YES QUALITY MANAGEMENT IMPROVEMENT AND ACCOUNTABILITY QUARTERLY REPORT

3rd Quarter SFY 2017

June 30, 2017

Youth Empowerment Services
Quality Management Improvement and Accountability

Data and Reports Committee
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YOUTH EMPOWERMENT SERVICES (YES)

Quality Management Improvement and Accountability (QMIA)Quarterly Report

June 30, 2017

INTRODUCTION

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 Agreement[2] and is a critical aspect of the YES project. The QMIA-Q report was 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 the YES project 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 and to receive mental health services.
- Correction or improvement of mental illness, reduction in mental disability and restoration of functioning.

A critical aspect of YES is the development of methods to evaluate how effective Idaho is at achieving the goals of the Jeff D 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.

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

- Profiles of Idaho's youth
- Access and barriers to care such as gaps in services

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[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 you can be located at: http://youthempowermentservices.idaho.gov.

- 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

The QMIA-Q report will be structured to concentrate on the delivery of care based on five key decision points. 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 Transformation Collaborative Outcomes Management (TCOM) system created by Dr. John Lyons and Dr. Nathaniel Israel and adopted by Idaho.

Five Key Decision Points:

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

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 by utilizing maximum youth and family participation throughout the process. The goal here is for youth and families to experience system services as useful and empowering.

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

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

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

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

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

YES QMIA QUARTERLY REPORT

This is the third of the YES Quality Management Improvement and Accountability Quarterly (QMIA-Q) reports to be published. This quarter, the QMIA report includes data about Idaho youth and youth risk behaviors, potential gaps in mental health services that may be a barrier to care, family engagement information based on Division of Behavioral Health (DBH) satisfaction surveys, utilization of services and possible unmet needs, use of restrictive levels of care such as hospital and residential services, and client outcomes and linkages.

Profiles of Idaho Youth

One general measure that can be used to assess the current condition of a state is the percentage of students who graduate high school. Per the 2017 County Health Rankings and Roadmaps (CHRR), a report published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, the percent of Idaho 9th graders on average who graduate in four years is lower than the U.S. average.

Table 1: Rate of Graduation

High school graduation: percent of 9th-graders who graduate in four years			
US. Median	Idaho	Idaho Counties Range	Best County
88%	79%	60%-94%	Valley- 94%

Another measure is youth risk behavior. The Idaho State Department of Education published a report on youth risk behavior as part of the national Youth Risk Behavior Surveillance System (YRBS). The following data on risk behaviors (Figures 1, 2 and 3) are based on responses from 1,760 students in 48 public high schools in 2015.

Figure 1: Mental Health Related Measures

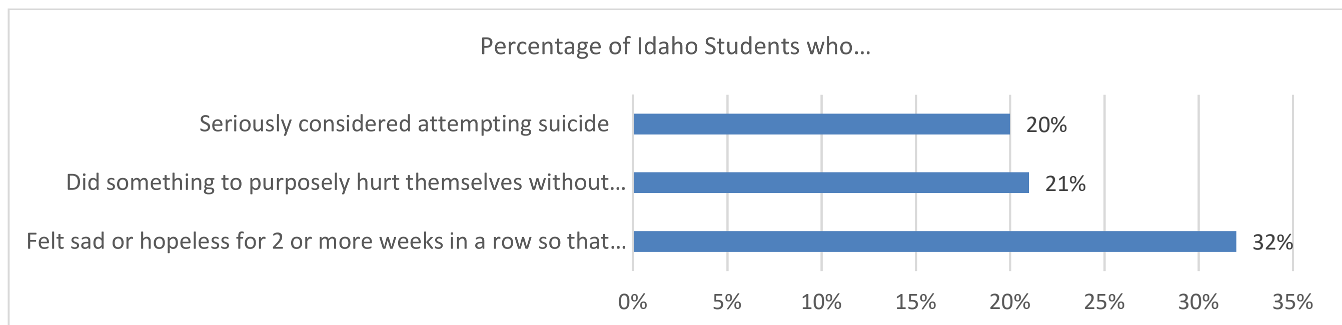


Figure 2: Percentage of Students Who Seriously Considered Attempting Suicide during Past 12 Months.

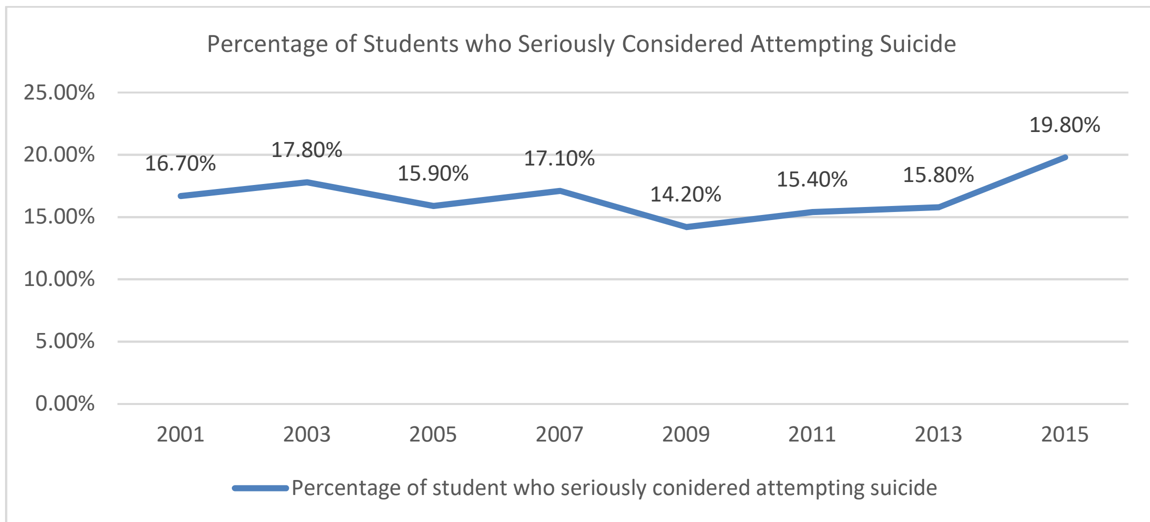
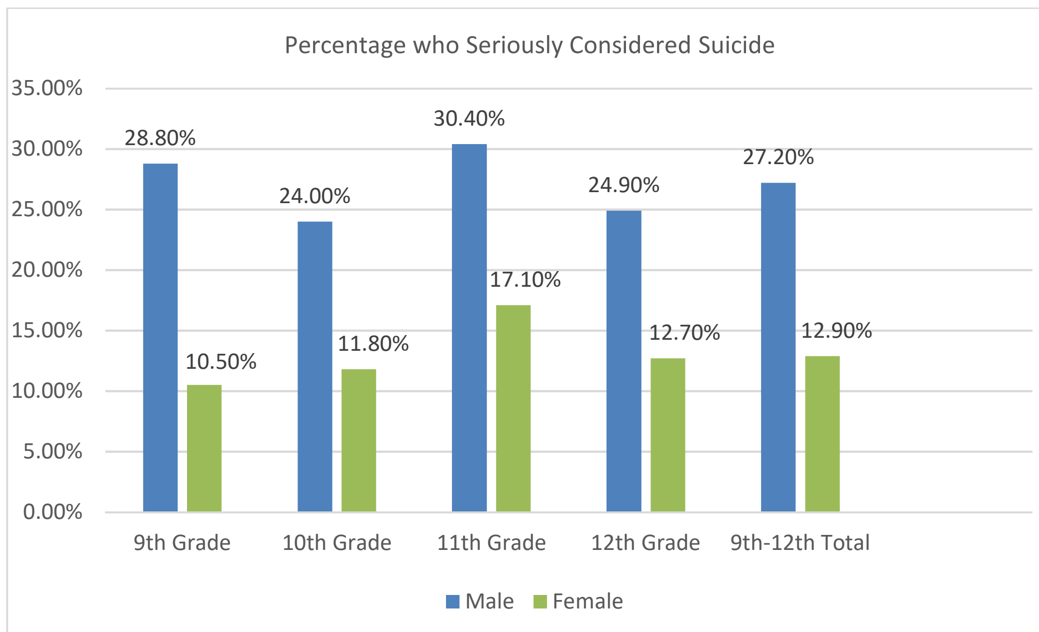


Figure 3: Percentage of Idaho students who Seriously Considered Attempting Suicide During the Past 12 Months by Grade.

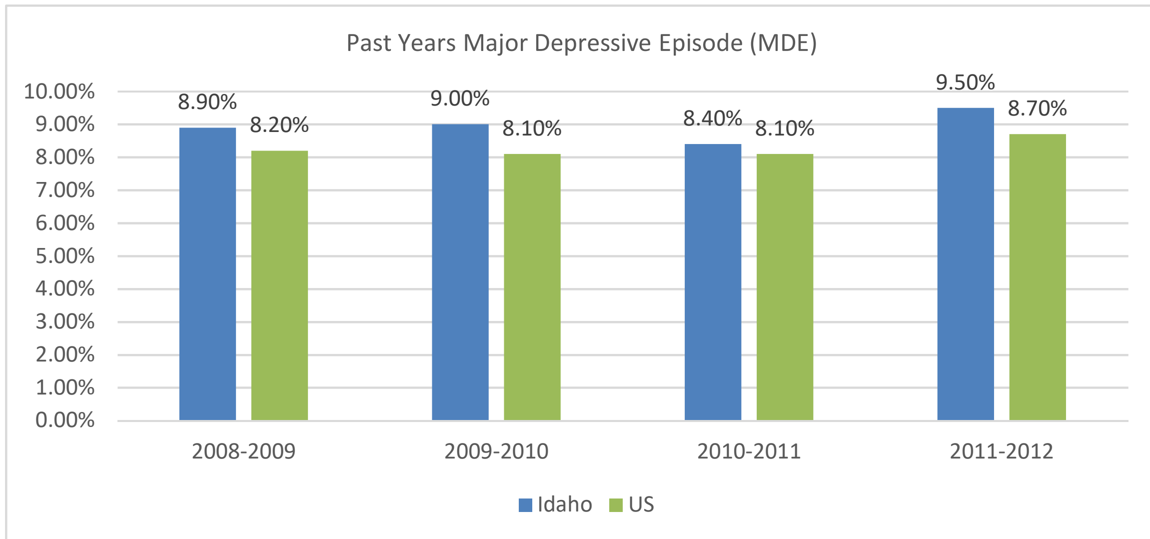


While adolescents are generally healthy, this data about risk behaviors for Idaho youth highlights the need for ongoing collaborative work to improve the child-serving system. More information about the YRBS can be attained by contacting the State Department of Education at 208-332-6947.

Potential Gaps in Mental Healthcare Services (Access)

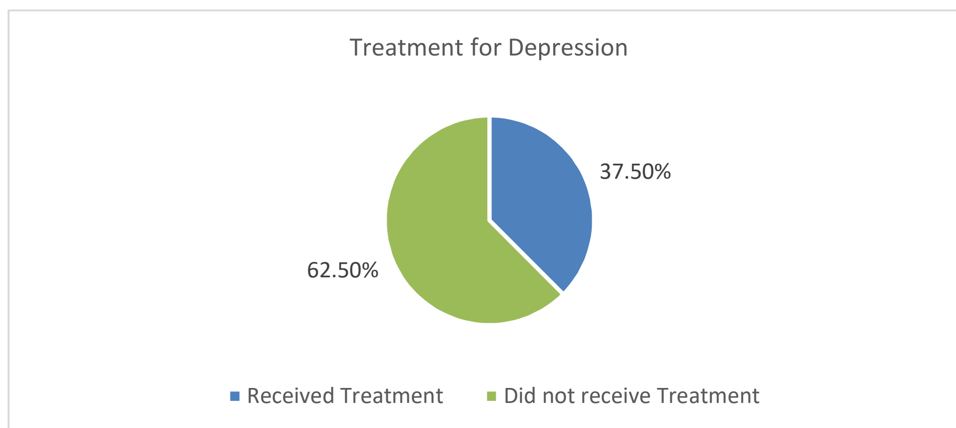
The Behavioral Health Barometer, 2013, a report about all 50 states provided by Substance Abuse and Mental Health Services Administration (SAMHSA), indicates the percentage of people aged 12-17 who have had a Major Depressive Episode (MDE) in the past year. Utilizing this data from SAMHSA, states can compare themselves to the average for the U.S.

Figure 4: Past year Major Depressive Episodes



The SAMHSA report also included information by state about the rate that that youth with a MDE received treatment. In Idaho, only about 37.5% received treatment. It was noted in the report that Idaho's rate of youth with MDE and rate of treatment for MDE are similar to the national rates. In each of the years included in the SAMHSA report, the percentage of youth with MDE in Idaho is slightly higher than the US average.

Figure 5: Treatment for Depression



The following data about possible gaps in services was previously reported in the last QMIA - Q report (QMIA-Q 3/31/2017) and is being repeated intentionally to ensure that the YES workgroups have a chance to review the data so other stakeholders, who may not have read past QMIA-Q reports, can find the information easily.

Table 2 is a comparison of presumed class members (PCM) who received mental health services and the distribution of Medicaid members across the state (penetration rate). This data can inform those who are developing plans for system improvement of possible geographical areas throughout Idaho that need to focus on reducing barriers and improving access to care.

Table 2: Distribution of Presumed Class Members (PCM) by region

DBH Regions	# PCM	% of PCM	# Medicaid Members	% of Medicaid	Penetration rate
Region 1	1,592	12.0%	29,290	12.5%	5.4%
Region 2	437	3.3%	9,997	4.3%	4.4%
Region 3	2,866	21.6%	52,048	22.2%	5.5%
Region 4	3,189	24.0%	48,662	20.8%	6.6%
Region 5	1,365	10.3%	33,345	14.2%	4.1%
Region 6	1,050	7.9%	19,178	8.2%	5.5%
Region 7	2,793	21.0%	41,979	17.9%	6.7%
Statewide Total	13,292	100.0%	234,499	100.0%	5.7%

In comparing the distribution of Medicaid members to the statewide average of penetration (5.7%), it is possible* that Class Members may be underserved in Regions 1 (5.4%), 2 (4.4%), 3 (5.5%), 5 (4.1%) and 6 (5.5%). These results indicate a need to monitor regional penetration rates to be able to make meaningful service determinations moving forward.

*Please note, this data is not accompanied by a confidence interval (CI) rating, therefore any interpretation should be considered a hypothesis at this time.

Table 3 is a comparison of presumed class members (PCM) served by age and by YES partner agency. This data can inform those who are developing plans for system improvement of possible age groups of children and youth throughout Idaho needing improved access to care.

Table 3: Distribution of Presumed Class Members by Age

Age	Medicaid	Medicaid	DBH	DBH	FACS	FACS	IDJC	IDJC	SDE*	SDE*
	#	%	#	%	#	%	#	%	#	%
0-4	477	3.6%	6	0.3%	83	16.6%	0	0%	NA	NA
5-9	4,363	32.8%	89	5.3%	119	23.8%	0	0%	203	15.1%
10-13	4,221	31.8%	277	16.6%	104	20.1%	22	10.4%	529	39.4%
14-17	4,231	31.8%	1301	77.8%	194	38.8%	189	89.6%	611	45.%

Percentages shown indicate % of presumed Class Member population each age group represents for each State agency.

Children ages 5-9:

- May be underserved in DBH. It is notable that this discrepancy may be due to the target population for DBH services being those in crisis or court-ordered.
- May be under-identified in FACS and in schools.

Children/youth ages 10-13:

- May be underserved in DBH. As noted previously, this may be due to the target population being those in crisis or court ordered.
- May be under-identified in FACS.

Youth ages 14-17:

- Expected prevalence is 21.4% to 22.2% for a mental illness.
- May be underserved in less restrictive levels of care as they make up the largest number of children and youth in any age group in DBH, FACS, and SDE.

**Please note SDE data has been updated to reflect Idaho State Department of Education 618 Part B Child Count Report 2015-2016. Previous QMIA report data was sourced from 2014-2015 report.*

Youth and Family Engagement

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

DBH administers an annual satisfaction survey to families of children and youth receiving its services. The survey instrument is the Youth Satisfaction Survey for Families (YSS-F). In the most recent survey, the results on several items related to family engagement are noted in Table 4.

*Although the response rate for this survey is quite low (n=41), it is consistent with the National average survey response rate. Generally, this response pool would be considered of low reliability and statistical significance, therefore we are not considering this sample an accurate representation of our

state. It is important to note, however, that these results are meaningful and were therefore included here because time was taken by families to complete this survey and share their experiences, which all have value. The below data allows us limited insight into youth and family perception of our current service delivery system. As we move forward in this system transition, we will see a myriad of comprehensive, significant and reliable data become available.

Table 4: Youth Satisfaction Survey – Family version Outcomes, SFY 2016.

YSS-F Items	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
I helped to choose my child's treatment goals.	21 (51.22%)	10 (24.39%)	1 (2.44%)	4 (9.76%)	3 (7.32%)	2 (4.88%)
I was given the opportunity to participate in my child's treatment.	22 (53.66%)	13 (31.71%)	2 (4.88%)	2 (4.88%)	1 (2.44%)	1 (2.44%)
Staff members were willing to see my child as often as I felt was necessary.	19 (46.34%)	13 (31.71%)	4 (9.76%)	3 (7.32%)	2 (4.88%)	0 (0%)

Appropriateness

An appropriate use of services is demonstrated by a match between needs and strengths to services that are sufficient to effectively address client intensity and types of needs. The data regarding current services delivery and utilization can be used to assess system gaps for additional and/or alternative types of services that may be needed.

One method to measure the appropriate use of services is a comparison of services used in Idaho to the national average.

Table 5: Comparison of State and National Medicaid Behavioral Health Utilization of Specific Services

	Members Currently Served by Division of Medicaid and Behavioral Health Type of Service					
	Individual Therapy by Non-Prescriber	Family Therapy	Medication Management		MH Assessment/ Tx. Plans	Case Mgmt.
			Psychiatric Diagnostic Evaluation	Prescriber Visits		
National %	53.1%	19.4%	22.3%		8.8%	8.7%
Idaho Medicaid %	28.1%	22.8%	30.2%		11.1%	7.8%
Variance	-25.0%	3.4%	7.9%		2.3%	-0.9%

- The percentage of medication management services for Medicaid appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho.
- Psychotherapy appears to be accessed significantly less in Idaho than it is accessed nationally.

Another measure of appropriateness of care available in Idaho is the rate of evidence-based practices (EBPs) used in Idaho by DBH compared to national rates. Per the Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) report, there is a comparison of two EBPs used in Idaho to national stats:

- Multi-systemic Therapy (MST): 4.6% nationally, 3.6% Idaho
- Functional family therapy (FFT): 4.8% nationally, 5.6% Idaho

Another EBP used in Idaho by DBH is Parenting with Love and Limits (PLL).

Table 6: Count of Families by Region served by Parenting with Love and Limits (PLL) fiscal year to date March 2017:

	PLL (SED)							Statewide total
Regions	1	2	3	4	5	6	7	
# families enrolled	13	14	9	23	27	17	31	134

As of March 2017, DBH has served 13 families in Region 1, 14 from Region 2, 9 families in Region 3, 23 from Region 4, 27 from region 5, 17 from region 6 and 31 families from region 7 (fiscal year to date.)

Effectiveness

Service effectiveness means that services are effective and efficient at supporting clients in meeting their goals. The more that children, youth, and families must depend on access to more restrictive levels of care, the more likely it is that the system may not be effectively or efficiently providing less restrictive levels of care. An example of this would be a child or youth who has been placed in a residential facility, but based on their needs, could be living at home if they had appropriate and effective community supports. For this reason, measures of effectiveness include assessing the use of restrictive levels of care. The following is current utilization information regarding children and youth who are involved in the DBH system.

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

Table 7 provides data about the use of Idaho Statute 20-511A which is a rule whereby a judge can order DHW to submit to the court a mental health assessment and a plan of treatment for a youth. Data is for fiscal year to date (YTD) through March 2017.

Table 7: Utilization of Rule 20-511A

	20-511A							Statewide total
Regions	1	2	3	4	5	6	7	
20-511A utilization	30	26	39	93	53	30	92	363

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

Tables 8 and 9 provide information about the use of hospitalization in State Hospital South and the use of Residential Services (out of home Placements). This data will be tracked and trended over time to assess changes in the utilization of these intensive services. Data is YTD.

Table 8: Utilization of State Hospital South (SHS):

	State Hospital South Usage							Statewide total
Regions	1	2	3	4	5	6	7	
# of utilizers	8	2	19	32	11	3	9	84

The above table shows the number of children/youth utilizing State Hospital South categorized by region.

Table 9: Utilization of Residential placements:

	Residential Placements							Statewide total
Regions	1	2	3	4	5	6	7	
# of placements	3	4	7	18	3	4	1	40

The above table shows the number of children/youth in residential placements categorized by region.

Linkages

The final category of data for this QMIA-Q is associated with cross-system linkage. This initial data is limited to data from the DBH client satisfaction survey. The items from the survey below indicate how the family felt about the effectiveness of the support they received that allowed them to experience gains that are meaningful in their communities.

DBH administers an annual satisfaction survey to families of children and youth receiving services from DBH. The survey instrument is the Youth Satisfaction Survey for Families (YSS-F). In the most recent survey, the results on several items related to linkages are noted in Table 10.

*Although the response rate for this survey is quite low (n=41), it is consistent with the National average survey response rate. Generally, this response pool would be considered of low reliability and statistical significance, therefore we are not considering this sample an accurate representation of our state. It is important to note, however that these results are meaningful and were therefore included here because time was taken by these families to complete this survey and share their experiences, which all have value. The below data allows us limited insight into youth and family perception of our current service delivery system. As we move forward in this system transition, we will see a myriad of comprehensive, significant and reliable data become available.

Table 10: Youth Satisfaction Survey – Family version Outcomes, SFY 2016.

YSS-F Items	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not applicable
My child is better at handling daily life	10 (24.39%)	18 (43.9%)	4 (9.76%)	5 (12.2%)	2 (4.88%)	2 (4.88%)
My child gets along better with family members	10 (24.39%)	16 (39.02%)	7 (17.07%)	2 (4.88%)	4 (9.76%)	2 (4.88%)
My child is better able to do things he or she wants to do	5 (12.2%)	19 (46.34%)	7 (17.07%)	4 (9.76%)	4 (9.76%)	2 (4.88%)

Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Of special note:
Comparison for SED and ED
These two terms are similar but are not synonymous.

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

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