



# Terms to Know

## YES System of Care Abbreviations and Terms Defined

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## Acronyms

<b>CANS</b>	Child and Adolescent Needs and Strengths
<b>CDA</b>	Comprehensive Diagnostic Assessment
<b>CFSP</b>	Certified Family Support Partner
<b>CFT</b>	Child and Family Team
<b>CMH</b>	Children’s Mental Health
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CPSS</b>	Certified Peer Support Specialists
<b>DBH</b>	Division of Behavioral Health
<b>DD</b>	Developmental Disabilities
<b>DHW</b>	Department of Health and Welfare
<b>DSM</b>	Diagnostic and Statistical Manual of Mental Health Disorders
<b>EPSDT</b>	Early and Periodic Screening, Diagnosis and Treatment
<b>FACS</b>	Division of Family and Community Services
<b>HCBS</b>	Home and Community-based Services
<b>IBHC</b>	Idaho Behavioral Health Cooperative
<b>IBHP</b>	Idaho Behavioral Health Plan
<b>ICC</b>	Intensive Care Coordination
<b>IDJC</b>	Idaho Department of Juvenile Corrections
<b>IGT</b>	Interagency Governance Team
<b>LoC</b>	Level of Care
<b>MAGI</b>	Modified Adjusted Gross Income
<b>PCP</b>	Primary Care Physician
<b>PCSP</b>	Person Centered Service Plan
<b>PM</b>	Practice Model
<b>PoC</b>	Principles of Care
<b>QMIA</b>	Quality, Management, Improvement and Accountability
<b>SDE</b>	State Department of Education
<b>SED</b>	Serious Emotional Disturbance
<b>SoC</b>	System of Care
<b>TCOM</b>	Transformational Collaborative Outcomes Management
<b>WDP</b>	Workforce Development Plan
<b>WInS</b>	Wraparound Intensive Services
<b>YES</b>	Youth Empowerment Services

## Agency

The term “agency” usually refers to any local, county, or state government entity. Examples include the Idaho Department of Health and Welfare, the Divisions of Behavioral Health, Medicaid, and Family and Community Services, the State Department of Education, and the Department of Juvenile Corrections. The term is sometimes used to refer also to government programs and services, such as Children’s Mental Health and Developmental Disabilities. The term agency may also refer to an entity that consists of numerous providers.

## CANS Screener

The CANS Screener is a tool based on the Child and Adolescent Needs and Strengths (CANS) that can help non-mental health providers identify unmet mental health needs so they may link families to resources for further assessment and treatment.

## Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services, (CMS) is a federal agency within the United States Department of Health and Human Services that works in partnership with states to administer the Medicaid program. Rules put into effect by CMS must be followed by State Medicaid programs.

## Certified Family Support Partners (CFSP)

See ***Family Support Partners*** below.

## Certified Peer Support Specialists (CPSS)

See ***Peer Support Specialists*** below.

## Checklist

The checklist is a short list of CANS-based questions designed to help parents and caregivers determine if their child may benefit from a full mental health assessment. There are currently two checklists: the Youth Mental Health Checklists for Families and the Mental Health Checklist for Youth.

## **Child and Adolescent Needs and Strengths (CANS)**

The Child and Adolescent Needs and Strengths (CANS) is a tool used in Idaho to identify a child's strengths and needs (including functional impairment). The CANS is an approved tool in Idaho that will be used throughout care to assist in treatment planning and monitor the outcomes of services.

The CANS uses the family's story to recognize strengths that can help them during treatment, as well as needs that may require intervention.

The Child and Family Team (CFT) uses the information gathered by the CANS to identify appropriate services and supports for the youth's coordinated care plan and then uses updates to the CANS to monitor progress towards goals.

More information about the CANS can be found at the Praed Foundation website.

## **Child and Family Team (CFT)**

The Child and Family Team (CFT) is a group of caring and invested individuals who are invited by the child and family to work together to support their child through a teaming approach.

Members of the CFT include the child and family and the mental health provider, but may also include extended family, friends, individuals from child-serving agencies, and community members.

The CFT uses the different perspectives of the individual members to create a more informed and collaborative coordinated care plan for the child and family.

The child and family are active participants of the CFT, and their goals, concerns, and perspectives inform all decisions.

The CFT will use the information gathered by the CANS to identify goals and then recommend appropriate services and supports to help children and families reach those goals.

Members of the CFT may change over time as the needs and goals on the coordinated care plan change.

## **Children's Mental Health (CMH)**

The Children's Mental Health (CMH) program is part of the Division of Behavioral Health under the Department of Health and Welfare and is a partner in a community-based system of care for children with SED and their families.

## **Comprehensive Diagnostic Assessment (CDA)**

A comprehensive diagnostic assessment (CDA), sometimes called a mental health assessment, is a process where a licensed clinician reviews the history of the person seeking care and identifies a mental health diagnosis, if applicable. Historical and current clinical information is gathered through a clinical interview and from other available resources to identify the child's mental health issues, the child's strengths, the family's strengths and the service needs. The results are recorded and include the child's background information, the results of a mental status exam, and the diagnosis.

The completed assessment is used to inform treatment planning for providers and may be used by the Child and Family Team (CFT) during their planning process.

The CANS is not part of a mental health assessment but may be completed by the same provider.

## **Continuum of Care**

A continuum of care is a range of services and supports that extend from the least intrusive (examples may include counseling or medication management) to the most restrictive (examples may include hospitalization or residential treatment programs). This range of services is intended to provide support for each phase of treatment from identification and diagnosis to the participant's transition out of the system.

## **Coordinated Care Plan**

The coordinated care plan is the result of the Child and Family Team (CFT) coordinating care from all providers involved in treatment and may take many forms. The coordinated care plan recognizes the strengths and needs identified by the CANS tool and determines the formal and informal services and supports that will help the youth and family reach their goals. The goals in the coordinated care plan are measurable, assess change (not compliance), and encourage the youth and family to work towards wellness and self-sufficiency.

## **Department of Health and Welfare (DHW)**

The Department of Health and Welfare (DHW) is tasked with promoting and protecting the health and safety of Idaho residents. They have multiple divisions, many of which work with children and their families. The Department of Health and Welfare is designated as the State Behavioral Health Authority under Idaho Statute Section 39-3123.

## **Department of Juvenile Corrections (IDJC)**

The Department of Juvenile Corrections (IDJC) is responsible for the youth ages 10 to 21 that are committed to their custody by the Idaho court system. IDJC operates juvenile corrections centers in Lewiston, Nampa, and St. Anthony, allowing most juveniles to remain close to their families and communities. They provide fully accredited school programs and strengths-based mental health services to meet needs identified by comprehensive assessments and treatment plans.

Most youth receive services at the county level. Detention centers and probation programs are both administered by the counties. There is a strong partnership between the juvenile court system, the counties, and IDJC. IDJC has funding to assist the courts and counties to keep young people in communities with their families and friends.

## **Developmental Disabilities (DD)**

The Developmental Disabilities (DD) program is administered by the Division of Family and Community Services under the Department of Health and Welfare and serves Medicaid-eligible children with developmental disabilities through home and community-based services (HCBS).

## **Diagnostic and Statistical Manual of Mental Health Disorders (DSM)**

The Diagnostic and Statistical Manual of Mental Health Disorders, frequently called “the DSM,” is the handbook used by healthcare providers to diagnose mental health disorders.

## **Division of Behavioral Health (DBH)**

The Division of Behavioral Health (DBH) is a part of the Department of Health and Welfare and is tasked with operating community-based mental health services in each of the seven regions of the state. DBH is responsible for multiple programs, including Children’s Mental Health.

## **Domains**

Domains are areas that are critical to the growth and development of a child and success of a family. On the CANS, items are grouped into domains such as Strengths, Behavioral and Emotional Needs, and Functioning.

The CANS uses domains as categories that capture and document information needed to help a child and family inform treatment planning.

## Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally required component of Medicaid for children under the age of 21. States are required to provide Medicaid-eligible children any additional healthcare services that are covered under federal Medicaid regulations and found to be medically necessary, even if that service is not covered in the State plan.

EPSDT includes screening, vision, dental, hearing, and other necessary healthcare services, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental health conditions.

More details about EPSDT can be found in “EPSDT – A Guide for States“ and in 42 CFR 441.50-62 and in the Idaho Administrative Procedures Act (IDAPA) rules at 16.03.09 Sections 880-889.

Information about EPSDT in Idaho, including the EPSDT Request Form, can be found on the Department of Health and Welfare website.

## Family and Community Services (FACS)

The Division of Family and Community Services (FACS) is part of the Department of Health and Welfare and is responsible for many social service programs such as child protection, adoption, foster care, developmental disabilities, and early intervention services for infants and toddlers.

## Family Support Partners

A Family Support Partner has lived experience raising a child with mental illness, navigating multiple child-serving systems, and assisting the child in developing the resiliency needed for recovery. Family Support partners have specialized training and provide support while offering hope to families in similar situations.

## Federal Poverty Guidelines

The federal poverty guidelines are established by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). They are used nationally to determine eligibility for income-based programs such as Medicaid. The federal poverty guidelines were previously called the federal poverty level (FPL).

## Formal Supports

A formal support is usually a trained professional providing a service. Examples include doctors, therapists, and behavioral aides.



## Home and Community-based Services (HCBS)

Home and community-based services (HCBS) are delivered to Medicaid participants in their own home or community rather than in institutions or other out-of-home placements. HCBS programs serve people with intellectual or developmental disabilities, physical disabilities, or mental illnesses.

## ICANS

ICANS is an electronic, internet-based system used to administer, score and manage the Children and Adolescent Needs and Strengths (CANS) Assessments in Idaho.

More information about ICANS, including resources and user guides can be found on the ICANS website.

## ICANS Automation Helpdesk

The ICANS Automation Helpdesk manages all agency and user access to the ICANS system.

The Helpdesk is also responsible for:

- providing training,
- creating supportive documentation for the functionality of the ICANS system, and
- assisting with technical support of the ICANS system for approved users.

The Helpdesk can be reached at [icanshelpdesk@dhw.idaho.gov](mailto:icanshelpdesk@dhw.idaho.gov) or by phone at 208-334-7316 or Toll-Free 1-844-726-7493.

## Idaho Behavioral Health Plan (IBHP)

The Idaho Behavioral Health Plan, (IBHP), provides outpatient mental health and substance use disorder services for adults and children enrolled in Idaho Medicaid. Inpatient services are covered through the Idaho Medicaid State Plan and EPSDT.

## Independent Assessor

An Independent Assessor works for an agency contracted by Medicaid to conduct a functional assessment and determine eligibility for home and community-based services (HCBS).

To meet requirements for YES, the Independent Assessor also conducts a comprehensive diagnostic assessment (CDA) to identify a mental health diagnosis, unless the family can provide the results of a CDA completed within the previous six months.

## Individualized Treatment Plan

An individualized treatment plan is created by each of a child's providers to address the goals that were identified in the coordinated care plan created by the Child and Family Team (CFT).

An individualized treatment plan identifies:

- Specific services or supports being offered by that provider.
- The strength being applied or built, or the need being addressed.
- Measurable goals as identified in the coordinated care plan created by the CFT.

## Informal Supports

Informal supports, sometimes referred to as natural supports, are people who are part of a family's community and social network. Examples of informal supports include extended family members, neighbors, colleagues, sports coaches, or religious leaders. These individuals support the child and family without payment.

## Intensive Care Coordination (ICC)

Intensive Care Coordination is case management for youth whose CANS score indicates they need a high level of care, or who are transitioning home from an out-of-home placement such as therapeutic foster care, an acute psychiatric hospital, or a psychiatric residential treatment facility (PRTF). ICC may also be appropriate when intervention is needed to keep a child from being moved to an out-of-home placement.

ICC includes both assessment of service needs and service planning utilizing a facilitated Child and Family Team process that is consistent with the Principles of Care and Practice Model.

Some families may choose to utilize the Wraparound model to provide ICC, but all intensive care coordinators will work with the child and family to coordinate care, create transition plans, and monitor progress towards goals.

The Department of Juvenile Corrections (IDJC) provides ICC to youth in their care under a model unique to their mission.

## **Level of Care (LoC)**

The level of care is the amount and intensity of services and supports needed to address identified needs.

For services and supports offered through the Idaho Behavioral Health Plan, review the level of care guidelines and/or provider manual for the current Idaho Behavioral Health Plan managed care provider.

## **Medicaid**

Medicaid is a federal program administered by the states, with a percentage of the benefits funded by federal dollars.

In Idaho, the Division of Medicaid is part of the Department of Health and Welfare and is responsible for administering the Idaho Medicaid State Plan, which increases access to medical care for children, low-income families, and disabled residents.

## **Mental Health Assessment**

A mental health assessment, sometimes called a comprehensive diagnostic assessment (CDA), is a process where a licensed clinician reviews the history of the person seeking care and identifies a mental health diagnosis, if applicable. Historical and current clinical information is gathered through a clinical interview and from other available resources to identify the child's mental health issues, the child's strengths, the family's strengths, and the service needs. The results are recorded and include the child's background information, the results of a mental status exam, and the diagnosis.

The completed assessment is used to inform treatment planning for the provider and may be used by the Child and Family Team (CFT) during their planning process.

The CANS is not part of a mental health assessment, but may be completed by the same provider.

## Natural Supports

See *Informal Supports* above.

## Needs

A need is an area that your child or family requires help with to reach identified goals.

## Peer Support Specialists

Peer Support Specialists, also called Certified Peer Support Specialists (CPSS), are individuals who work in the adult mental health system who are in recovery from mental illness (or mental illness with co-occurring substance use disorder) who use their lived experience and specialized training to assist other individuals in their own recovery.

Peer Support Specialists act as supports and advocates for adult participants currently navigating the system.

There are not currently any peer support programs in Children's Mental Health.

## Person Centered Service Plan (PCP)

A person-centered service plan, is required for participants to access Medicaid home and community-based services (HCBS). If your child does not qualify for Medicaid under traditional income limits and was eligible for Medicaid only after meeting with the independent assessor, or you access respite, you will need a PCSP.

The PCSP includes information about the child, including preferences, strengths and needs as identified in the CANS, and goals.

The PCSP also includes a list of all the formal and informal services and supports needed to achieve the identified goals, whether or not they are reimbursable by Medicaid. Care is taken to make sure there is no duplication of services delivered through other agencies or programs.

## Practice Manual

The Practice Manual is a document that provides details about Youth Empowerment Services (YES) to both families and providers. It contains information about:

- Access to YES and YES Services and Supports
- Principles of Care
- Practice Model

- Definitions
- System of Care
- Identification, Referral, Screening, and Assessment
- Child and Family Teams (CFT)
- Coordinated Care Plans
- Services and Supports
- Billing and Reporting Requirements
- Decision Making Criteria
- Appeals Process

### Practice Model (PM)

The Practice Model describes the six key components to provide care in the Youth Empowerment Services (YES) System of Care.

The six components are:

- Engagement—actively involving youth and their families in the creation and implementation of their coordinated care plan.
- Assessment—gathering and evaluating information to create a coordinated care plan.
- Care planning and implementation —identifying and providing appropriate services and supports in a coordinated care plan.
- Teaming—collaborating with children, their families, providers and community partners to create a coordinated care plan.
- Monitoring and adapting—evaluating and updating the services and supports in the coordinated care plan.
- Transition—altering levels of care and support in the coordinated care plan.

### Primary Care Physician (PCP)

A primary care physician is a doctor who is trained to be your first point of contact for an undiagnosed condition and is able to provide continuing care for various medical issues.

## Principles of Care (PoC)

The Principles of Care are 11 values that are applied in all areas of Youth Empowerment Services (YES).

The 11 principles are:

- Family-centered—emphasizes each family’s strengths and resources.
- Family and youth voice and choice—prioritizes the preferences of youth and their families in all stages of care.
- Strengths-based—identifies and builds on strengths to improve functioning.
- Individualized care—customizes care specifically for each youth and family.
- Team-based—brings families together with professionals and others to create a coordinated care plan.
- Community-based service array—provides local services to help families reach the goals identified in their coordinated care plan.
- Collaboration—brings families, informal supports, providers, and agencies together to meet identified goals.
- Unconditional—commits to achieving the goals of the coordinated care plan.
- Culturally competent—considers the family’s unique needs and preferences.
- Early identification and intervention—assesses mental health and provides access to services and supports.
- Outcome-based—contains measurable goals to assess change.

## Provider

A provider is a person or agency that directly delivers a service or support to a child or family. Providers are frequently referred to as formal supports and are usually paid for their service.

## Respite

Respite care is short-term or temporary care for a child/youth with SED provided in the least restrictive environment that provides relief for the usual caretaker and is aimed at de-escalation of stressful situations.

Respite may be provided on an individual level or in a group setting.

Medicaid reimbursed respite may be provided by a credentialed behavioral health agency in the participant's home, another private residence, at the agency's facility, or in community locations that are not institutional in nature, such as parks, malls, stores, and other activity centers.

Voucher respite is available through the regional Children's Mental Health (CMH) offices and reimburses families for the respite providers they hire, up to \$600 per six months. More details about this program can be found at the CMH offices in each region.

## Safety Plan and Crisis Plan

The terms "safety plan" and "crisis plan" are frequently used interchangeably, but these plans have two separate functions. A safety plan is created to address acute risk of harm to self and others and explains the steps used to keep the child and family safe during a crisis. A crisis plan is created to address ongoing challenges due to the mental health of your child and details the triggers that can lead to a future crisis and how to avoid or manage them.

Both plans are created by individual providers with the family, or by the full Child and Family Team (CFT).

## Screening

A screening is a method of determining if a child may need to access mental health services. A CANS-based screening tool has been created for use by doctors and other medical professionals to determine whether there is a need to refer for a full mental health assessment.

## Serious Emotional Disturbance (SED)

Serious emotional disturbance is a term used to identify children under the age of 18 who have both a mental health diagnosis from the DSM and a functional impairment as identified by the CANS.

A functional impairment limits a child's ability to participate socially, academically, and emotionally at home, at school, or in the community.

The legal definition of SED is found in Section 16-2403, Item 13 of the Idaho Code.

## Services and Supports

“Services and supports” is a Medicaid term that identifies the difference between medically necessary services (examples includes doctors, dentists, etc.) and functional supports needed to help a child and their family live their lives and access medically necessary services (examples include transportation, respite, etc.).

When a Child and Family Team (CFT) identifies needed services and supports for a child, they do not need to limit themselves to options provided by Medicaid but can identify any formal and informal services and supports that are appropriate for the child.

When a CFT identifies appropriate services and supports, that does not guarantee that the service or support will be payable by Medicaid or is currently available in the community.

## Stakeholders

The term “stakeholders” refers to people who have an interest in a specific subject. In relation to YES, a stakeholder is a person or group that has an interest in mental healthcare for children. Children, their families, service providers, governmental agencies, and advocacy groups, and the insurance agencies that pay for services are all examples of stakeholders. Other examples include educators, law enforcement, local and state government officials, and private social service organizations.

## State Department of Education (SDE)

The Idaho State Department of Education is a state level agency that supports local schools and students. They are responsible for implementing policies, distributing funds, administering statewide assessments, licensing educators, and providing accountability data. The SDE is committed to providing leadership, expertise, research and technical assistance to school districts and schools to promote the academic success of all students.

The Special Education Department is one of many departments located within the SDE, and is responsible for ensuring that school districts are compliant with special education and federal program regulations.

## Strengths

A strength is a capability, knowledge, skill, or asset that can be used to attain a goal or address a need. Strengths are identified and documented by the CANS tool.



## System of Care (SoC)

The YES system of care is a spectrum of services and supports for children with serious emotional disturbance and their families that is built on the Principles of Care and Practice Model. The YES system of care creates meaningful partnerships between families, youth, providers and government agencies to address the specific needs of the youth and family in order to help them function better at home, in school, in the community, and throughout life.

## TCOM (Transformational Collaborative Outcomes Management)

Transformational Collaborative Outcomes Management, usually referred to by the acronym TCOM, describes how providers and child serving agencies work with people at every level of a system to improve outcomes for children and their families. The approach focuses on gaining various perspectives on a situation before a decision is made. TCOM recognizes that each participant in the mental health system has a different perspective, focus, and responsibility. These differences can create tension, and tension can make it difficult to focus on obtaining a common objective, specifically the wellness of the child and family in treatment. TCOM creates a system to return all participants back towards a shared vision of addressing needs and building the strengths of children and families. This shared vision helps people at every level of the system work together with families and children.

The CANS tool and Child and Family Team (CFT) are built on the philosophy of TCOM.

More information about TCOM can be found at the Praed Foundation website.

## Transition

Transition is the process of changing levels of service, switching between higher and lower levels of intensity and duration, as the needs of the child and family change. An example of transition is the movement between inpatient hospitalization and community-based services. Transition can also refer to the process of moving between systems, for example, the movement between the juvenile corrections system to the community. In the Wraparound model, transition is the shift away from the formal Wraparound process and towards formal and informal supports in the community. Not all transitions are from higher level services to lower level. Sometimes transitions increase the intensity of services as the needs of the child and family change.

Transition planning identifies when transitions will be needed, and how to switch between levels of services. It also includes a plan to determine when services and supports are no longer needed.

## **Wraparound Intensive Services**

Wraparound Intensive Services is a team-based, family-driven, and youth-guided planning process that is led by guiding principles, has a structured format, and is implemented with facilitated activities. The Wraparound process is used to address complex needs for both families and their children and is successful by creating relationships with a team of involved people to support treatment needs.

## **Youth Partners**

Youth Partners are individuals who have lived experience with mental health concerns and have been trained to participate on Wraparound teams. Their role is to act as an advocate for the child or youth who is currently participating in a Wraparound planning process.

## **Youth Empowerment Services (YES)**

Youth Empowerment Services, known by the acronym YES, is the name chosen by Idaho youth for the new children's mental health System of Care.

## **Youth Partners**

Youth Partners are individuals who have lived experience with mental health concerns and have been trained to participate on Wraparound teams. Their role is to act as an advocate for the child or youth who is currently participating in a Wraparound planning process.