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

6th Quarterly Report

July 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 Report.

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 at: http://youthempowermentservices.idaho.gov

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 sixth of the Youth Empowerment Services (YES) Quality Management Improvement and Accountability Quarterly (QMIA-Q) reports to be published. 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:

- YES Class Size Estimation
- Independent Assessment Process
- CANS 50 and CMH CANS Data
- Wraparound Utilization
- Training Information
- Complaints and Appeals
- Quality Improvement Projects

This report has been formatted of 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 email YES@dhw.idaho.gov with your questions, concerns, or suggestions.

Note: Idaho's Division of Behavioral Health regions are referenced in this report. A regional map has been provided for reference on page 19, Appendix A.

Who will YES serve?

Youth Empowerment Services Class Size Estimation

The YES QMIA Data and Reports Subcommittee is charged with providing an annual estimate of how many children in the state of Idaho have a serious emotional disturbance (SED), and subsequently could be classified as YES Class Members. This is the second class-size estimation report to be produced. The YES Class Size Estimation Team (CSET) consisted of data and quality assurance staff from the divisions of Medicaid and Behavioral Health.

Methodology

The Department of Health and Welfare contracted with Boise State University (BSU) School of Social Work to evaluate the methodology used by the CSET to formulate the previous year's class size estimation. BSU found that the claims data-based methodology used in the previous estimate was acceptable, considering the limited data that was available to CSET at the time. BSU did note, however, that using claims data is not ideal for future estimations, as this only captures information about youth that are currently being served within the data contributing systems. Within BSU's report, a recommendation was made for future CSET efforts to include an in-depth review of existing literature to inform the estimation. The full report from BSU, titled *Evaluation of a Methodology to Estimate the Prevalence of Serious Emotional Disturbance in Idaho, Williams 2017*, can be found here.

For this estimate, data limitations remained, and therefore the CSET focused on conducting a thorough, research-centered approach. Six studies and five claims-based estimates were used to inform the CSET report. These 11 sources were weighted based on factors such as study size, relevance, and fidelity. Studies that were conducted with greater fidelity were weighted more than those based on claims data.

Below is a forest plot of the estimated ranges of the studies and estimates consulted in this report. Report findings regarding the potential number of children with SED in Idaho is marked by the vertical blue line.

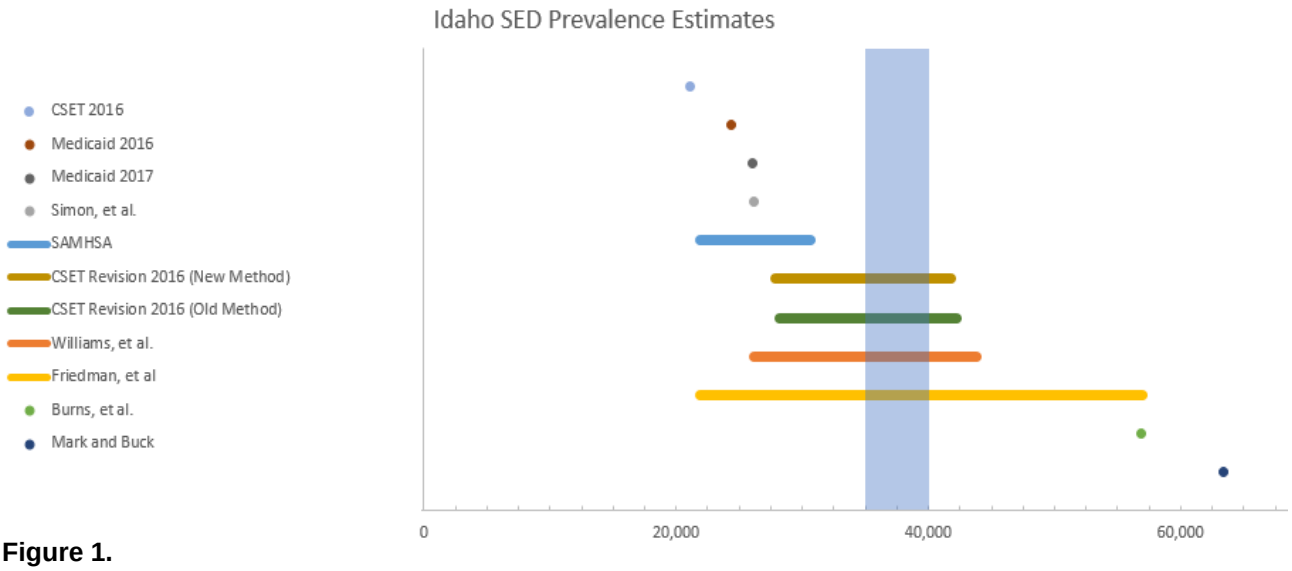


Figure 1.
Data Source: *YES Class Size Estimation Team (2017/18)*

Findings

After combining the weighted studies and estimates, the CSET estimated that there are potentially 35,000-40,000 children in the state of Idaho who have a serious emotional disturbance (SED).

It is important to note that the above-mentioned estimate is not reflective of the number of youth expected to engage in services through YES. As per the research, in the most engaged scenarios, only about half of children with serious mental health conditions will receive mental health services. Studies consulted for this estimate found levels of service engagement ranging from 34-56%. No study yet identified has found a service engagement rate higher than 56%. Based on this research, it is suggested that the maximum potential number of Idaho youth with SED who seek and receive services will be between **12,000-22,000**. This estimate includes youth who may receive services through private insurance.

Future Work

Moving forward, the CSET intends to continue collecting available data, studies and research to further inform and improve this estimate. It is expected that the next estimate will be informed by the following:

- 1 full year of Child Adolescent Needs and Strengths (CANS) data
- Class membership eligibility
- Level of care results
- Class Member demographics
- Engagement and drop-out rates
- Rate of newly Medicaid eligible Class Members

With this data, the CSET will be better equipped to make a more accurate, Idaho-specific estimate of class size and engagement.

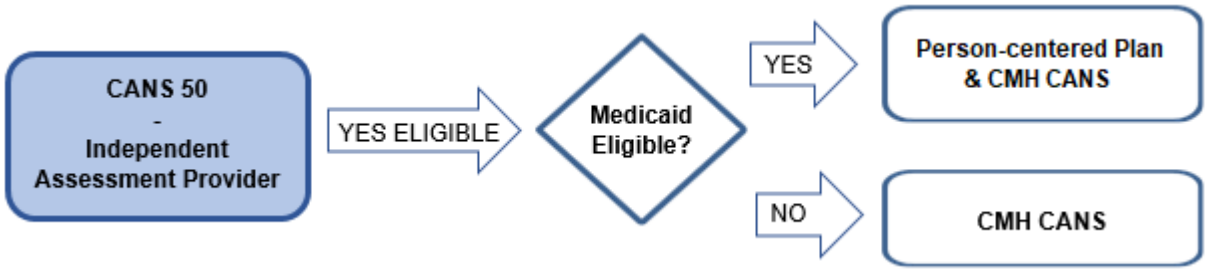
The full CSET report has been published on the Youth Empowerment Services website and can be found here.

Who are we serving now?

Independent Assessment Process

To increase access to services, Medicaid developed and submitted a 1915(i)-state plan option application to the Centers for Medicare and Medicaid Services (CMS) that establishes eligibility to Medicaid for YES program class members with family incomes from 150-300% of the federal poverty level (FPL). 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 the CANS 50 to determine Youth Empowerment Services Class Membership.

The CANS 50 is a subset to the Children's Mental Health (CMH) CANS that was used during this reporting period to determine YES Class Membership and subsequent Medicaid eligibility.



Figures 2-5.
Data Source: *YES ICANS System (March 2018)*

From January 1 to March 31, 2018, 352 CANS 50s were completed for 340 youth.

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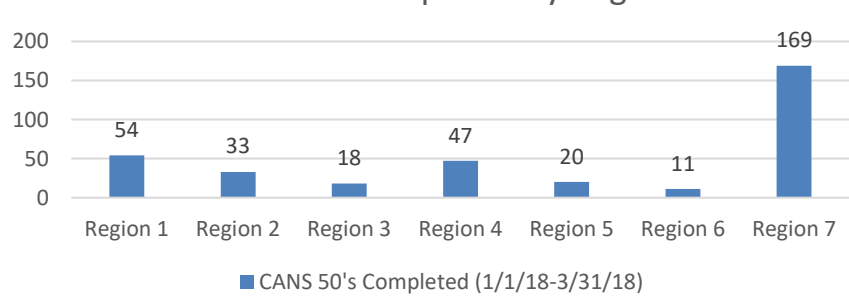

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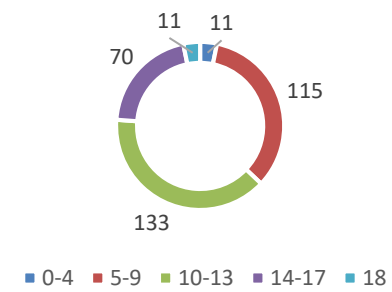

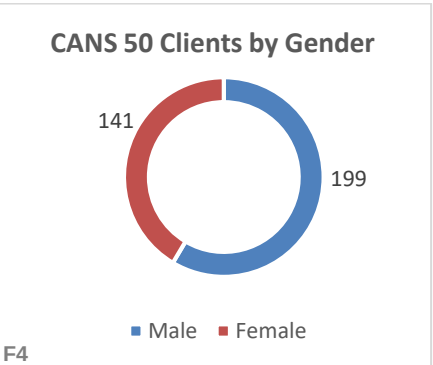

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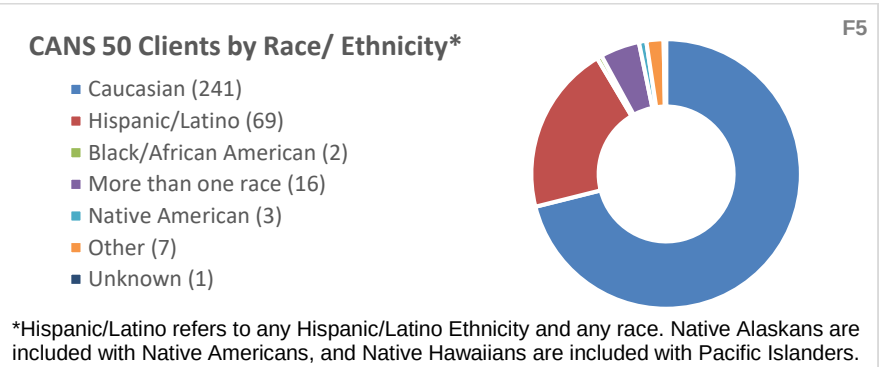

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*Hispanic/Latino refers to any Hispanic/Latino Ethnicity and any race. Native Alaskans are included with Native Americans, and Native Hawaiians are included with Pacific Islanders.

According to the data displayed in Figure 2, The Independent Assessors in Region 7 have completed almost half of the total CANS 50 assessments within the reporting period (48%), followed by Region 1 (15%), Region 4 (13%), Region 2 (9%), Region 5 (6%), Region 3 (5%), and then Region 6 (3%).

Most of the youth who were seen by the IAP during this period were between the ages of 10-13 (39%) and 5-9 (34%). An interesting note: about 3% of children who had a CANS 50 completed were under the age of five.

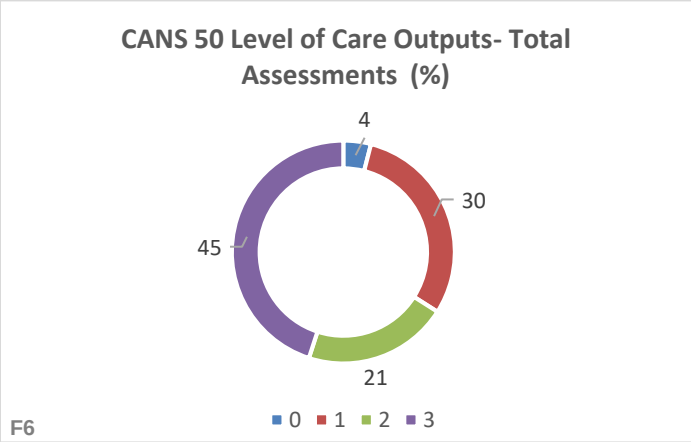
Additional demographic data from figures 4 and 5 show that the majority of youth who were given a CANS 50 during this period were male (59%) and reported Non-Hispanic Caucasian as their Race/Ethnicity (71%).

CANS 50: Recommended Level of Care

When a CANS is completed, a total 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 Class Membership 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 requires extensive service collaboration
- **3**: SED identified, child/youth is considered to have high treatment needs and is at risk of out of home placement

Figures 6 & 7.
Data Source: *YES ICANS System (March 2018)*



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CANS 50 Recommended Level of Care Outputs- Individual Youth Count		
CANS LoCG	# of Youth	% of Youth
0	8	2%
1	99	29%
2	74	22%
3	159	47%
Total	340	100%

According to Figure 7 above, it appears that only a small percentage (2%) of youth who received a CANS 50 from the IAP were not found to meet Class Membership criteria and therefore were not eligible for YES services. Nearly half (47%) of the youth who were assessed by the IAP received a CANS 50 recommended level of care designation of 3, followed by recommended level of care 1 (29%) and recommended level of care 2 (22%).

It is hypothesized that youth and families with the highest needs are more likely to be those who will have received information and accessed YES through the IAP before those who have less intensive needs. As youth continue to enter the system through the IAP, it is expected that the CANS 50 output will begin to show a more even level of care distribution, and potentially a lower percentage of youth with a recommended level of care of 3.

CANS 50: Primary Diagnostic Category

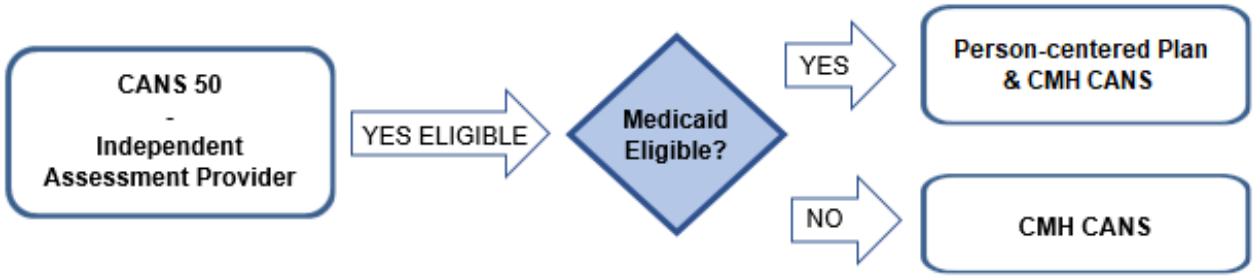
The following table identifies the primary diagnostic categories of the youth who were referred to the Independent Assessment Provider. The most prevalent diagnostic category for these youths was behavioral and emotional disorders with childhood onset (46%). Examples of diagnoses within this category are conduct disorder, attention-deficit hyperactivity disorder, oppositional defiant disorder, and reactive attachment disorder. A full categorized list of diagnoses can be found here.

Figure 8.

Data Source: *YES ICANS System (March 2018)*

CANS 50; Youth's Primary Mental Health Diagnostic Category		
Diagnostic Category of Primary Diagnosis	**# of Youth**	**% of Youth**
Behavioral and emotional disorders with childhood onset	158	46.4%
Neurotic, stress-related and somatoform disorders	87	25.6%
Mood [affective] disorders	72	21.2%
Disorders of psychological development	14	4.1%
Encounter for observation for other suspected diseases and conditions ruled out	5	1.5%
Disorders of adult personality and behavior	3	0.9%
Schizophrenia, schizotypal, and delusional disorders	1	0.3%
Total	340	100%

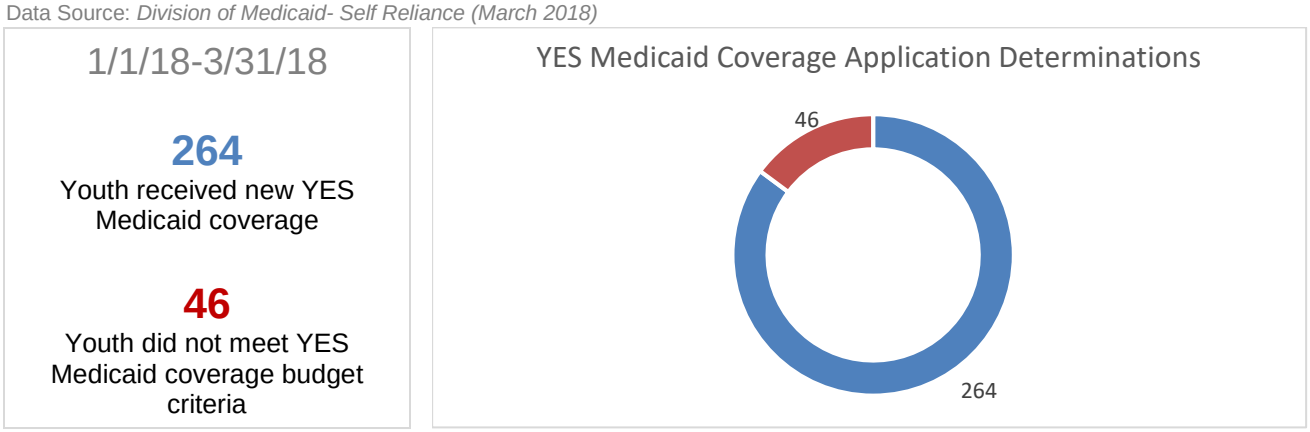
Youth Newly Eligible for Medicaid Coverage



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).

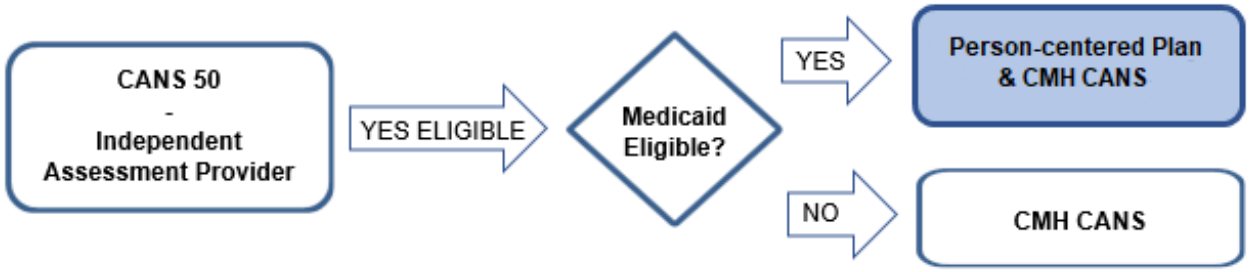
Figure 9.

Data Source: *Division of Medicaid- Self Reliance (March 2018)*



As of March 31st, 264 youth received YES Medicaid coverage and 46 youth had a family income exceeding 300% of the federal poverty level and didn't qualifying for Medicaid coverage. Planning is currently under way to develop a process that will provide access to YES services for this population.

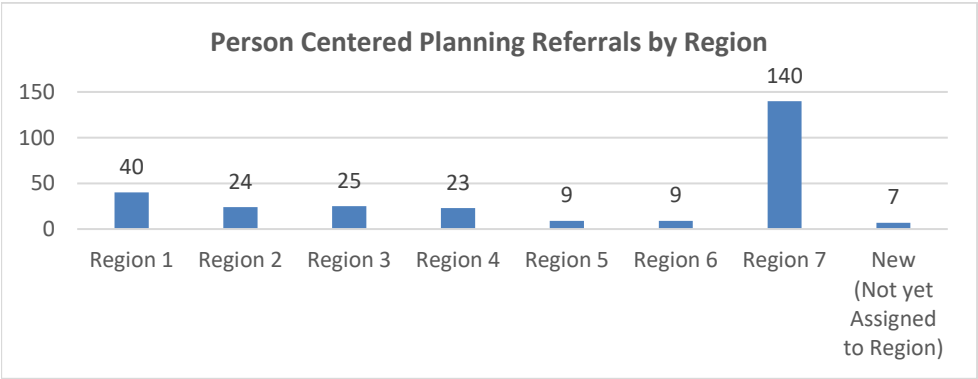
Person-Centered Planning



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.

Figure 10.
Data Source: *Division of Behavioral Health (March 2018)*



Person Centered Plans 1/1/2018-3/31/2018	
Total # of Referrals	277
# Completed	71
Average Completion Time (days)	54.9

As of March 31st, Region 7 had received over 50% of the referrals to complete a Person-centered Plan. This is a direct reflection of the number of youth who were seen by the Independent Assessment Provider for a CANS 50 in Region 7. QMIA will continue to monitor the Person Centered Planning process, which includes determining a timeliness performance goal for plan completion.

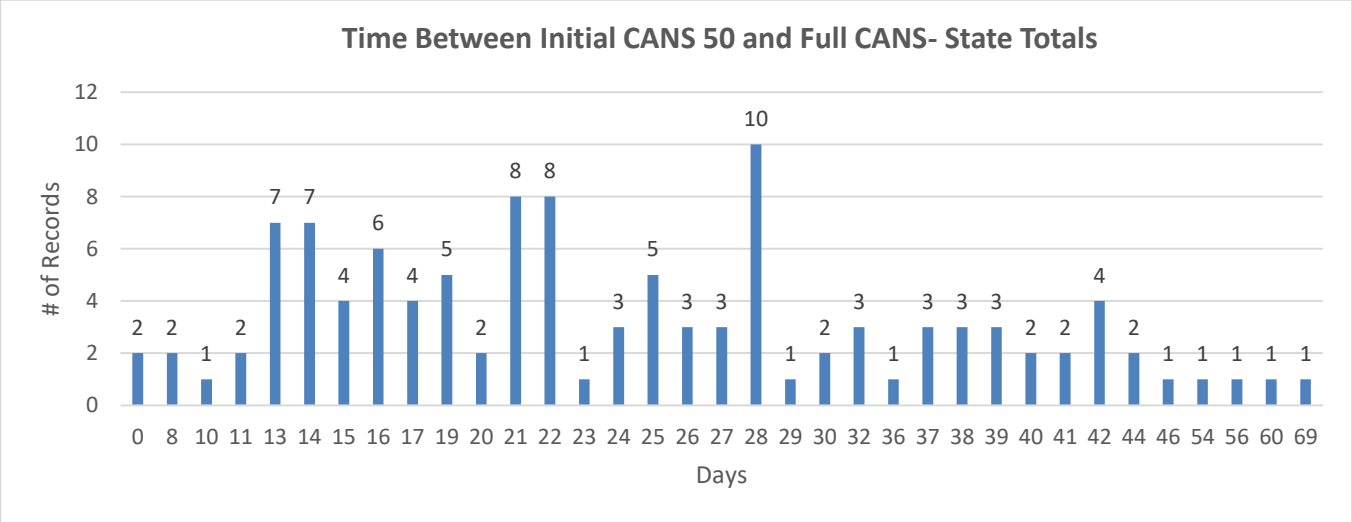
CANS Timeliness- CANS 50 to CMH CANS

Transformational Collaborative Outcomes Management (TCOM) value in monitoring timeliness in terms of the family and child experience:"When a child needs help, they get it immediately, and easily."

The sooner a youth and family complete the CMH CANS, the sooner an individualized treatment plan can be developed to best meet their needs.

The following figures show the time in days between when a youth received a CANS 50 and when they received a CMH CANS. For this analysis, only youth who received a CANS 50 before the CMH CANS were considered. Youth who were involved in the CANS pilot would have received a CMH CANS prior to the CANS 50 being available, and therefore would not be included here.

Figure 11.
Data Source: *YES ICANS System (March 2018)*



Time Between a CANS 50 Assessment and a CMH CANS Assessment (January-March 2018) *

	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	State
# of Clients	18	10	10	10	2	5	59	114
Median Time (days)[1]	25.5	23.0	15.0	15.0	43.5	21.0	24.0	22.0
Minimum[2]	8	8	13	0	27	15	0	0
Maximum[3]	42	44	69	27	60	28	56	69

*Those who completed a CANS 50 assessment prior to a CMH CANS assessment, with both assessments completed between 1/1- 3/31
[1]Median number of days between CANS 50 assessment completion and CMH CANS assessment completion
[2]Minimum number of days between CANS 50 assessment completion and CMH CANS assessment completion
[3]Maximum number of days between CANS 50 assessment completion and CMH CANS assessment completion

The graph in Figure 11 shows state-wide timeliness from completion of the CANS 50 to the start of the CMH CANS for 114 youth who received both assessments between January and March. This graph breaks down the number of youth that received both assessments by the amount of days between them, for example; 10 youth received both the CANS 50 and CMH CANS within 28 days, 16 youth were administered both the CANS 50 and CMH CANS within 21-22 days, 1 youth had a 69-day span between the CANS 50 and CMH CANS, etc. The table in Figure 11 shows the median, maximum and minimum time between the CANS 50 and CMH CANS by region as well as state-wide.

It is important to note that this is a new process for the Division of Behavioral Health regional offices, each of which are working through the change in operations and re-allocation of clinicians' roles and

time. The volume of cases per region also has an impact on timeliness, although Region 7, despite heavy volume has a median time between assessments of 24 days which is not far from the statewide median of 22 days. Timeliness will continue to be tracked and monitored as time goes on and the data becomes more stable and less influenced by the impact of a new process.

Statement of limitation: It is important to note that a youth's CANS 50 assessment data was matched to their CMH CANS assessment data using a combination of the client's name and date of birth. The Division of Behavioral Health Analytics Team has recognized that while this matching process is currently the best available, it is imperfect. Therefore, there may be a small number of clients not represented here who completed both the CANS 50 and CMH CANS assessments. Though the number of clients whose assessment data cannot be matched has been determined to be small and should not particularly impact overall trends, their potential absence should be noted when interpreting this data. A small workgroup has convened to develop a methodology for a Unique Client Identifier (UCI) that will enable more successful data matching.

Children's Mental Health (CMH) CANS

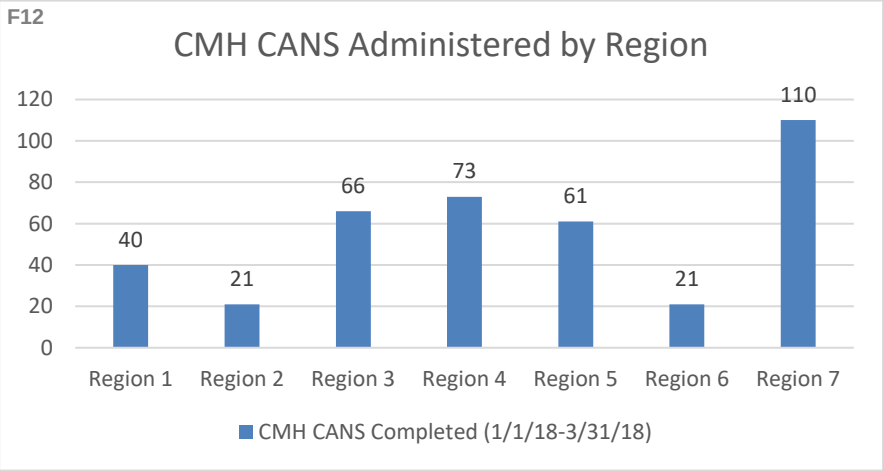
The CMH CANS:

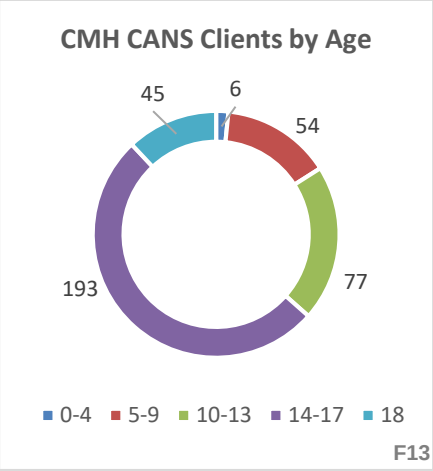
- Assesses youth's individual and family strengths and needs
    - If a CANS 50 was completed beforehand, this information will be used as a foundation for the CMH CANS
- Supports clinical decision-making and practice, including treatment plans and level of care decisions
- Measures and communicate outcomes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

The CMH CANS is currently exclusively being administered by regional Division of Behavioral Health clinicians. CANS expansion to the Idaho Behavioral Health Provider network is planned to begin in July of 2018.

Figures 12-15.
Data Source: *YES ICANS System (March 2018)*

From January 1 to March 31, 2018 392 CMH CANS were administered for 375 youth





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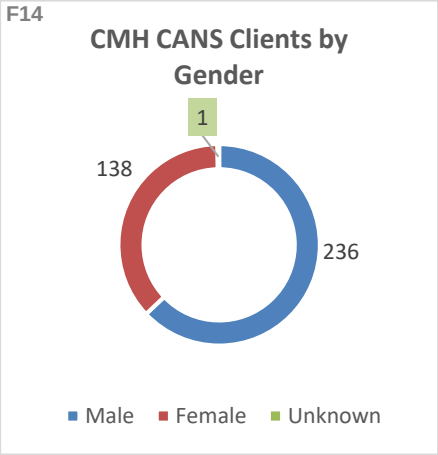

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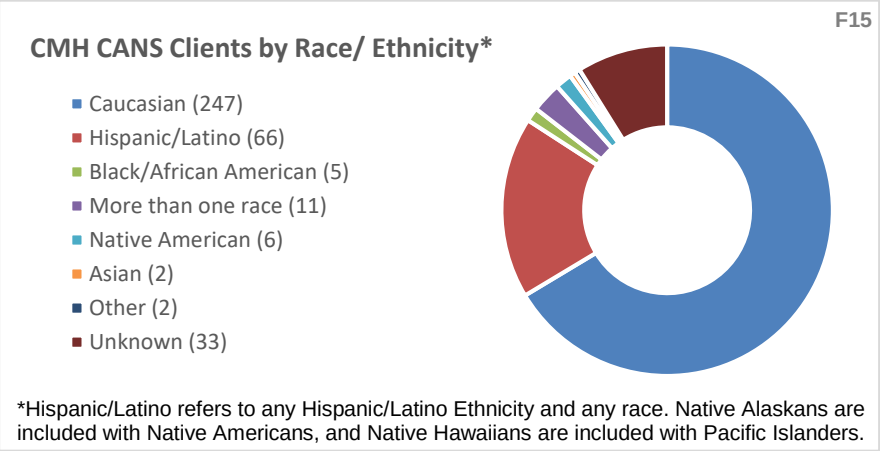


*Hispanic/Latino refers to any Hispanic/Latino Ethnicity and any race. Native Alaskans are included with Native Americans, and Native Hawaiians are included with Pacific Islanders.

For this reporting period, there were 392 CMH CANS administered for 375 youth. These CMH CANS assessments were administered for youth in one of the following situations:

- Following positive YES Class Membership determination through the CANS 50/ Independent Assessment Provider
- Initial CMH CANS for an existing Division of Behavioral Health youth client
- CMH CANS update- 90 days following initial assesment or as otherwise appropriate
- CMH CANS at discharge from services

Out of the 392 CMH CANS, Region 7 administered 28%, followed by Regions 4 (19%), 3 (17%), 5 (16%), 1 (10%), and both Regions 2 and 6 with 5% respectively.

Slightly more than half of the youth who were administered a CMH CANS were between the ages of 14-17 (51%), differing from the CANS 50 demographics in which most youth were between the ages of 5-13. Similar to the CANS 50, the majority of youth who were administered a CMH CANS during this period were male (63%), and were reported as Non-Hispanic Caucasian (66%).

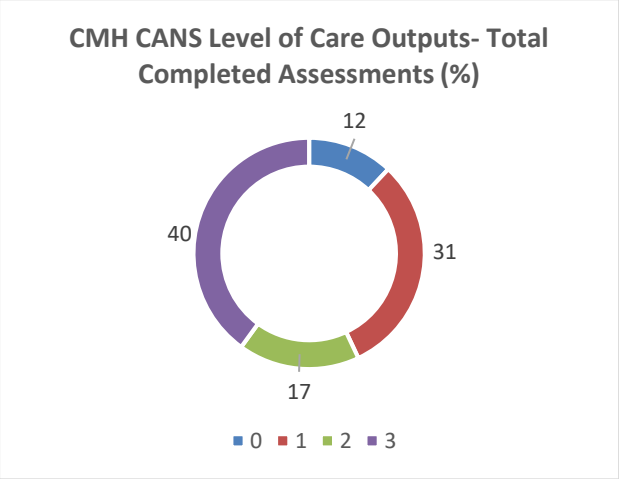
It is important to note that the CMH CANS that were administered within the reporting period are not necessarily representative of all of the youth who were administered a CANS 50. Not all youth who receive a CMH CANS will access YES through the Independent Assessment Provider, and therefore not all youth will receive a CANS 50. In addition, as data in previous sections has shown, the CMH CANS may have been initiated up to 60+ days following the CANS 50. Finally, it is important to reiterate that data matching has been identified as a limitation for the QMIA Data and Reports team, although a plan to address this is underway.

CMH CANS: Recommended Level of Care

When a CANS is completed, a total 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 Class Membership 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 requires 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 16.
Data Source: *YES ICANS System (March 2018)*



CMH CANS Recommended Level of Care Outputs 1/1/18-3/31/18		
CANS LoCG	# of Assessments	% of Assessments
0	43	12%
1	110	31%
2	63	17%
3	142	40%
Total	358	100%

*34 CANS in progress/Incomplete

Out of the 358 completed CMH CANS assessments, 40% were completed with a recommended level of care output of 3, followed by recommended level of care 1 (31%) and recommended level of care 2 (17%). There is a smaller percentage gap between the recommended levels of care 1 and 3 than what was seen with the CANS 50 level of care output data. Of the completed CMH CANS, 12% resulted in a recommended level of care output of 0.

CMH CANS: Primary Diagnostic Category

The following table identifies the primary diagnostic categories of the youth who were administered a CMH CANS. Similar to the CANS 50 referrals, cited earlier in this report, the most prevalent diagnostic category for these youths was Behavioral and emotional disorders with childhood onset (36%). Examples of diagnoses within this category are Conduct disorder, Attention-deficit hyperactivity disorder, Oppositional defiant disorder, and Reactive attachment disorder. A full categorized list of diagnoses can be found here.

Figure 17.
Data Source: *YES ICANS System (March 2018)*

CMH CANS; Youth's Primary Mental Health Diagnostic Category		
Diagnostic Category of Primary Diagnosis	**# of Youth**	**% of Youth**
Behavioral and emotional disorders with childhood onset	135	36%
Neurotic, stress-related and somatoform disorders	95	25.3%
Mood [affective] disorders	91	24.3%
Disorders of psychological development	19	5.1%
Other	19	5.1%
Mental retardation	5	1.3%
Schizophrenia, schizotypal, and delusional disorders	5	1.3%
Disorders of adult personality and behavior	3	0.8%
Encounter for observation for other suspected diseases and conditions ruled out	2	0.5%
Mental disorders due to known physiological conditions	1	0.3%
Total	375	100%

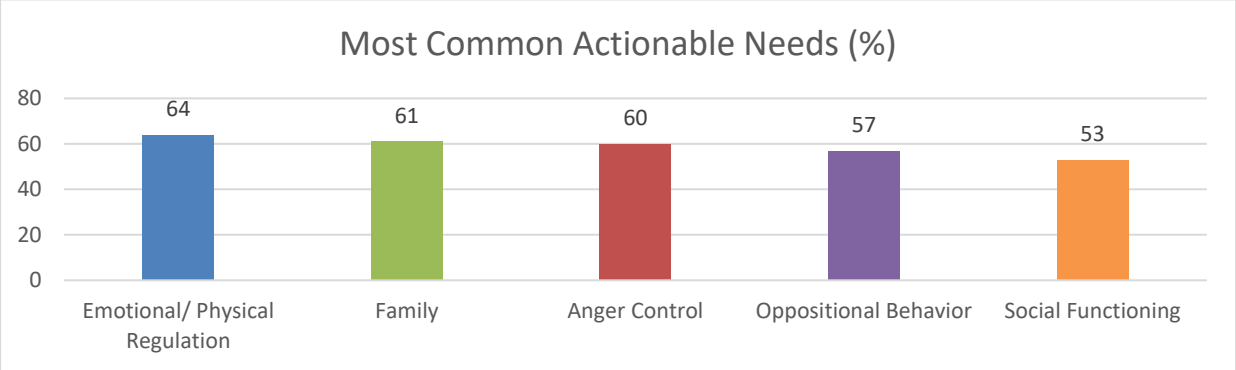
CMH CANS: Youth Needs and Strengths

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 its serving. Identifying the most prevalent system-wide needs could indicate that the addition of services and supports targeted to address these needs should be explored, or help determine which evidence based practices may be a valuable investment. Clinicians who administer the CANS have the opportunity to view this type of report at the individual client or caseload level, allowing for individualization of treatment and approach.

The following figure shows the most prevalent actionable needs of the 375 youth who were administered a CANS between January and March. For youth who had more than one CANS on file, identified needs from their most recent CANS were reported.

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 the problem is interfering with functioning and requires action or intervention to ensure that the need is addressed. A rating of 3 indicates the problem is dangerous or disabling and requires immediate and/or intensive action.

Figure 18.
Data Source: *YES ICANS System (March 2018)*



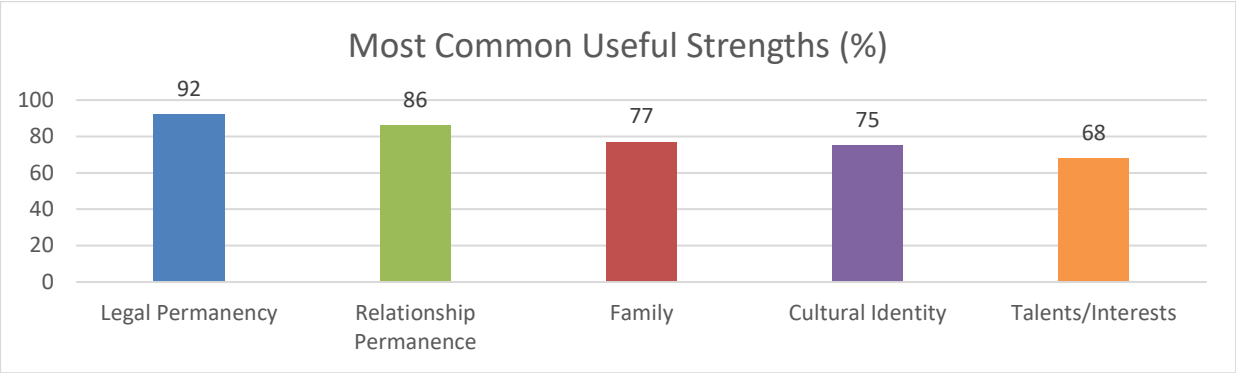
Emotional/ Physical Regulation		Family		Anger Control		Oppositional Behavior		Social Functioning	
#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
239	64%	229	61%	226	60%	213	57%	197	53%

According to the above figure, 64% of youth within this cohort had emotional/physical regulation identified as an actionable treatment need, followed by family (61%), anger control (60%), oppositional behavior (57%) and social functioning (53%).

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 375 youth who were administered a CANS between January and March. For youth who had more than one CANS on file, identified strengths from their most recent CANS were reported.

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.

Figure 19.
Data Source: *YES ICANS System (March 2018)*



Legal Permanency		Relationship Permanence		Family		Cultural Identity		Talents/Interests	
#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
346	92%	322	86%	289	77%	283	75%	254	68%

According to the figure above, 92% of youth within this cohort had legal permanency identified as a useful strength, followed by relationship permanence (86%), family (77%), cultural identity (75%) and talents/interests (68%).

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 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 item 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

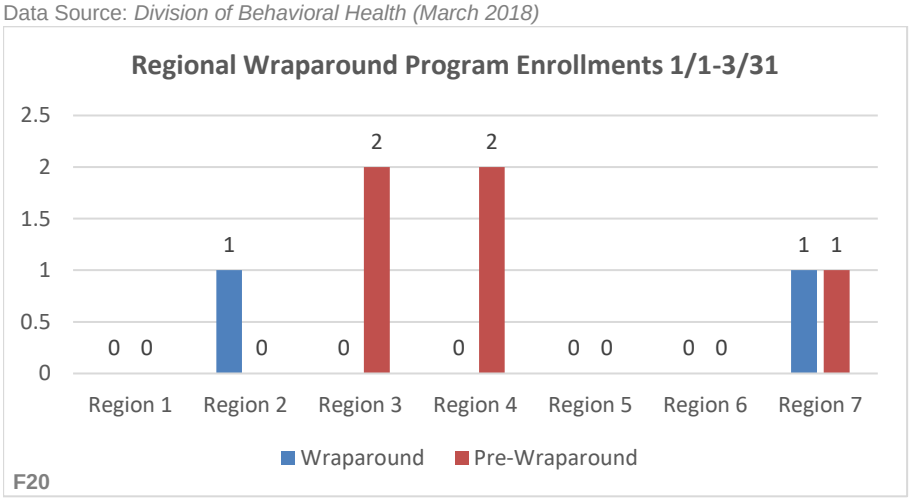
A Wraparound utilization report was recently completed by Boise State University (BSU) School of Social Work to estimate the number of youth who are likely to need/use Intensive Care Coordination (ICC). BSU's report suggested that 1,350 Idaho youth would have benefited from Intensive Care Coordination 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 presented with more detail in the previous quarterly report, and the full report, titled "Estimated Need for Intensive Care Coordination among Idaho Youth" can be found on the Youth Empowerment Services website.

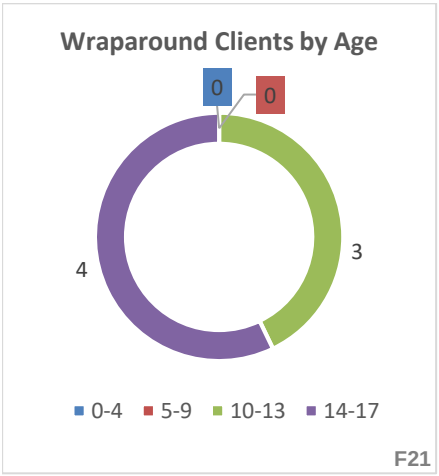
The "emerging program" utilization goal for the YES Wraparound program is that all seven Division of Behavioral Health Regional Program Specialists will have an initial caseload of four families.

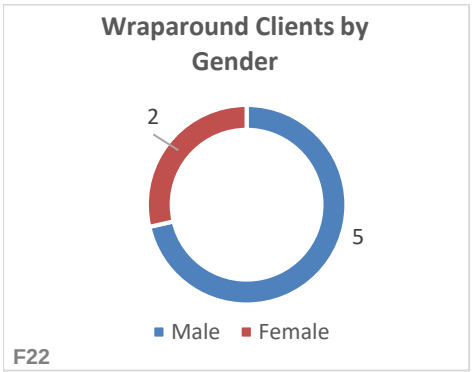
The Division of Behavioral Health began enrolling currently served youth into Wraparound programs in February 2018. From January 1st to March 31st, 2018, there were seven youth enrolled in Wraparound or Pre-wraparound. The Pre-wraparound program designation is used when families are considering wraparound or have agreed to Wraparound, but have not started yet.

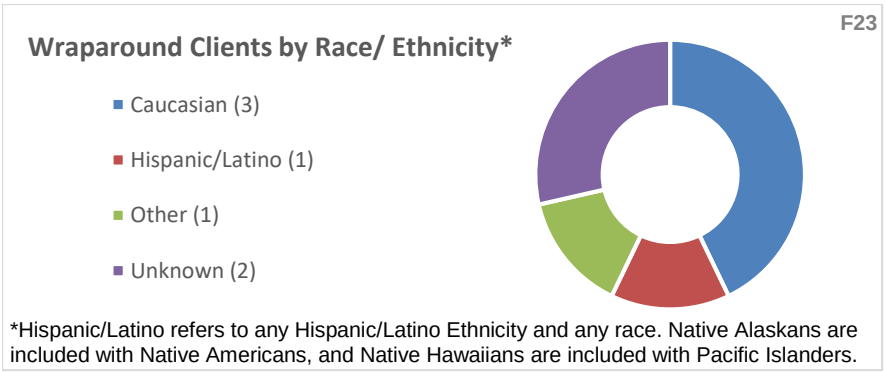
Regional and demographic information for youth enrolled in a Wraparound program is displayed below:

Figures 20-23.
Data Source: *Division of Behavioral Health (March 2018)*









*Hispanic/Latino refers to any Hispanic/Latino Ethnicity and any race. Native Alaskans are included with Native Americans, and Native Hawaiians are included with Pacific Islanders.

As of March 31st, out of the seven youth currently being served by DBH regional offices, three youth were enrolled in Wraparound, and four in Pre-wraparound. Regions 2, 3, 4 and 7 were serving youth within these programs at the time of the analysis. The age range of youth being served was 11-17.

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 Transformational Collaborative Outcomes Management (TCOM) Fundamental Tenet:

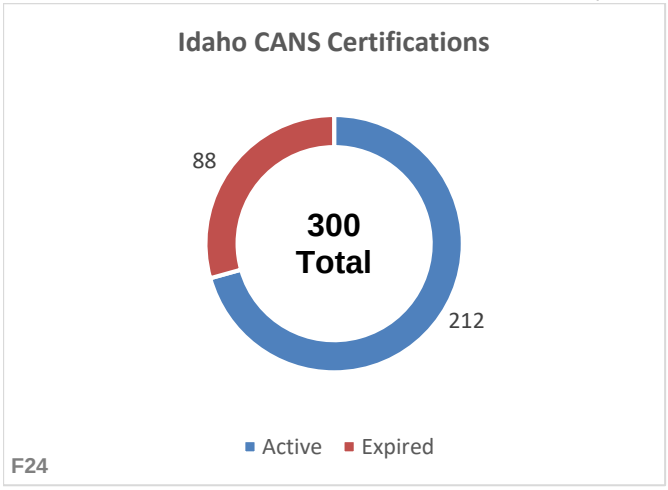
- A required focus of a shared vision of the children and families receiving services
- Collaboration of multiple partners
- Communication facilitation among partners, including youth and families
- Shared commitment to serving youth and families despite differences
- Collective accountability to the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

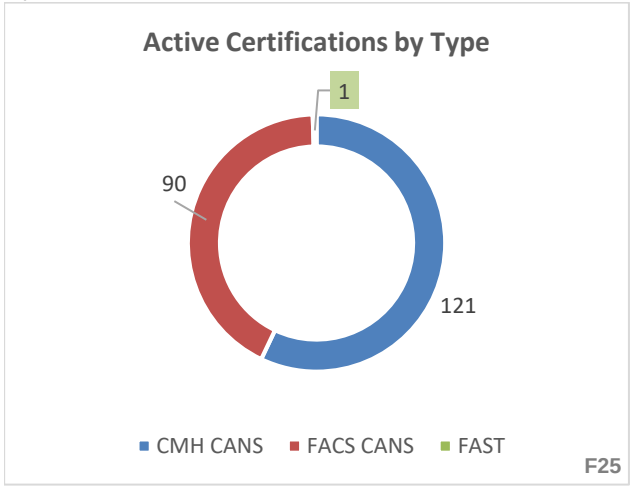
The number of providers and key individuals who are CANS-certified represents system progress toward improved youth and family engagement practices and meaningful change.

Idaho CANS Certifications as of 3/31/2018

Figures 24 & 25.

Data Source: *Division of Behavioral Health, Praed Foundation (March 2018)*





A few notes about the CANS and other communimetric tools in Idaho:

- Since 2015, 300 providers and stakeholders have become CANS certified. Certification is valid for one year. As of March 31st, 2018, there were 212 individuals with active CANS certifications in Idaho, an increase from 179 in November 2017.
- CMH CANS stands for Children's Mental Health CANS. The FACS CANS tool is used in the Division of Family and Community Services.
- The Family Advocacy and Support Tool (FAST) is designed to maximize communication about the needs and strengths of families. There is currently 1 active FAST certification in Idaho.

CANS Trainings

The following information was extracted from Division of Behavioral Health YES Training Reports for January through March 2018. In addition to tracking training attendance, this report also includes survey data which captures trainee's experiences and is used to guide the future delivery of trainings.

Figure 26.
Data Source: *YES Training Specialist, Division of Behavioral Health (March 2018)*

Training	Date/s	Location	Total Trained	# In Person	# Webinar
CANS for Stakeholders	1/18-1/19	Boise	149	86	63
CANS for Stakeholders	1/25-1/26	Coeur d' Alene	55	32	23
CANS for Stakeholders	2/14	Idaho Falls	27	12	15
CANS for Stakeholders	2/15	Idaho Falls	42	30	12

Description of CANS for Stakeholders Training: This training will educate parents, caregivers and other stakeholders on the Child and Adolescent Needs and Strengths (CANS) that will be used as the assessment tool in the new system of care. Training focuses on what to expect during the assessment and how a provider will use the results to inform treatment planning.

Other YES Trainings

Figure 27.
Data Source: *YES Training Specialist, Division of Behavioral Health (March 2018)*

Training	Date/s	Location	Total Trained		# In Person	# Webinar
Wraparound Coordinator and Implementation	1/29-2/2	Boise	Division of Behavioral Health/ Children's Mental Health	20	25	N/A
			Division of Medicaid	1		
			Developmental Disabilities	1		
			Optum	3		
			Total	25		
YES Foundations	1/18-1/19	Boise	164		91	73
YES Foundations	1/25-1/26	Coeur d' Alene	65		43	22
YES Foundations	2/14	Idaho Falls	47		19	28
YES Foundations	2/15	Idaho Falls	26		16	10

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

Description of YES Foundations Training: The purpose of this training is to prepare families and other stakeholders for the new system of care, to understand what to expect when looking for guidance and mental health treatment for children.

The YES Workforce Development team recently distributed a survey to provide parents and caregivers the opportunity to share their thoughts and ideas regarding engaging, educating and involving parents and caregivers in the training process. The survey was open from March 28th to April 30th, distributed throughout the state primarily via email and social media, and 65 total responses were received. Key results of the survey are summarized in the following table:

Parent Survey for Youth Empowerment Services Trainings	
Question	**Key Findings**
Other than information you can access from the YES website, what are other ways you like to learn or ways you would appreciate receiving training about YES?	▪ One-on-one discussion with a member of child's treatment team (53.9%) ▪ In-person training with question and answer session (49.2%)
What specific topics related to YES would you like to know about?	▪ What services are available now (89.2%) ▪ What new YES services will look like (81.5%) ▪ What can I expect from the YES system and services (75.4%) ▪ Becoming eligible for YES (72.3%) ▪ The assessment process (72.3%)
How likely are you to participate in trainings offered in each of the following ways: webinars, in-person, panel, one-on-one discussion with a member of your child's treatment team?	▪ One-on-one discussion with a member of child's treatment team (86.2%) ▪ Over 50% of all respondents indicated that they would be likely or highly likely to participate in webinars, in-person training, and panel discussions
What supports would you need to participate in educational opportunities or trainings?	▪ Evening options (55.4%) ▪ Child care (52.3%)
What are the most effective ways of getting information about education and training out to families/you?	▪ Email (81.5%) ▪ Direct Mail (53.9%)
If given the appropriate training, what types of leadership roles would you be interested in pursuing?	▪ Parent Support Leadership role (67.7%)

A more detailed description of all survey questions and results can be accessed by reviewing the full *Parent Survey for Youth Empowerment Services Trainings Results and Analysis* report. This report will be published on the YES website within the next few weeks.

The Division of Behavioral Health is also working with youth to create and operationalize a training plan to develop youth-specific trainings, a youth train-the-trainer concept, and a plan to design educational and informational communications.

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 the settlement agreement, QMIA is working toward the collection and reporting of 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 information regarding plans for centrally tracking and reporting system-wide complaints.

Medicaid/Optum Complaints and Appeals: January 1st- March 31st, 2018

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: 10 business days for Quality of service complaints, 30 calendar days for Quality of care complaints.

Figure 33.
Data Source: *Division of Medicaid (March 2018)*

Complaints 1/1/18-3/31/18	
# Quality of service complaints	4
# Quality of care complaints	0
Average # of days to resolve	7.5 days

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.

Figures 34 & 35.
Data Source: *Division of Medicaid (March 2018)*

Non-Urgent Appeals 1/1/18-3/31/18	
# of appeals	9
# overturned appeals	0
# partially overturned appeals	7
Average # of days to resolve	4.3 days

Urgent Appeals 1/1/18-3/31/18	
# of appeals	3
# overturned appeals	0
# partially overturned appeals	3
Average # of hours to resolve	46.7 hours

Division of Behavioral Health Complaints: January 1st- March 31st, 2018

The Division of Behavioral Health launched a complaint line and began collecting data in January of 2018.

The following complaint information is currently being collected:

- Complainant type
- Region
- Service
- Type of concern
- Description of concern
- Persons involved in resolution
- Status with date tracking
- Resolution

From January 1 to March 31, the Division of Behavioral Health had 2 complaints in the tracking log. Details regarding all complaints logged since January through the next QMIA Quarterly reporting period will be available in the next Quarterly report.

Centralized Complaints Process

According to the Settlement Agreement, *"Defendants shall develop and adopt a centralized and impartial process to address and track complaints… The process will include documentation of the complaint, a specific time frame to act upon the complaint, and documentation of the outcome."*

Progress is being made to satisfy this commitment:

- A Centralized Complaints committee has been established.
- The existing individual agency systems for tracking complaints have been reviewed.
- The QMIA Data and Reports subcommittee is working on developing a method to incorporate each agency's individual tracked complaints into one report.
- Planning for centralized data reporting has begun.

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

EPSDT Quality Improvement Project

In the previous 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 on which 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 37.
Data Source: *Division of Medicaid (2017)*

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

For this report, Medicaid provided updated data covering January 1st through March 31st, 2018:

Figure 38.
Data Source: *Division of Medicaid (March 2018)*

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	28 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.

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.

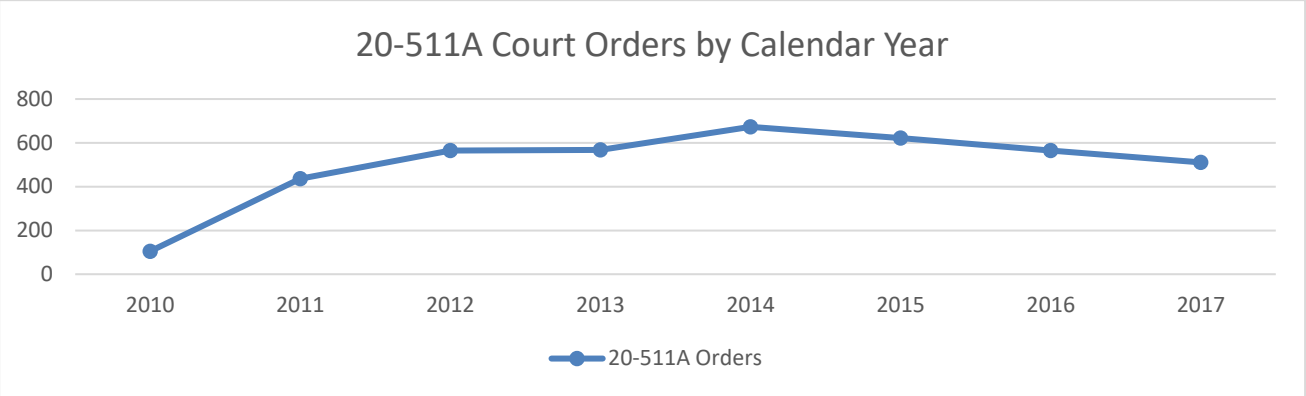
20-511A Analysis Report

The 20-511A order is a rule within the Juvenile Corrections Act whereby a judge can order the Department of Health and Welfare to submit to the court a mental health assessment and a plan of treatment for a youth.

One of the goals of YES is to improve access to services to potentially reduce justice involvement being utilized as a primary avenue to receiving needed mental health services.

The Division of Behavioral Health (DBH) recently completed a descriptive analysis using data from clients with a 20-511A order date from calendar year 2010 to calendar year 2017. The purpose of this study was to describe this population of clients to inform future planning related to the YES program, DBH Regions, and the Quality Assurance unit at DBH Central Office.

Figure 41.
Data Source: *Division of Behavioral Health (March 2018)*



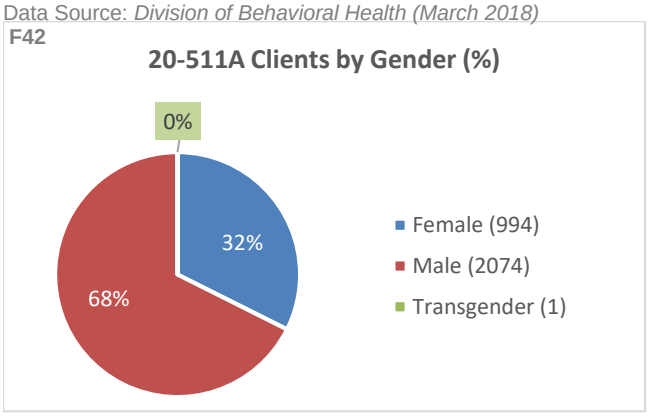
	2010	2011	2012	2013	2014	2015	2016	2017
Total 20-511A Court Orders	105	436	565	567	673	622	564	510
First Documented 20-511A Order*	102	412	501	484	599	504	478	443

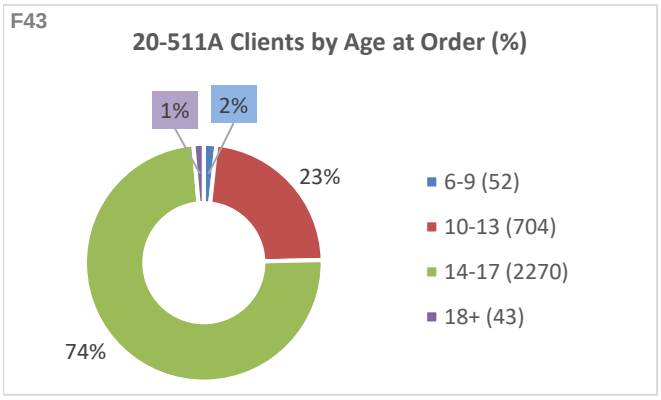
**Clients for which there was not a prior 20-511A order*

According to the analysis: Since 2012, the number of 20-511A orders has hovered between 500-700, leveling off and decreasing slightly since peaking in 2014. As such, it can reasonably be assumed that the number of clients will remain in this range over the next few years, unless significantly influenced.

Demographic information for clients with a 20-511A order from 2010-2017:

Figures 42 & 43.
Data Source: *Division of Behavioral Health (March 2018)*

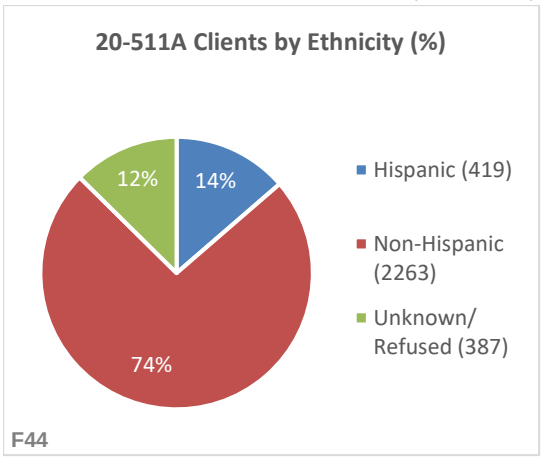


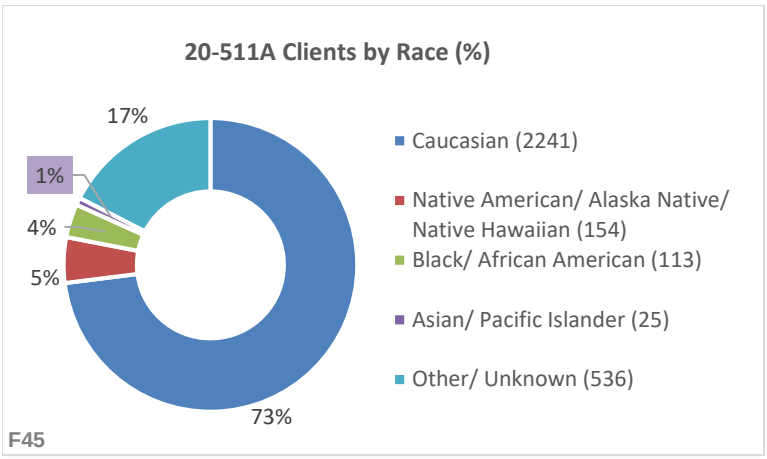


The figures above show that most of 20-511A cases between 2010 and 2017 were male and were between the ages of 14-17 at the time of the order. The ages with the largest number of 20-511A orders was 15 and 16 with 642 and 650 respectively.

Figures 44 & 45.

Data Source: *Division of Behavioral Health (March 2018)*



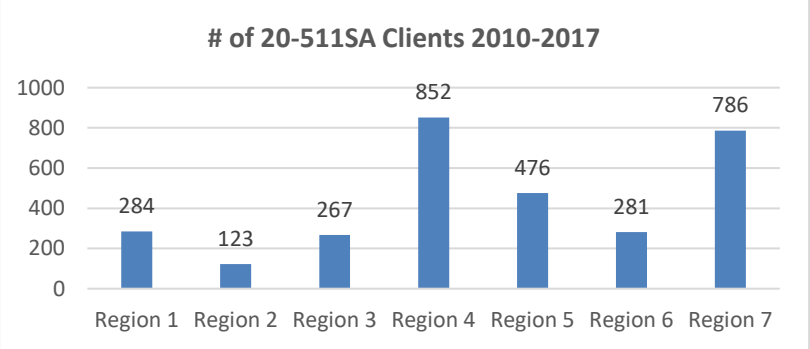


According to the analysis: Overall, clients are primarily white and non-Hispanic, however, minorities appear to be overrepresented in the 20-511A client population. While Native Americans/ Alaska Natives comprise less than 2% of Idaho's general population, they encompass 5% of the 20-511A population. Similarly, African-Americans comprise nearly 4% of the 20-511A population, but less than 1% of Idaho's general population.

20-511A Descriptive Analysis Report regional findings:

Figure 46.

Data Source: *Division of Behavioral Health (March 2018)*



20-511A Clients 2010-2017 by Region

Region	#	%
1	284	9.3%
2	123	4.0%
3	267	8.7%
4	852	27.8%
5	476	15.5%
6	281	9.2%
7	786	25.6%
Total	3069	100%

Regions 4 and 7 combined had over 50% of the 20-511A client population within this period. It is important to note that each region varies in terms of population size, so a reliable utilization comparison cannot be made solely based on the information provided above.

The rate of 20-511A's per 100,000 children by year was calculated for each Idaho county based on 2016 US Census population estimates. This rate calculation eliminates population size variance and allows us to more fairly compare counties to each other as well as to the entire state. Although there are other factors that may influence data on individual regional use, this utilization rate calculation

allows us to eliminate difference in population size as one of those factors. The state of Idaho's 20-511A rate per 100,000 youth was calculated to be 125.

The highlighted counties had a 20-511A rate that was higher than that of the State of Idaho for 2016:

Figure 47.
Data Source: *Division of Behavioral Health (March 2018)*

Region	County	20-511A Rate (Per 100,000 youth)	Region	County	20-511A Rate (Per 100,000 youth)
Region 1	Bonner	95	Region 5	Blaine	79
	Boundary	101		Cassia	231
	Kootenai	95		Gooding	222
	Shoshone	402		Jerome	58
Region 2	Clearwater	93		Lincoln	80
	Idaho	42		Minidoka	377
	Latah	117		Twin Falls	244
	Lewis	151	Region 6	Bannock	313
	Nez Perce	308		Caribou	68
Region 3	Canyon	109		Power	57
	Gem	67	Region 7	Bingham	246
	Owyhee	44		Bonneville	269
	Payette	22		Fremont	344
	Washington	56		Jefferson	71
Region 4	Ada	113		Madison	148
	Elmore	44		Teton	47
	Valley	141		**State**	**125**

As the YES program develops and increases access to services and supports for youth and families, it is expected that we may see a decrease in utilization of 20-511A court-ordered treatment.

The Division of Behavioral Health will continue to monitor 20-511A utilization to help measure progress regarding access and effectiveness of the YES system of care.

The Division of Behavioral Health Quality Assurance Unit is subsequently conducting a statewide random sample case review to gain understanding about utilization of the 20-511A order from a referral, assessment, and treatment perspective.

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.

- **ED:** ED is an acronym for an emotional disturbance used by schools. It is 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 and young adults 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 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 and 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. It is 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.

References

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

Youth Empowerment Services Class Size Estimation Team, *Class Size Estimation Report*, Idaho Department of Health and Welfare (2018)

Appendix A

Idaho Division of Behavioral Health Regional Map

APPENDIX B

Actionable Needs and Useful Strengths most frequently identified by the CMH CANS tool: January-March 2018

Idaho CMH CANS- Needs	
Item	**Description**
Emotional/Physical Regulation	This item describes the individual's difficulties with arousal regulation or expressing emotions and is 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.
Oppositional Behavior	This item rates the individual's relationship with authority figures. Generally oppositional behavior is displayed in response to conditions set by a parent, teacher or other authority figure with responsibility for and control over the individual.
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.