. The majority of youth assessed in Region 5 were given a primary diagnosis of Oppositional defiant disorder (24% of youth assessed). About 40% of youth initially assessed using the CANS statewide received a primary diagnosis of Attention-deficit hyperactivity disorder, combined type, Oppositional defiant disorder, or Generalized anxiety disorder. Other prevalent diagnoses within the regions worth noting are Post-traumatic stress disorder (Region 1, 11%), Major depressive disorder (Region 3, 8% and Region 6, 11%), and Disruptive mood dysregulation disorder (Region 5, 7%).

Data about prevalence of diagnoses within the broader diagnostic categories was also collected and analyzed for this cohort of youth. Statewide, the most prevalent diagnostic category was Behavioral and emotional disorders with childhood onset (44%). This was also the most common diagnostic category in Regions 2 (66%), 4 (36%), 5 (39%), 6 (63%) and 7 (52%). Examples of diagnoses within this category are Conduct disorder, Attention-deficit hyperactivity disorder, Oppositional defiant disorder, and Reactive attachment disorder. The most prevalent diagnostic category for Region 1 was Neurotic, stress-related and somatoform disorders (40%). Examples of diagnoses within this category are anxiety and adjustment disorders. For Region 3, the most prevalent diagnostic category was Mood [affective] disorders (34%). Examples of diagnoses within this category are depressive and bi-polar disorders. A full categorized list of diagnoses found within each diagnostic category can be found here.

Youth Needs and Strengths

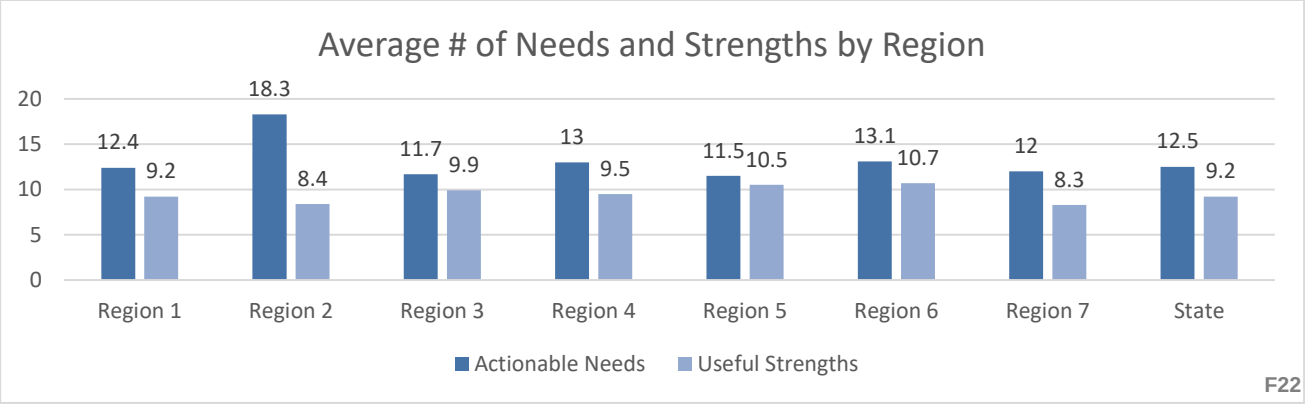
Collecting data on the most common treatment needs and useful strengths can inform the system of the direction in which practice needs to go to best support those it's serving. Identifying the most prevalent system-wide needs could indicate that the addition of services and supports targeted to address 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.

An actionable need is identified when an item is rated as a 2 or 3 by the family, youth and provider team. A rating of '2' indicates that the problem is interfering with functioning and requires action or intervention to ensure that the need is addressed. A rating of '3' indicates that the problem is dangerous or disabling and requires immediate and/or intensive action.

A useful strength is identified when an item is rated as a 0 or 1 by the family, youth and provider team. A rating of '0' indicates a well-developed or centerpiece strength that may be used as a centerpiece of a strength-based plan. A rating of '1' indicates that a useful strength is evident, but some effort is needed to maximize the strength. This strength may be built upon in treatment.

The figure below shows the average number of actionable needs and useful strengths that have been initially identified by the CANS for youth in each region and statewide. This data has been extracted from 551 initial CMH CANS assessments completed by either the IAP or DBH between April and June of 2018.

Figure 22.
Data Source: *YES ICANS System (April-June 2018)*



CANS Records (#): *Region 1: 75, Region 2: 29, Region 3: 62, Region 4: 86, Region 5: 71, Region 6: 19, Region 7: 209, State total: 551*

The number of actionable needs that are identified for a youth can be an indication of the overall intensity of their need for services and supports. Typically, the amount of actionable needs that are identified indicates the amount of work that will need to be done with the youth and family to address them. Useful strengths are utilized as tools within the treatment plan to support the youth and family in their work toward addressing their needs. The goal is for the youth and family to build their strengths and decrease their needs over time.

For this cohort of youth, the average number of actionable needs was 12.5 statewide. Regionally, the average number of actionable needs was similar to that of the statewide average, with the exception of

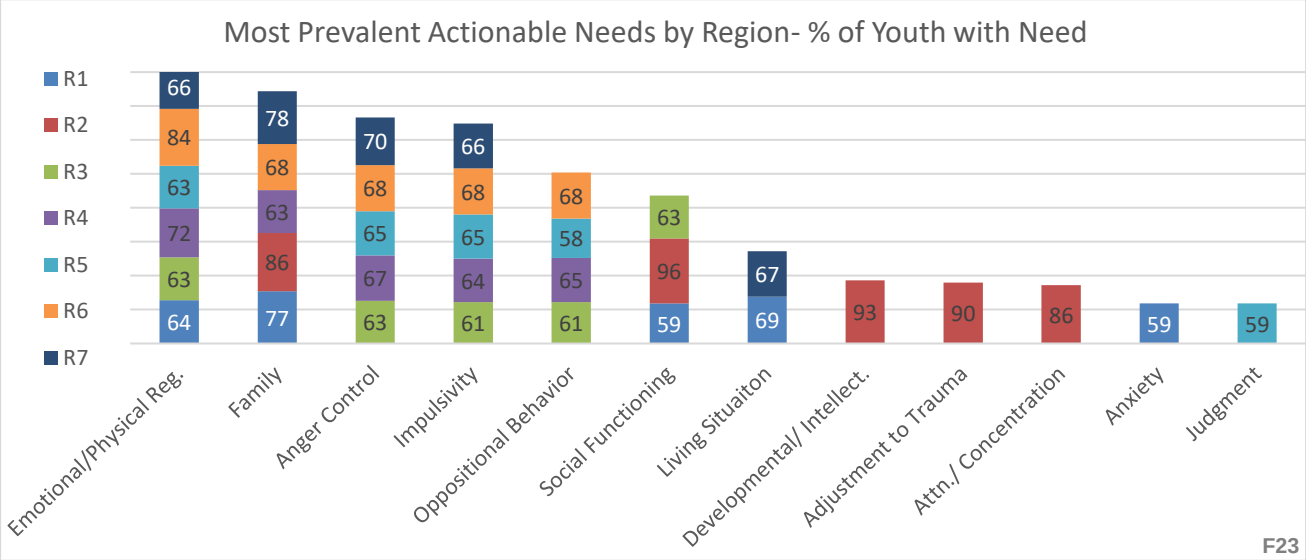
Region 2. The statewide average of useful strengths for this group of youth was 9.2. Regionally, there was not a significant variance regarding average number of strengths.

The following figure shows the most prevalent actionable needs of the 551 youth who were administered an initial CMH CANS between April and June. For youth who had more than one initial CMH CANS on file, identified needs from their most recent CANS were reported.

Figure 23.

Data Source: *YES ICANS System (April-June 2018)*

Most Prevalent Initial Actionable Needs Identified Statewide				
Family	Emotional/Physical Regulation	Anger Control	Impulsivity	Social Functioning
70%	67%	66%	64%	60%



CANS Records (#): *Region 1: 75, Region 2: 29, Region 3: 62, Region 4: 86, Region 5: 71, Region 6: 19, Region 7: 209, State total: 551*

The table above shows the five most prevalent actionable needs identified for youth who received an initial CMH CANS statewide during this reporting period. The graph below the table shows the top five most prevalent actionable needs identified in each region; calculated by how many youth identified the need as actionable, divided by the total number of youth assessed.

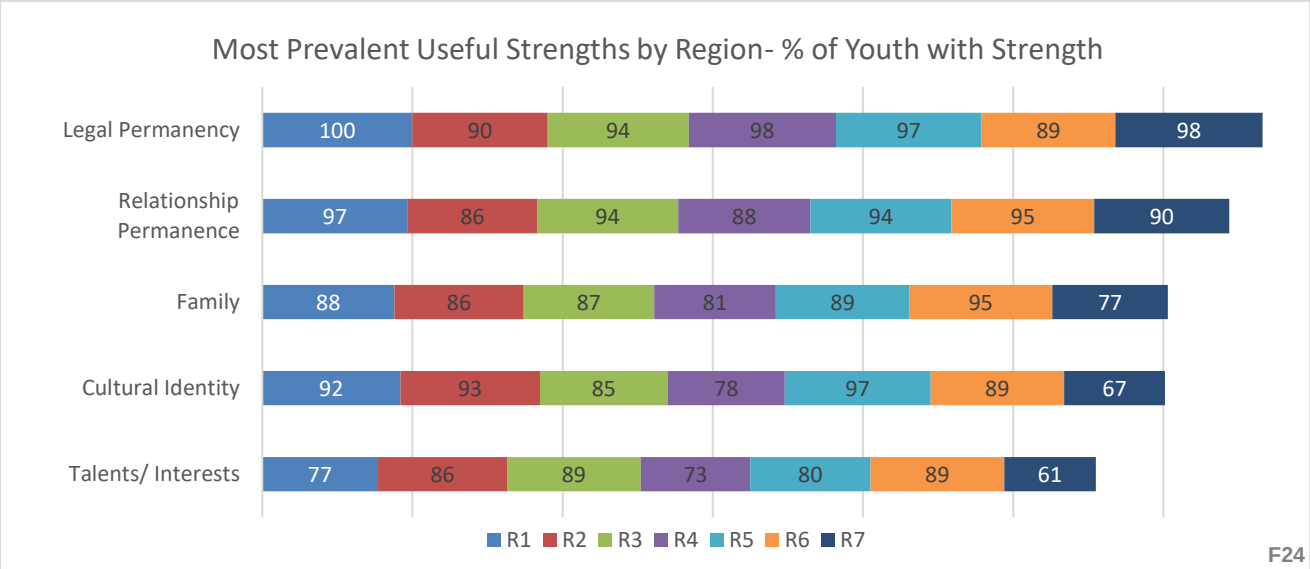
Statewide, 70% of the youth in this cohort had identified Family as an actionable need. Family was followed by Emotional/Physical Regulation (67% of youth), Anger Control (66%), Impulsivity (64%) and Social Functioning (60%). All regions with the exception of Region 2 had Emotional/Physical Regulation as one of their most prevalent actionable needs. Region 2 appears to have a higher percentage of youth identifying needs such as Developmental/Intellectual, Adjustment to Trauma, and Attention/Concentration than any other region.

Strengths describe the assets of the child or youth and family that can be used to support and advance healthy development.The following figure shows the most prevalent useful strengths of the 551 youth who were administered an Initial CMH CANS between April and June. For youth who had more than one initial CMH CANS on file, identified strengths from their most recent CANS were reported.

Figure 24.

Data Source: *YES ICANS System (April-June 2018)*

Most Prevalent Useful Strengths Identified Statewide				
Legal Permanency	Relationship Permanence	Family	Cultural Identity	Talents/Interests
97%	92%	83%	80%	73%



CANS Records (#): *Region 1: 75, Region 2: 29, Region 3: 62, Region 4: 86, Region 5: 71, Region 6: 19, Region 7: 209, State total: 551*

The table above shows the five most prevalent useful strengths identified for youth who received an initial CMH CANS statewide during this reporting period. The graph below the table shows the top five most prevalent useful strengths identified in each region; calculated by how many youth identified the need as actionable, divided by the total number of youth assessed.

Statewide, 97% of the youth in this cohort had identified Legal Permanancy as a useful strength. Legal Permanancy was followed by Relationship Permanence (92% of youth), Family (83%), Cultural Identity (80%) and Talents/Interests (73%). These same strengths were calculated to be the most prevalent in all of the regions, although the percentage of youth that identified these strengths in each region varied significantly.

It is important to note that strengths are not the opposite of needs. The absence of an actionable need does not mean that a useful strength is present, and similarly the absence of a strength does not necessarily mean that there is a need. 'Family' has been identified as both a top need and strength statewide for this cohort of youth; further rating details for these particular items have been provided below.

Life Functioning (Need) Domain; Family- a rating of a '2' on this Family item typically indicates that the youth is having problems with parents, siblings or other family members that are impacting functioning. There is frequent arguing and there may be difficulty maintaining positive relationships. A rating of a '3' for this Family item indicates that the youth is having severe problems with family members which could include domestic violence or absence of any positive relationships.

Strengths Domain; Family- a rating of '1' on this Family item typically indicates that the family has some good relationships and good communication, they are able to enjoy each other's company and there is at least one family member who has a strong, loving relationship with the youth who is able to provide limited emotional support. A rating of '0' on this Family items indicates that the family has

strong relationships and significant family strengths and there is at least one family member who has a strong loving relationship with the youth and is able to provide significant emotional support. Needs and Strengths item ratings will fluctuate throughout a youth's episode of treatment. As we begin to collect more CANS data, we will be able to monitor progress by analyzing reassessment and discharge CANS level of care outputs as well as individual item ratings over time.

For more detail regarding the needs and strengths identified above, please see Appendix B.

Wraparound

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 Youth Empowerment Services 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	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	FACS DD Program[1]
4	4	4	4	5	3	5	6

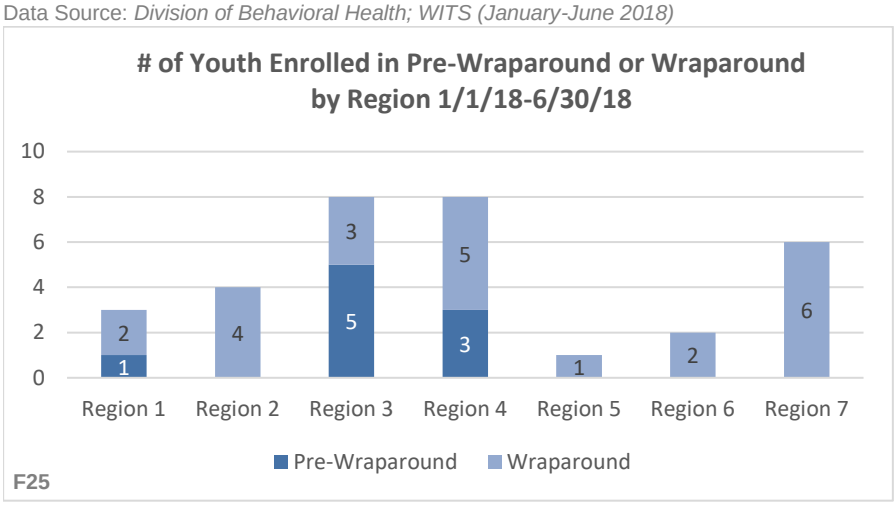
[1]*Family and Community Services (FACS) Developmental Disabilities Program staff have been trained to work with youth who have been dual-diagnosed with both a developmental and mental health concern.*

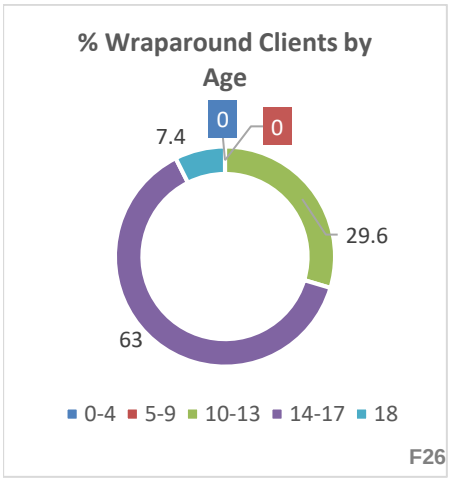
The Division of Behavioral Health began enrolling currently served youth into Wraparound programs in February of 2018. From February to June 30th, 2018, there were 32 youth enrolled in Wraparound or Pre-wraparound. The Pre-wraparound program designation is used when families are considering wraparound 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. 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.

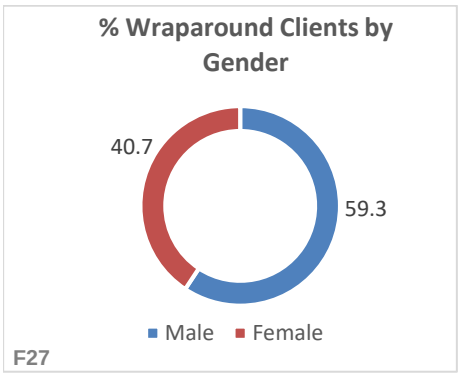
Regional and demographic information for the youth who were enrolled in a Wraparound program is displayed in figures 25-28. Figure 25 indicates that since January, Region 1 had enrolled three youth into Wraparound or Pre-wraparound. Region 2 enrolled four youth into Wraparound, but one youth exited before the end of the reporting period, leaving three enrolled. Region 3 enrolled eight youth, but two exited before June 30th, leaving six. Region 4 also enrolled eight youth, with one leaving the program in the reporting period, leaving seven being served. Region 5 enrolled one youth into Wraparound and region 6 enrolled two. Region 7 enrolled six youth into Wraparound, one exited the program, leaving five enrolled as of June 30th. The demographic information provided in figures 26-28 is representative of the 27 youth still enrolled in a Wraparound program as of the end of the reporting period.

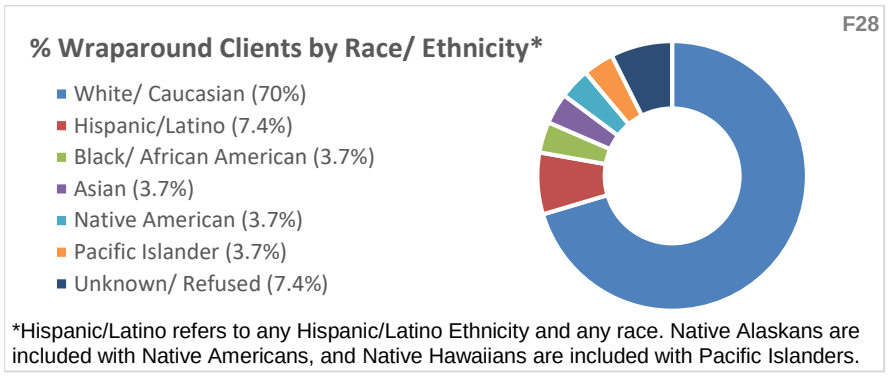
Figures 25-28.

Data Source: *Division of Behavioral Health; WITS (January-June 2018)*









As of June 30th, most of the youth enrolled in a Wraparound program were male (60%) and identified as White/Caucasian and non-Hispanic (70%). Youth being served in Wraparound during this reporting period were between the ages of 11-18, the majority being between the ages of 14-17.

How are we preparing stakeholders to use the CANS tool?

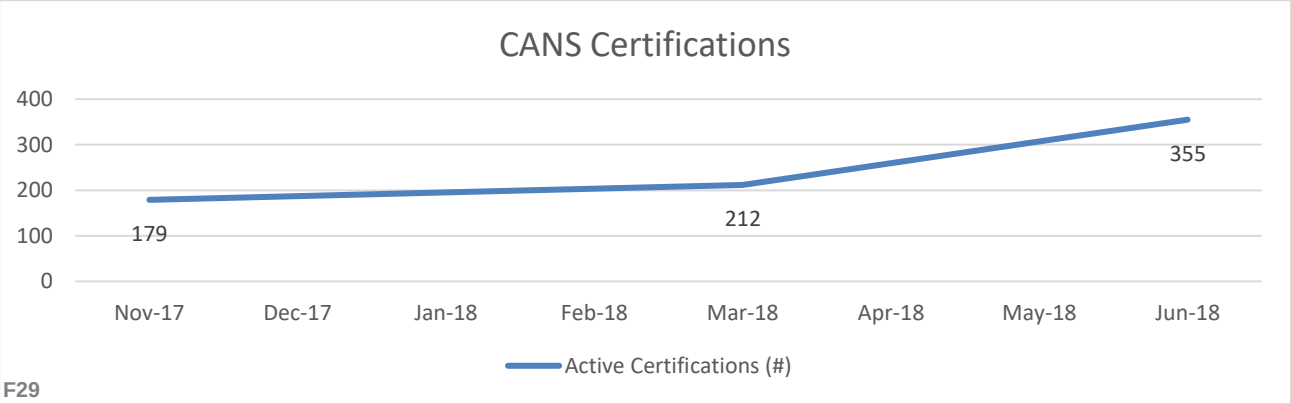
CANS Certifications

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:

- A required focus of a shared vision of the children and families receiving services
- Collaboration of multiple partners
- Communication facilitation among partners, including youth and families
- Shared commitment to serving youth and families despite differences
- 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.

Figure 29.
Data Source: *Division of Behavioral Health, Praed Foundation (June 2018)*



From November of 2017 to March of 2018, there was an 18% increase in the number of individuals certified to use the CANS tool in Idaho. From March of 2018 to June of 2018, there was a 67% increase in the number of individuals who were certified.

Community Agencies ready to use the ICANS

Community agencies outside of the Division of Behavioral Health and the Independent Assessment Provider gained the ability to use the ICANS in July. As of September, **60** community agencies were set up to use the ICANS. Information about the CANS that were completed for youth at these agencies will be included in future QMIA Quarterly reports.

Division of Behavioral Health: CANS Trainings

The following information was received from the Division of Behavioral Health (DBH) YES Training Specialist for the months of April through June of 2018.

Figure 30.

Data Source: *YES Training Specialist, Division of Behavioral Health (June 2018)* F30

Training	Date/s	Audience	Total Trained	Mode of Training
ICANS	4/10, 6/11, 6/19, 6/21, 6/25, 6/27	DBH Staff	31	Webinar
CANS/ACCESS	4/17	Juvenile Justice County Administrators	20	In-person
ICANS User Support	4/19, 6/27	Independent Assessment Providers	4	Conference Call, Webinar
The Parent CANS Experience	5/3	Parent Consultants	5	In-person
Targeted Regional CANS Coaching	5/21, 5/22. 5/23, 5/24, 5/25	Regions 1-7 DBH Clinicians	50	In-person
ICANS Training for Community Agency	6/4, 6/5, 6/6, 6/7, 6/8	Community Agencies	16	Webinar
ICANS Training for Community Partners	6/12, 6/19, 6/20, 6/26, 6/27, 6/28	Division of Family and Community Services	22	Webinar
CANS for Behavioral Health Board	6/19	Region 6 Behavioral Health Board	30	In-person

Division of Behavioral Health: Other YES Trainings

Figure 31.

Data Source: *YES Training Specialist, Division of Behavioral Health (June 2018)* F31

Training	Date/s	Audience	# Attended	Mode of Training
Clinical Wraparound Support Call	4/5, 4/12, 4/19, 4/26, 5/7, 5/17, 5/21, 5/31, 6/11, 6/17, 6/22	Wraparound Coordinators- weekly support	Avg. 10 participants per call	Conference Call
Person-Centered Planning Support Call	4/6, 4/13, 4/20, 4/27, 5/4, 5/11, 5/18, 5/25, 6/1, 6/8, 6/15, 6/22, 6/29	DBH Staff- weekly support	Avg. 40 participants per call	Conference Call
Wraparound Coordinator Training	6/26-6/29	DBH Staff, Developmental Disabilities Staff	27	In-person

Description of Wraparound Coordinator Training: In-depth clinical approach and application of Wraparound services. Care Coordinators gain understanding of principles, phases and activities of Wraparound and the Wraparound implementation process in Idaho.

Information about YES trainings can be found on the YES website. (About YES > Resources and Training > YES Training Page). For those unable to attend trainings in person or via webinar on the training dates, or those who would like a refresher, recordings of previous trainings are available on this site.

Division of Medicaid: CANS Trainings

Figure 32.

Data Source: *Division of Medicaid (June 2018)* F32

Training	Date/s	Audience	# Attended
CANS General Overview	4/30, 5/7- Boise	Providers	75
	6/11- Pocatello	Providers	44
	6/18- Moscow	Providers	24
CANS Treatment Planning	5/1, 5/8- Boise	Providers	61
	6/12- Pocatello	Providers	46
	6/19- Moscow	Providers	19
CANS Supervision	5/1, 5/8- Boise	Providers	61
	6/12- Pocatello	Providers	46
	6/19- Moscow	Providers	19
CANS Trainer	5/2, 5/9- Boise	Providers	26
	6/13- Pocatello	Providers	15
	6/20- Moscow	Providers	12
CANS TCOM for Administrators	5/5, 6/21- Boise	Providers	25
	6/20- Pocatello	Providers	12
	6/27- Moscow	Providers	3

Division of Medicaid: Other YES-related Trainings

Figure 33.

Data Source: *Division of Medicaid (June 2018)* F33

Training	Date/s	Audience	# Attended
Respite Care for Families of Youth with Serious Emotional Disturbance	5/1 (Live)- Available on demand	Providers	169
Psychiatric Rehabilitation Association (PRA): Skills Building	5/15, 5/17- Webinar	Providers	123
Respite Care for Families of Youth with Serious Emotional Disturbance- Supervisor Training	5/31 (Live)- Available on demand	Providers	26
YES Navigation Series	6/14, 6/20 (Live)- Available on demand	Providers	79

Department of Juvenile Corrections: YES/ other Mental Health Trainings

Figure 34.

Data Source: *Idaho Department of Juvenile Corrections (June 2018)* F34

Training/ Audience	Topics/ Description
YES for County Juvenile Detention Center Clinicians and Administrators	Training on Youth Empowerment Services, Principles of Care and Practice Model, CANS, and Treatment interventions for working with youth affected by Trauma
DBH/ Praed Targeted Training Meetings	Meetings with Praed and Division of Behavioral Health staff to fully understand current assessment tools and begin cross walking them with the CANS in all three state facilities
CANS for Juvenile Service Coordinators, Clinicians and Clinical Supervisors	Training on using the CANS and ICANS system
All Direct Care Staff: Peace Officer Standards and Training (POST) Academy	POST training modules include many topics but the several YES related include: • Mental Health Training Curriculum for Juvenile Justice (and Refresher annually) • Suicide Prevention Course (and Refresher annually) • Effective De-escalation (and Refresher annually) • Cultural Awareness • Think Trauma (Trauma informed care for juvenile and staff) • Floor Management-Unit operations • Legal liability • Ethics • Drug & Alcohol Addictions
Additional Trainings offered to Direct Care Staff	Dialectical Behavioral Therapy, Positive Peer Culture, Medication Management, Restorative Conferences
Sponsored trainings for Police Officers	Sponsored seven trainings on Policing the Teen Brain in six jurisdictions throughout Idaho, sponsored 10 trainings for police officers on how to work with individuals with autism

How is the children's mental health system experienced by children, youth and families?

Complaints and Appeals

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's newly established Complaints process, and complaints data from the Department of Juvenile Corrections, State Department of Education and Family and Community Services.

Complaints and Appeals, reported by the Division of Medicaid

The information below has been reported by the Division of Medicaid on behalf of two of their contractors, Optum Idaho and Liberty Healthcare. Optum manages outpatient behavioral health benefits for Idaho Medicaid members and Liberty is the Independent Assessment Provider for YES.

Complaints

Quality of Service complaint: an expression of dissatisfaction concerning the administration of the plan and services received.

Quality of Care complaint: a concern that relates to the quality of clinical treatment services provided by an individual provider or agency in the Optum Idaho network.

Average # of days to resolution performance goal: Ten business days for Quality of Service complaints, 30 calendar days for Quality of Care complaints.

Figure 35.
Data Source: *Division of Medicaid (June 2018)* F35

Optum Complaints 1/1/18-6/30/18	
# Quality of service complaints	7
# Quality of care complaints	0
Average # of days to resolve	4.3 days

Figure 36.
Data Source: *Division of Medicaid/ Liberty Healthcare (June 2018)* F36

Liberty Complaints 1/1/18-6/30/18
Liberty received **one** complaint during this reporting period. The complaint received was regarding access. The Executive Director contacted the family and resolved this complaint with no further action necessary.

Appeals

Appeal: An appeal can be filed when a member is not happy with an Optum Idaho adverse benefit determination or decision. For example, when a covered service is denied, delayed, limited or stopped.

Urgent Appeal: An urgent appeal can be requested if there is an immediate threat that could seriously jeopardize the member's life, health, or ability to regain maximum functioning.

Average time to resolution performance goal: 30 days for Non-Urgent Appeals, 72 hours for Urgent Appeals.

Figure 37.
Data Source: *Division of Medicaid (June 2018)*

F37

Optum Non-Urgent Appeals		**Optum Urgent Appeals**	
1/1/18-6/30/18		1/1/18-6/30/18	
Total # of Non- Urgent Appeals	37	Total # of Urgent Appeals	4
Upheld Appeals	14	Upheld Appeals	0
Overturned Appeals	12	Overturned Appeals	1
Partially Overturned Appeals	11	Partially Overturned Appeals	3
Average Days to Resolution	6.1 days	Average Hours to Resolution	40.5 hours

Complaints and Appeals, reported by the Division of Behavioral Health

Complaints: January 1-June 30, 2018

Figure 38.
Data Source: *Division of Behavioral Health (June 2018)*

F38

Total Calls to the Division of Behavioral Health Central Office Complaints Line: 24							
Total DBH Complaints: 8						Non-DBH Redirected*: 16	
Complaints by Region							
Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	No ID
2	**2**	**0**	**1**	**0**	**0**	**2**	**1**
Complaints by Complainant							
Family		Advocate			Provider		
6		**1**			**1**		
Complaints by Type							
Quality				Access			
5				**3**			
Complaints by Service							
CANS	Person-Centered Plan		Residential Treatment		Referral/Eligibility		Complaint Process
1	**3**		**1**		**1**		**2**

**Non-DBH Redirected: Calls received that do not involve a DBH-specific service or process; Child Protection, Liberty Healthcare, Medicaid, Optum*

Appeals: From the dates of January 1 to June 30, the Division of Behavioral Health did not have any appeals filed.

Complaints reported by the Division of Family and Community Services, State Department of Education, and the Department of Juvenile Corrections

Important Note on 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.

Figure 39.

Data Source: *Division of Family and Community Services (June 2018)* F39

Family and Community Services- Complaints Received 1/1/18-6/30/18	
# Formal Complaints reported to the Director's office	23*

**Although the Division of Family and Community Services was unable to report details about each complaint, they were able to share that complaints are typically related to how a case is being handled or a disagreement with one or more elements of the family case plan.*

Figure 40.

Data Source: *Idaho State Department of Education; Data and Reporting Coordinator for Special Education (June 2018)* F40

State Department of Education- Administrative Complaints 1/1/18-6/30/18	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	State
# Total Complaints	5	4	13	2	3	2	29
# Denied*	1	2	-	-	1	-	4
# Cases Closed	2	2	5	1	-	1	11
Average Time to Close (days)	71.5	54	49.2	127	-	117	67.4
# Total Allegations**	17	11	62	21	10	13	134
# Founded Allegations	5	-	5	3	5	5	23
# No findings/ Unfounded	8	11	42	18	5	8	92
# Allegations Pending	4	-	9	-	-	-	13
# Allegations Withdrawn	-	-	6	-	-	-	6

**A 'denied' status refers to a complaint that is not accompanied by sufficient information to investigate*
***Complaints are made up of allegations, for one complaint there can be one or multiple allegations.*

Figure 41.

Data Source: *Idaho Department of Juvenile Corrections (June 2018)* F41

Idaho Department of Juvenile Corrections Complaints Received 1/1/18-6/30/18 *Family and YES Class Members whose complaint/concern was directed to the Superintendent*					
Family Concerns					
Region	**# Complaints**	**# Resolved**	**Complaint Type**	**Status**	**Time to Resolve (days)**
3	3	3	Language difficulty	Resolved	Unknown
			Safety concern	Resolved	Unknown
			Behavior concern (others)	Resolved	Unknown
Juvenile Concerns					
Region	**# Complaints**	**# Resolved**	**Complaint Type**	**Status**	**Time to Resolve (days)**
1	2	2	Staff behavior	Resolved	8 days
			Group behavior	Resolved	8 days
2	17	17	Staff behavior (7)	Resolved (7)	3-16 days (avg. 6.6)
			Others' behavior (8)	Resolved (8)	2-17 days (avg. 8.5)
			Medication (2)	Resolved (2)	14 days, 23 days
3	3	3	Others' behavior	Resolved	9 days
			Did not get phone call	Resolved	8 days
			Wanted to be with group	Resolved	16 days

The Department of Juvenile Corrections reported that most concerns were resolved in the following ways:

- Worked through Clinical Supervisor, JSC, Unit Manager, and/or Group Leader
- Discussion with juveniles, processing situations
- Review of juvenile rights
- Follow up and discussion with staff
- Investigation opened

Note: Complaints reported by Family and Community Services, the Department of Juvenile Corrections and the State Department of Education 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.

Centralized Complaints

Complaints data will be collected from all YES partners beginning October 1st. This information will be included in future QMIA Quarterly reports.

Measuring Client Satisfaction

Division of Behavioral Health: Youth Satisfaction Survey- Family Version

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

The YSS-F response rate was 9.8% (549 families were sent surveys; 54 responses were received). YSS-F survey response for this year increased by 2.3% compared to the previous year. Although this low percentage of completed surveys indicates questionable validity of results, it is still assumed that at least some of the indicators are informative and can be useful. The Division of Behavioral Health is working on a plan to increase YSS-F survey engagement. 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.

For the following figures, reporting positively is defined by a rating of 'Agree' or 'Strongly Agree'. Ratings of 'N/A' were removed from the analysis.

Figure 42.
Data Source: *2017 YSS-F Survey, Division of Behavioral Health*

Do families feel that services are accessible?

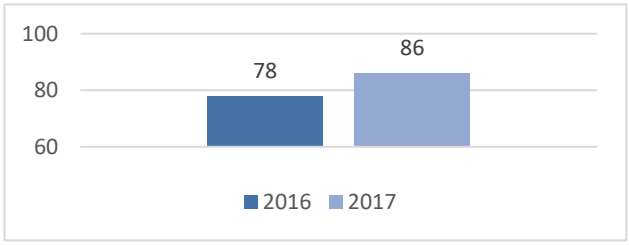
TCOM Goal: youth and families experience timely access to system services.

% Reporting Positively 2016	**78%**
% Reporting Positively 2017	**86%**

YSS-F 'Access' Items

- The location of services was convenient
- Services were available at times that were convenient

F42



From 2016 to 2017, there was an increase in positive responses for both YSS-F items that represent the access category. There was a substantial increase in perception of convenient location of services, and a slight increase in positive feelings about the time in which services were available. Overall, there was an 8% increase in positive ratings regarding access to services.

Figure 43.
Data Source: *2017 YSS-F Survey, Division of Behavioral Health*

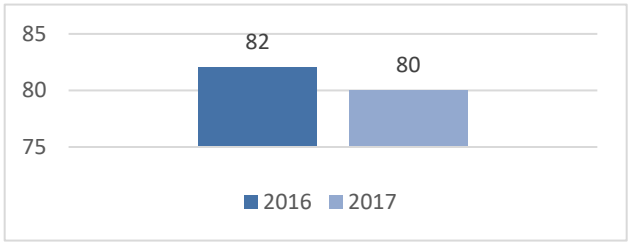
How well are we engaging with families?

TCOM Goal: youth and families experience system services as useful and empowering.

% Reporting Positively 2016 (Participation)	82%
% Reporting Positively 2017 (Participation)	80%

YSS-F 'Engagement' Items (Participation)

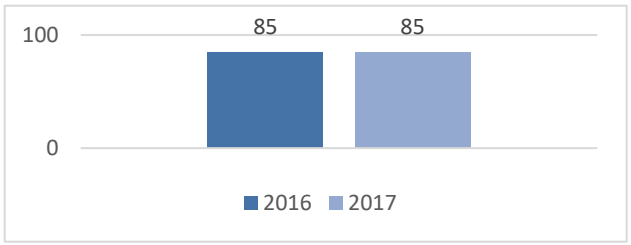
- I helped choose my child's services.
- I helped choose my child's treatment goals.
- I was given the opportunity to participate in my child's treatment.



% Reporting Positively 2016 (Respect)	85%
% Reporting Positively 2016 (Respect)	85%

YSS-F 'Engagement' Items (Respect)

- My child and I were treated with respect by staff.
- Staff respected my family's religious/ spiritual beliefs.
- Staff were sensitive to my family's cultural/ethnic background.
- Staff spoke with me in a way that I understood.



F43

For survey items within the 'engagement' category, there was a slight decrease (2%) in families reporting positively about participation from 2016 to 2017 and no change regarding respect and cultural sensitivity. For questions within the participation category, all three items had a decrease in favorable responses, with 'I helped choose my child's treatment goals' decreasing the least (1%) from 2016 to 2017.

Figure 44.
Data Source: *2017 YSS-F Survey, Division of Behavioral Health*

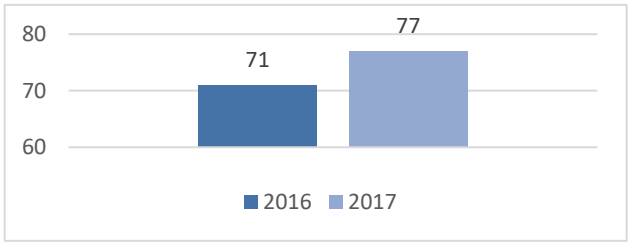
Do families feel that services are appropriate?

TCOM Goal: routing to services should be focused on individualization regarding both type and intensity.

% Reporting Positively 2016	71%
% Reporting Positively 2017	77%

YSS-F 'Appropriateness' Items

- The services my child and/or family received were based on our strengths, skills and knowledge.



F44

From 2016 to 2017, there was a marked increase in the one YSS-F item that represents the appropriateness category; this overall increase was (6%).

Figure 45.
Data Source: *2017 YSS-F Survey, Division of Behavioral Health*

How do families feel about service effectiveness?

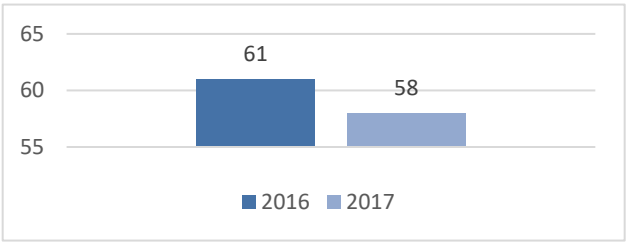
TCOM Goal: services are increasingly effective and efficient at supporting youth and families in meeting their goals.

% Reporting Positively 2016	61%
% Reporting Positively 2017	58%

YSS-F 'Effectiveness' Items

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

F45



From 2016 to 2017, there was a slight overall decrease in perception of service effectiveness. Out of the 6 YSS-F items that represent the effectiveness category, four saw a decrease and two items slightly increased. There was a substantial (16%) decrease in families reporting that their child is better at handling daily life.

Figure 46.
Data Source: *2017 YSS-F Survey, Division of Behavioral Health*

How do families feel about linkages/ social connectedness?

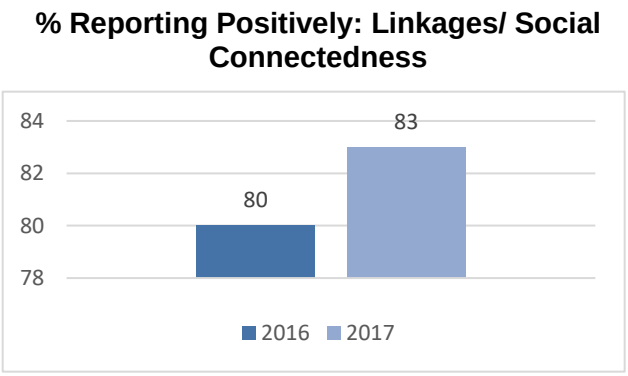
TCOM Goal: routing to services should be focused on individualization regarding both type and intensity.

% Reporting Positively 2016	80%
% Reporting Positively 2017	83%

YSS-F 'Linkages/ Social Connectedness' Items

- I was provided with the information I needed to help support my child's recovery and my family's needs.
- I know people who will listen and understand me when I need to talk.
- I have people that I am comfortable talking with about my child's problems.
- In a crisis, I would have the support I need from family or friends.
- I have people with whom I can do enjoyable things.

F46



Overall, families' positive perception of linkages and social connectedness slightly increased from 2016-2017. There was a significant increase in the individual item 'I was provided with the information I needed to help support my child's recovery and my family's needs' (11%).

Department of Juvenile Corrections: Exit Surveys

When a juvenile exits a facility, they are asked to complete an exit survey. In 2018, YTD (August 2018) there were a total of 77 questionnaires completed for juveniles exiting from state facilities. Below is a summary of the responses to three of the exit survey questions:

Figure 47.
Data Source: *Idaho Department of Juvenile Corrections* F47

1. Do you feel you have the skills necessary to establish positive relationships in the community?	Strongly Agree/ Agree: 97%
	Neutral: 3%
	Disagree/ Strongly Disagree: 0%
2. While in Juvenile Corrections custody, do you feel the staff were concerned about your wellbeing?	Strongly Agree/ Agree: 93%
	Neutral: 7%
	Disagree/ Strongly Disagree: 0%
3. Do you believe the treatment programs you had while in Juvenile Corrections have reduced your risk to commit a future crime?	Strongly Agree/ Agree: 96%
	Neutral: 4%
	Disagree/ Strongly Disagree: 0%

The Department of Juvenile Corrections conducts family surveys for those with juveniles who have left state custody. This measure combines Agree and Strongly Agree responses to the question: "Overall, I was satisfied with services provided during my child's program placement." **The last four quarters average is 82.1%.**

How are system gaps and opportunities for quality improvement being identified?

EPSDT Quality Improvement Project

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 application 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.

Figure 48.

Data Source: *Division of Medicaid (2017)* F48

Period	Total Applications	Total Placements	Average Time to Determination
2016	56	11	60-90 Days
2017	96	35	27 Days

Data from January through March was included in the last QMIA Quarterly report. For this report, Medicaid provided updated data covering April 1st through June 30st, 2018:

Figure 49.

Data Source: *Division of Medicaid (June 2018)* F49

Period	Total Applications	Approved	Denied	In process/ Awaiting Completed Application		Withdrawn/ Closed		Average Time to Determination*
1/1/18-3/31/18	34	7	5	18	1	2	1	45 Days
4/1/18-6/30/18	44	10	11			15	8	54 Days

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

For 2018, it appears that Medicaid is continuing to make determinations in a significantly shorter amount of time than when the quality improvement project began. It also appears that the amount of applications is on track to be greater than in previous years.

Medicaid was able to provide updated data for Quarter 1 of SFY 2019, which has been included below and will also be included in the next quarterly report.

Period	Total Applications	Approved	Denied	In process/ Awaiting Completed Application		Withdrawn/ Closed		Average Time to Determination*
7/1/18-9/30/18	35	21	7		1	3	1	28 days

The QMIA Quarterly will continue to report on this quality improvement project in addition to others as progress is made and data and other information becomes available.

Workforce Development Capacity Analysis

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 findings from this survey will be utilized to inform the YES Workforce Development Plan. This survey report provides information regarding the current state of behavioral health services available to youth throughout Idaho, as well as recommendations for expansion and enhancements that may assist in better meeting the needs of the population.

About the survey: The target population of the survey was mental health providers who deliver Medicaid-funded services to youth and their families in Idaho. The researchers surveyed Optum network mental health providers who deliver Medicaid-funded services to youth and their families. Two survey instruments were generated, one for organizations and one for solo practitioners. The total number of organizations and solo providers invited to participate in the survey was 392. Two hundred forty-four responded to the survey: 152 responded to the organization survey, and 92 responded to the solo provider survey. The total response rate was 65%. It is important to note that out of the 244 total respondents, 194 reported that they provide services to children and youth (125 organizations, and 69 solo practitioners). The remainder of the respondents (50) were found to be ineligible for the survey as they did not indicate that they served the target population. Survey responses were submitted anonymously.

Summary of findings:

Ages served: According to the responding organizations, all 125 serve children and youth between the ages of 4 and 18. Only 47 or 37.6% of these organizations serve children from birth to 3 years old. For responding solo providers, all 69 provide services for children and youth ages 4-18, and 20 or 28.9% serve children from birth to 3 years old.

Communities served: For this analysis, cities with a population of over 100 individuals were considered. Survey results indicated that all but 6 of the 187 cities in Idaho with populations over 100 have some services available. Survey responses from Organizations revealed that most of the respondents serve communities within regions 3, 4, 6, and 7. Solo practitioner responses indicated that most respondents serve communities in regions 1, 3 and 4. City-level service maps and data have been included in the full report.

Service availability: Organization responses indicated that almost all respondents provide weekday services (Monday through Friday). About 39% of communities have access to services from the responding organizations on Saturdays, and about 35% have access to services on Sundays. In all but 21 communities, responding organizations indicated that they offer services from 8 a.m. to 5 p.m. on weekdays, and 60 communities being served have access to services from 10 p.m. to 8 a.m. Most of solo practicing respondents indicated that services are offered Monday through Thursday with a distinct drop-off on Fridays and between noon and 5 p.m. Only 27% of these providers offer services on Saturdays and between 8 p.m. and 10 p.m. City-level service maps and data have been included in the full report.

Services offered: The following table provides information about the communities with the highest density of services as indicated by both organizations and solo practicing respondents.

Figure 50.
Data Source: *Boise State University School of Social Work (April 2018)* F50

Service	Responding Organizations (102)	Responding Solo Providers (64)
Individual Counseling	Individual counseling is widely available in most communities of populations over 100. Communities with the highest density of service are Boise (23.5%), Nampa (20.58%), Caldwell (18.6%) and Meridian (17.6%), followed by Idaho Falls (15.68%) and Blackfoot (10.8%)	Individual counseling is provided by solo practicing respondents in 94 communities (50%). Most provide services in Boise (35.9%) and Meridian (21.87%)
Child and Family Counseling	Most organizations provide this service in Boise (22.5%), Nampa (20.58%), Caldwell (18.6%), Meridian (16.67%) and Idaho Falls (15.68%)	This service is offered by solo practitioners in 93 communities (49.7%). Services are clustered in Boise (29.6%), Meridian (25%), Nampa (14%), Coeur d'Alene (14%), Caldwell (14%), Sandpoint (12.5%), Eagle (10.9%) and Kuna (10.9%)
Group Counseling	63% of organizations surveyed offer group counseling. This service is offered by the largest number of organizations in Boise and Nampa, followed by Caldwell and Idaho Falls	13% of solo practitioners surveyed offer group counseling. These services are offered in Boise, Meridian, Eagle, Star, Nampa and Caldwell
Crisis Services	It was reported that crisis services are available from organizations in 152 of the 187 communities (81.28%). Boise, Idaho Falls and Caldwell have the most crisis service availability. Services are largely offered face-to-face with 32.25% providing text services and 3.2% offering web-based	Solo practitioners surveyed offer crisis services in 75 of the 187 communities (40.1%)
Case Management Services	Case management is reportedly being mostly provided by the responding organizations in Boise (17.6%), Meridian (13.7%), Nampa (12.7%), Caldwell (12.7%), Idaho Falls (12.7%), Blackfoot (10.7%) and Eagle (9.8%). 43 communities receive no case management services from the respondents	9 solo respondents reported providing case management services (13.4%) in 27 communities (14.4%). These services are provided mainly in regions 1, 3 and 4
Community-based Rehabilitation	56 of the 102 organizations who responded in this area reported providing this service. This service is provided most in Idaho Falls (12.7%), Blackfoot (11.7%), Boise (11.7%), Nampa (10.7%), Ammon (9.8%), Rexburg (9.8%) and Shelley (9.8%)	17 communities out of the 187 are provided this service by the responding solo practitioners (9%)
Wraparound	Organizations reported serving Caldwell and Nampa primarily, followed by Boise. There is a noted deficit in wraparound service providers in the northern part of the state	Very few solo providers indicated that they offer wraparound services. Services are offered minimally in Kuna, Boise, Nampa, Eagle, Caldwell and Garden City
Medication Management	64% of communities have access to medication management services from the responding organizations; lead by Nampa (10.78%), Boise (9.8%), Caldwell (9.8%), Idaho Falls (7.8%) and Ammon (6.8%)	Communities served by reporting solo practitioners are Boise, Nampa and Caldwell (1 provider each)
Respite Care	36 of the 187 communities are being served by responding organizations (19.25%)	No solo respondents reported providing respite care
Social Skills Training	Social skills training is offered most by responders in Meridian (5.88%), Nampa (5.88%), and Idaho Falls (4.9%). Most of the state has no identified provider for this service based on survey responses	Solo providers reported offering this service largely in Coeur d'Alene (9.37%), Boise (6.25%), Burley (6.25%), Sandpoint (6.25%), Rathdrum (6.25%). Other communities listed were Dalton Gardens, Bonners Ferry, Ponderay, Lewiston, Hayden, Hayden Lake, Rupert, Hayburn and Moscow

Telehealth: Of the 104 organizations that responded to this survey item, 76% stated that they do not provide any services via Telehealth. Organizations that reported utilizing Telehealth methods offer individual counseling (14.4%), medication management (12.5%), crisis services/ crisis management (6.7%), and case management (4.8%). Of the 57 solo providers that responded to this survey item, 77%

do not use Telehealth. This service is used by these practitioners for individual counseling (19.3%) and family counseling (10.5%).

Prescribers: Most of the organizations who responded to this survey item do not work with a prescriber. Almost no reporting practitioners work with a prescribing professional.

Workforce: According to the report, Idaho appears to be on track to addressing its shortage of counselors, social workers and other mental health professionals as evidenced by the increase in the number of LPCs and LCSWs in the past five years which has almost doubled (Ref. P. 114). Responses indicated that gender of staff is predominantly female (organizations: 75.38%, solo providers: 86%). Almost half of the responding organizations reported that they have staff that speak and understand Spanish, with the ability to deliver services in Spanish. Of solo practicing respondents, 11% speak and understand Spanish. While the diversity of organization employees appears to be similar to statewide population, there are opportunities to expand diversity of the field overall.

Additional survey items captured information about services that respondents do not currently offer but may want to offer in the future, as well as what supports they would need to be able to provide the services. More information about these supports as well as provider titles, licensure, demographics, caseloads, skill sets and recruitment can be found by accessing the full report.

Recommendations: Below is a summary of recommendations. Additional detail and context is provided within the full report.

Services

- Expand certain services, particularly for times of day and days
- Explore financial incentives such as rate differentials to provide services in evenings, overnight, and on weekends

Medication Management

- Work with providers and prescribers to expand access to medication management

Evidence-based Practices

- To encourage use of evidence-based practices, ensure that low-cost training is offered frequently and locally to providers around the state

Case Management

- Watch for conflict-free case management requirements which requires the case management agency to be separate from service delivery agency

Critical Community-based Services

- Support providers in developing services statewide (Wraparound and Respite).
- Confirm and clarify billing practices for wraparound services, including coordination and other non-clinical services

Telehealth

- Educate providers on billing codes that are available for telehealth

Crisis Services

- Target resources for crisis services. Data on crisis care needs may be best identified by engaging emergency service agencies statewide. When crises are not addressed at a behavioral health level, local emergency service providers (police, fire, and hospitals) generally end up addressing the crisis
- Technology such as text and web-based services can provide better access to crisis services for youth and young adults

Workforce

- The state, educators and providers can look at the reported demographics as an opportunity to grow the field in targeted ways: educating and placing more Hispanic and Latino, Indian and Native people specifically.
- The state and university systems can work directly with tribes to ensure that tribal communities have access to culturally appropriate services delivered by American Indian providers.

- The state and university systems can work with predominant Hispanic and Latino communities to recruit Hispanic or Latino workers into the field, particularly those who speak Spanish.
- The state and university systems can encourage men to study and work in the field to balance the gender mix of providers.

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.

Using the above-mentioned survey results, Boise State University completed a detailed workforce capacity and gaps analysis report. The results of this analysis will be summarized in the next QMIA Quarterly report. The full document can be found here.

State Department of Education: Disciplinary Removals

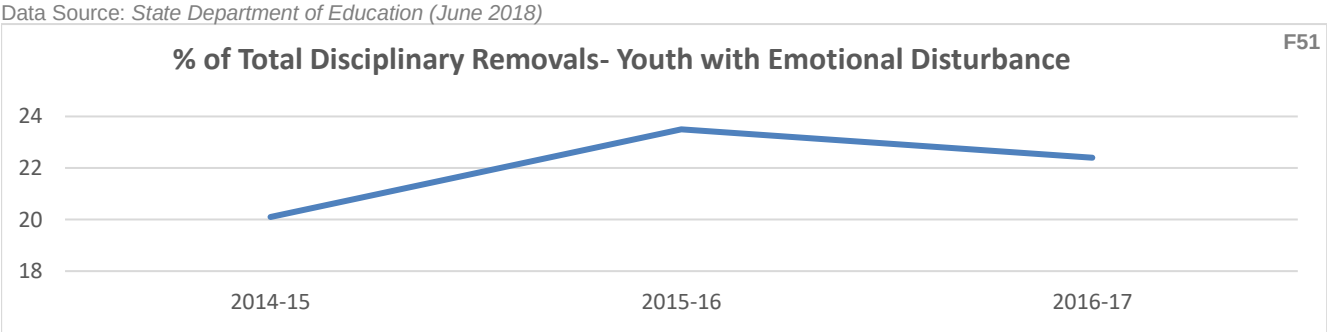
The following information has been provided by the State Department of Education (SDE) regarding disciplinary removals for youth classified as having an Emotional Disturbance. It is important to note that SDE's definition of Emotional Disturbance is not equal to the definition of Serious Emotional Disturbance used by the YES program. SDE's definition of Emotional Disturbance as well as definitions of the other disability categories listed to establish context have been provided in the glossary.

Disciplinary Removal - Any instance in which a child with a disability is removed from his/her educational placement for disciplinary purposes, including in–school suspension, out–of–school suspension, expulsion, removal by school personnel to an interim alternative educational setting for drug or weapon offenses or serious bodily injury, and removal by hearing officer for likely injury to the child or others.

According to the above definition, if a youth has been given placed on a disciplinary removal, they either are no longer in school, or they have been moved to an alternative, more restrictive learning environment. One of the outcome goals of YES is to keep youth in school by providing services and supports that build skills necessary for successful functioning in school as well as the home and community. One indication that YES may be having a positive impact on this goal would be to see a decrease in the number and percentage of disciplinary removals for youth with Emotional Disturbance.

Figure 51.

Data Source: *State Department of Education (June 2018)*



School Year	Top 3 Disability Categories (Prevalence)	# All Removals*	% of Total Removals
2014-2015	1. Other Health Impairments	302	32.7%
	2. Specific Learning Disabilities	210	22.7%
	3. Emotional Disturbance	186	20.1%
2015-2016	1. Other Health Impairments	633	36.7%
	2. Emotional Disturbance	405	23.5%
	3. Hearing Impairments	337	19.6%
2016-2017	1. Other Health Impairments	719	34.4%
	2. Emotional Disturbance	467	22.4%
	3. Specific Learning Disabilities	454	21.7%

**Due to data being redacted, only total combined disciplinary removal figures were available*

According to Figure 51, the percent of disciplinary removals for youth categorized as having an Emotional Disturbance has remained at about 20-22% of all disciplinary removals for the three school years reported. The Emotional Disturbance disability category consistently ranked between 2nd and 3rd highest with regard to number of youth who received a disciplinary removal.

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.

- **Communimetrics**: Theory of measurement in human service settings. Communimetric tools include the Child Adolescent Needs and Strengths (CANS), Adult Needs and Strengths (ANSA), and Family Advocacy and Support Tool (FAST). The primary purpose of these tools is to better communicate with all parties involved in care, each TCOM tool is based on communication theory rather than psychometric theories of measure.

- **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 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.

- **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.

Other IDEA Definitions used by the State Department of Education:

- **Other Health Impairment:** A youth exhibits limited strength, vitality, or alertness, including heightened alertness to environmental stimuli that results in limited alertness with respect to the educational environment that is due to chronic or acute health problems. These health problems may include, but are not limited to, asthma, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), cancer, diabetes, epilepsy, Fetal Alcohol Syndrome, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, Tourette syndrome, and stroke to such a degree that it adversely affects the student's educational performance. A student with ADD/ADHD may also be eligible under another category (generally specific learning disability or emotional disturbance) if he or she meets the criteria for that other category and needs special education and related services. All students with a diagnosis of ADD/ADHD are not necessarily eligible to receive special education under the IDEA, just as all students who have one of the other conditions listed under other health impairment are not necessarily eligible, unless it is determined to adversely affect educational performance and require specially designed instruction.

- **Specific Learning Disability**: a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Specific Learning Disability does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of intellectual disability, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

References

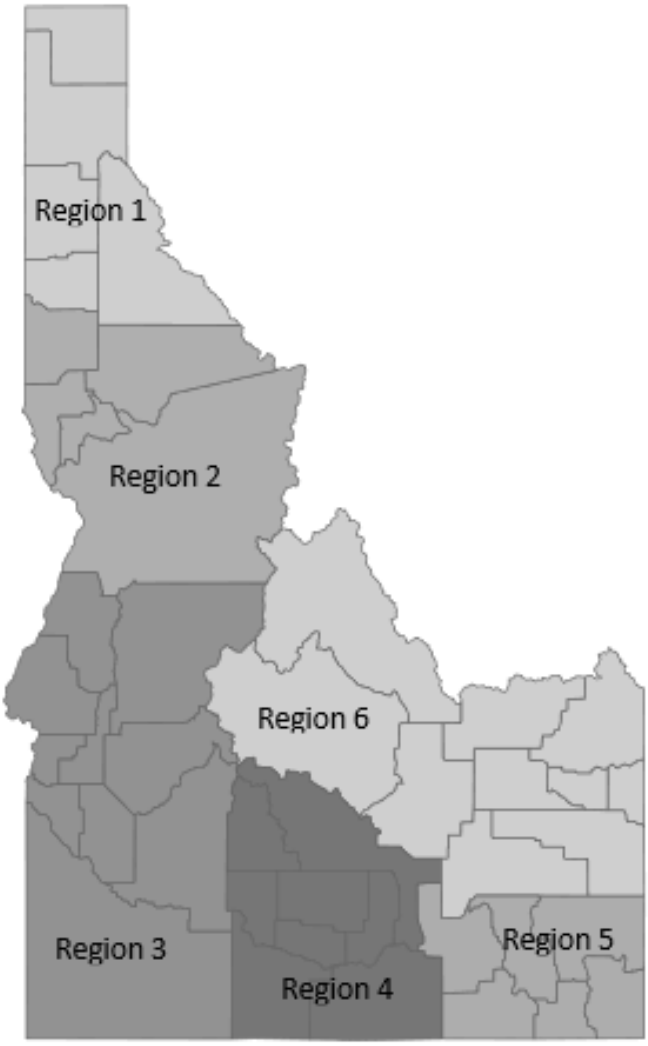
Rider, M.E, *Children's Mental Health Workforce Development Plan: Provider Survey Results*, Boise State University & Rider Consulting (2018)

Williams, N.J, *Estimated Need for Intensive Care Coordination among Idaho Youth*, Boise State University (2017)

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 by the CANS tool: April-June 2018

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.