Workforce Development and Training Plan

Submitted By:

The Workforce Development and Training Plan Workgroup

May 1, 2017

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Introduction

The Workforce Development and Training (WFD) Plan is a requirement of the Jeff D. Settlement Agreement. It is intended to be a living document that will begin spring 2017 and span into 2020 and beyond. The initial WFD Plan provides a framework and a phased approach for how the state will address the current and future demands for a sufficient and competent mental health workforce and begin to envision the infrastructure needed to operate the System of Care over time. As well, the Plan will focus on developing the capacity and competencies needed for creating sufficient access to care. The WFD Plan is broken down into four (4) sections as follows;

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History

The Jeff D lawsuit began in 1980 when children were co-mingled with adults at State Hospital South (SHS). There was a lack of appropriate treatment and education services at SHS and a lack of community-based mental health services across Idaho. After many hearings over 30 years, the Court encouraged a mediation process to occur in order to identify solutions. Mediation occurred from September 2013 through December 2014.

A Settlement Agreement filed in 2015 was the result of collaboration, mediation and more than a year of negotiations among key community stakeholders representing parents, advocates and private providers, representatives from the Idaho Department of Health and Welfare (DHW), the Idaho Department of Juvenile Corrections (IDJC), the Idaho State Department of Education (SDE) and attorneys representing the Class Members.

The Settlement Agreement is a high-level description of what the state agrees to do to have the lawsuit dismissed. The Settlement Agreement laid the foundation for the Idaho

Implementation Plan, which is the roadmap for Idaho's transition to the new system of care. The work to build the Settlement Agreement and the Implementation Plan required a cross-system partnership between the IDHW's Division of Behavioral Health (DBH), Division of Medicaid, and Division of Family and Community Services (FACS), IDJC, and SDE, as well as plaintiff attorneys and stakeholders involved in the Jeff D. class action lawsuit. This partnership will continue through the life of the Youth Empowerment Services (YES) project.

The Idaho Implementation Plan was approved by the District Court in May, 2016. The YES project will follow the framework of the Implementation Plan to accomplish the full transition to the new system of care by 2020. The participation of stakeholders in workgroups and committees will be a key component of the project moving forward. The project is authorized by DHW in response to the Settlement Agreement. The agreement requires the state to develop a mental health system of care for children with serious emotional disturbance. The new system will be implemented and sustained in a manner that is family-driven, community-based, coordinated and comprehensive. The state developed the Idaho Implementation Plan as the framework for building the YES Project Plan.

Workforce Training and Development requirements in the Settlement Agreement:
The following are the outcomes noted in the Settlement Agreement associated with workforce development:

Section 74. Defendants shall:
      a. Develop and implement a workforce development plan, as described in
      paragraph 39;
      b. Develop and adopt a Practice Manual, as described in paragraph 40;
      c. Consistently use a Practice Manual to guide clinical and programmatic
      activities statewide, as described in paragraph 41;
      d. Educate and train agency staff, providers, and other community and system
      partners, as set forth in paragraphs 41 and 42, to use and follow the Access
      Model, Practice Model, and Practice Manual:
            i. To identify and refer potential Class Members for screening; and
            ii. Deliver services and supports to Class Members; and
      e. Educate and train agency staff and providers to use the Child and Adolescent
      Needs and Strengths (CANS) tool.

Idaho's Implementation Plan: Objective 4

Sustainable Workforce and Community Stakeholder Development — The agencies participate in workforce development and stakeholder education to create the infrastructure necessary to provide education, training, coaching, supervision, technical assistance and mentoring to providers and community stakeholders to enable them to consistently and sustainably provide quality care in accord with the Practice Manual as described in the agreement. The work of this objective will be led by the Workforce Development Workgroup.

The workforce meets the needs of Class Members and their families for services/supports under the agreement. The workforce has adequate training and support to identify, engage, and link Class Members to services; to use the Child and Adolescent Needs and Strengths (CANS) tool in screening, assessment, and clinical practice; and to deliver the full array of services/supports that are medically necessary, consistent with the Principles of Care (PoC) and Practice Model (PM), and the individualized strengths and needs of eligible youth. The agencies have developed, adopted, and are consistently using a Practice Manual to guide clinical and programmatic activities statewide. A sustainable infrastructure is in place for ongoing education, training, and technical assistance for providers who serve Class Members pursuant to the terms and conditions of the Agreement. Stakeholders understand their various roles in the System of Care.

Overview of the Workforce Development and Training Plan

Defining Workforce

As identified in the Jeff D. Settlement Agreement, agency staff, providers, other system and community stakeholders are considered to be the target for workforce development, education and training. Specifically, these groups primarily include employees DHW's DBH, Division of Child Welfare, IDJC and SDE.

Additionally, providers under the Medicaid Idaho Behavioral Health Plan and other agencies providing services to children are a focus of the WFD Plan. Moving further out, numerous child serving agencies will be targeted for specific outreach, training and education.

While not traditionally considered members of the workforce, it is important to include youth and family members as pivotal members of the workforce, as they have critical roles in caring for themselves and each other, whether informally through self-help and family caregiving or more formally through organized peer- and family-support services. Families are increasingly knowledgeable about health and healthcare and expect to participate in the decisions impacting their children and loved ones.

Defining Workforce Development

The term Workforce Development can be considered very broadly; for the purpose of this Workforce Development and Training Plan it refers to three primary objectives as described in Objective 4 of the Settlement Agreement.

- Meeting the workforce capacity needs to ensure access to Services and Supports
- Providing training, education, coaching and supervision to the workforce
- Ensuring the sustainability of the workforce to deliver services and supports

Workforce Development Workgroup

The Workforce Development Workgroup serves in a research, development and design capacity to DBH for the development of the Workforce Development Plan and the Practice Manual as described in the Idaho Implementation Plan.

The Workforce Development workgroup is composed of children's system of care stakeholders who have specific knowledge of Idaho's healthcare workforce environment as well as state and community representatives.

The purpose of the Workforce Development workgroup is a) to develop and strengthen the workforce in order to deliver Services and Supports as listed in Appendix C of the Settlement Agreement; and (b) to operationalize the Principles of Care and Practice Model system wide. This work will be operationalized through the development and

implementation of the two deliverables, the Workforce Development Plan and the Practice Manual.

The WFD Plan will include a roadmap how the state will address any identified gaps in workforce capacity necessary to meet the needs of Class Members and deliver services in sufficient amount to meet their service needs. The WFD Plan will also include strategies to develop sustainable regional and statewide education, training, coaching, mentoring, and technical assistance to public and private providers who serve Class Members.

The Practice Manual will also be designed so that it can effectively guide and facilitate access to services listed in Appendix C of the Settlement Agreement. The Practice Manual will be based on the Principles of Care, the Practice Model, and the Access Model. The Practice Manual will include instructions and guidance for agency staff, providers, and other system and community stakeholders.

Workgroup Role and Responsibility
The role of the Workforce Development Workgroup is to participate in the YES project and to work together with the staff of the DBH and Medicaid to develop the initial Workforce Development Plan by May 2017. The WFD Workgroup will deliver updated versions of the WFD Plan through Phase 2 (January 2018) and Phase 3 (January 2019) of implementation. The WDF Workgroup will report to the Interagency Governance Team (IGT) and to the Quality Management, Improvement and Accountability (QMIA) Council on a quarterly basis to ensure goals, objectives, tasks and timelines are on track.

Workforce Development and Training Plan Process
The Workforce Development and Training Plan Workgroup was established in November 2015 to meet the requirements set forth in Object 4 of the Settlement Agreement. The Workgroup has representation from the Agencies as well as other child serving stakeholders. Initial work focused on orienting work group members to the Settlement Agreement and Objective 4 of the Implementation Plan. As well, it was important to develop a mutual understanding and framework of the scope of workforce development as it related to the Settlement Agreement. Over the course of the first five) 5 months of planning the workgroup conducted a SWOT analysis reviewing the current system, identifying stakeholders and developing some initial recommendations regarding training content and training methods. Research was done on national trends, issues and challenges related to the behavioral health workforce. Later work focused on establishing a vision statement and five (5) working goals that articulate objectives for developing and training the workforce. The WFD Workgroup will continue to meet through 2017 and 2018 to ensure the WFD and Training Plan is on target with its goals and objectives and to ensure updated versions of the Plan are delivered at the beginning of Phase 2 (2018) and Phase 3 (2019).

Workgroup Membership

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Suzette Driscoll- Grant/Contracts Management Supervisor, Division of Medicaid, DHW

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National Workforce Development and Training Considerations

When reviewing national trends and primary concerns regarding the current behavioral health workforce, a number of variables must be considered and addressed. Some of these issues include recruitment and retention, the aging workforce, the absence of career ladders, low wages and benefits, access to relevant and effective training and the erosion of supervision and leadership. While it is assumed that these issues also impact Idaho's behavioral health workforce, more work must be done to further research and analyze Idaho-specific trends.

Recruitment and Retention

Despite the passage of the Mental Health Parity and Addiction Equity Act of 2008, and the expansion of covered services with the passage of the Affordable Care Act, there has been a limited increase in the delivery of behavioral health services according to a 2014 *U.S. News and World Report* article. Following are some key facts illustrating workforce challenges in regards to recruitment and retention: There is a concentration of psychiatrists, psychologists and other behavioral health professionals in affluent urban and suburban areas. In contrast, it has been difficult to recruit and retain behavioral health professionals in rural areas. For example, there is a shortage of 2,800 psychiatrists in rural and underserved areas, contributing to the fact that 85 percent of federally designated behavioral health professional shortage areas are in rural locations.

As cited in the YES Capacity Report 2017, there are known shortages in Idaho's capacity to provide mental health services as demonstrated by the states' Health Provider Shortage Area (HPSA) designation. A HPSA is an area designated by the Health Resources & Services Administration (HRSA) as having a shortage of primary care, dental care or mental health providers. Although some counties in Idaho are not defined as having shortages in mental service providers (such as Ada County) there are many others that are designated. Based on the number of counties that are HRSA designated, HRSA considers the state of Idaho overall to be designated as a HPSA state for mental health.

Also cited in the YES Capacity Report 2017, the State Behavioral Health Planning Council noted the following in their 2016 Report to the Governor: "Idaho continues to experience a shortage of child and adolescent psychiatrists. And while this shortage is found nationwide, in Idaho we continue to see families driving up to four hours from their home to access needed psychiatric services." As of 2009, Idaho's rate was 5.0 children's psychiatrists per 100,000 youth. There are only 3 states with rates that are worse than Idaho's rate. It is notable that while the Substance Abuse and Mental Health Services Administration (SAMHSA) data about Idaho regarding the total number of psychiatrists is useful, it is not known if the numbers reflect the number of psychiatrists working in the public mental health system or currently practicing.

It is of additional concern that many health care employers say it is hard to retain behavioral health workers, specifically those specializing in the treatment of substance

use conditions, due to low wages and benefits, heavy caseloads and the stigma associated with both having addictions and working with people who do. With respect to diversity, it has been hard to recruit and retain a diverse behavioral health workforce. Of note, only 6 percent of psychologists, 6 percent of advanced practice psychiatric nurses, 13 percent of social workers, and 21 percent of psychiatrists come from diverse backgrounds.

An Aging Workforce

Supported by an article written by the American Hospital Association: Literature Review Key Focus Areas-Recruitment and Retention, there are many factors that drive the need for attention to workforce recruitment and retention. One of the most significant is the aging U.S. population which is growing at a rate that is unprecedented in modern history. As well, the U.S. Bureau of Health Professions estimates that, in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312.

The workforce shortage for specialty behavioral health is daunting when you consider the facts above compounded with the realities that, in the field of psychiatry, nearly 55 percent of providers are 55 years or older and recently only 4 percent of U.S. medical school graduates have been applying for residency training in psychiatry.

Education and Training

As previously mentioned, the behavioral health specialist workforce is aging. Retraining the incumbent health care workforce will be critical to address future behavioral health needs. The literature review revealed that there is a lack of medical and health professional students specializing in behavioral health. Often, behavioral health students are siloed in education programs.   For example, there is no curriculum in U.S. undergraduate or graduate psychology programs that focuses on primary care.   As well there is a lack of behavioral health training for Advanced Practice Registered Nurses (APRNs) and physician assistants (PAs). Currently, more than 50 percent of patients get treated for behavioral health issues by their primary care provider (PCP); however, most PCPs have not received adequate training in behavioral health. Increasingly, PCPs, PAs and Nurse Practitioners (NPs) have picked up a significant amount of the responsibility for behavioral health care, which appears to be the trend in Idaho.

The YES Capacity Report found that "The percent of medication management services appears to be higher than the national average despite the affirmed shortage in child and adolescent psychiatrists in Idaho. This suggests that physician extenders are filling the psychiatrist gap for the provision of prescriber services (or medication management)."

Wages and Funding

According to reports issued by SAMHSA and the Centers for Disease Control and Prevention (CDC), spending on behavioral health care as compared to other health care expenditures is unbalanced. Financial issues related to workforce shortages include:

- Salaries in behavioral health professions are well below those for comparable positions in other health care sectors and in business.
- Federal financing for innovative models of behavioral health care has been provided only for short periods, leading to program cancellations.
- Salaries and reimbursements are so much lower for psychiatrists and psychologists.
- Because of significant student loan debt, many may be pursuing better reimbursed clinical specialties, so they can begin to pay off debt.
- The median compensation for psychiatrists is the third-lowest among the 30 medical specialties.
- Current fee-for-service (FFS) codes are inadequate for reimbursing providers utilizing integrated behavioral health specialist consultation.
- Inconsistency regarding who can bill for what service.

Leadership

Research indicates that, over the last two decades, the need for leadership and the demands on leadership have increased exponentially. The current health care environment has become much more complex due to major changes in financing that have created enormous pressures for efficiency in behavioral health programs and systems. As well, there have been many new demands to improve services by providing evidence-based practices, reducing cultural disparities, increasing patient safety, and demonstrating outcomes, among other things.

While it is natural to focus on the need for leadership in treatment organizations, non-clinical leadership is essential among all key stakeholder groups and sectors of the field if improvements in the equity, efficiency, and effectiveness of behavioral health care are to be achieved. Other relevant groups include educators, prevention specialists, policy makers, and administrators engaged in the certification and licensure of the workforce and in accrediting training and service organizations. Developing and expanding leadership roles among people in recovery and their family members is particularly critical to achieving transformation of current service systems and models of care.

Often, individuals at the top of an organizational hierarchy are referred to as leaders, but individuals at multiple levels have responsibilities that require leadership skills, including supervisors, team and program directors, and executive or senior managers. Each role involves leadership functions that are essential to the successful operations of an organization or group, whether in prevention or treatment systems, peer-support programs, educational systems, regulatory and oversight organizations, or consumer and family advocacy initiatives.

In summary, the development of the behavioral health workforce has many aspects to consider and will require not only a multi-pronged approach, but a long term vision. The next section of the Workforce Development and Training Plan will describe the current

environment in which Children's Behavioral Health services are provided, the future system and identify some initial gap analysis recommendations.

Section II

Current Environment

Children's Behavioral Health services in Idaho are delivered through three primary avenues, through the State of Idaho, Division of Behavioral Health Children's Mental Health program, through the Medicaid Idaho Behavioral Health Plan (IBHP) and through medical providers not currently in under the IBHP. As referenced in the YES Capacity Analysis 2017 produced by the QMIA Committee, it is estimated that there are approximately 21,000 potential Class Members requiring behavioral health services. Within that group, it is estimated that 12,624 are currently served in the Medicaid system, 6,446 are privately insured and 1,554 remain uninsured.

DBH Children's Behavioral Health
The Children's Behavioral Health program is a partner in the development of a community-based system of care for children with a Serious Emotional Disturbance (SED) and their families. While most children are referred to private providers for treatment services, the program provides crisis intervention, case management and other supports that increase the capacity for children with SED and their families to live, work, learn and participate fully in their communities.

DBH Children's Behavioral Health services are provided in seven (7) regional locations across the state. In FY 2016, 1,066 children were served throughout the state of Idaho. The most frequently provided services included case management, psychiatric diagnostic assessment, nursing services, 15 minute outpatient services, Parenting with Love and Limits and Wraparound. While caseloads vary, most clinicians carry a caseload of 15-20 children. Nearly all of the 53 clinicians providing services to children are licensed within their profession with over 50% having obtained an advanced clinical endorsement to practice independently. Of note, only 5 of 53 clinicians report being bilingual.

Currently, the Child and Adolescent Functional Assessment Scale (CAFAS) is used as an eligibility and outcome measure in youths qualifying for and receiving services from Children's Behavioral Health. This behaviorally based instrument is backed by extensive research supporting its validity and sensitivity to measure change.

Inpatient services for children and adolescents are offered through community psychiatric hospitals and State Hospital South, which has a capacity for 16 beds for adolescents. Unfortunately, many children in Idaho in need of behavioral health inpatient services must receive their care through facilities far from home, which isolates them from their support systems and community services that are crucial for recovery.
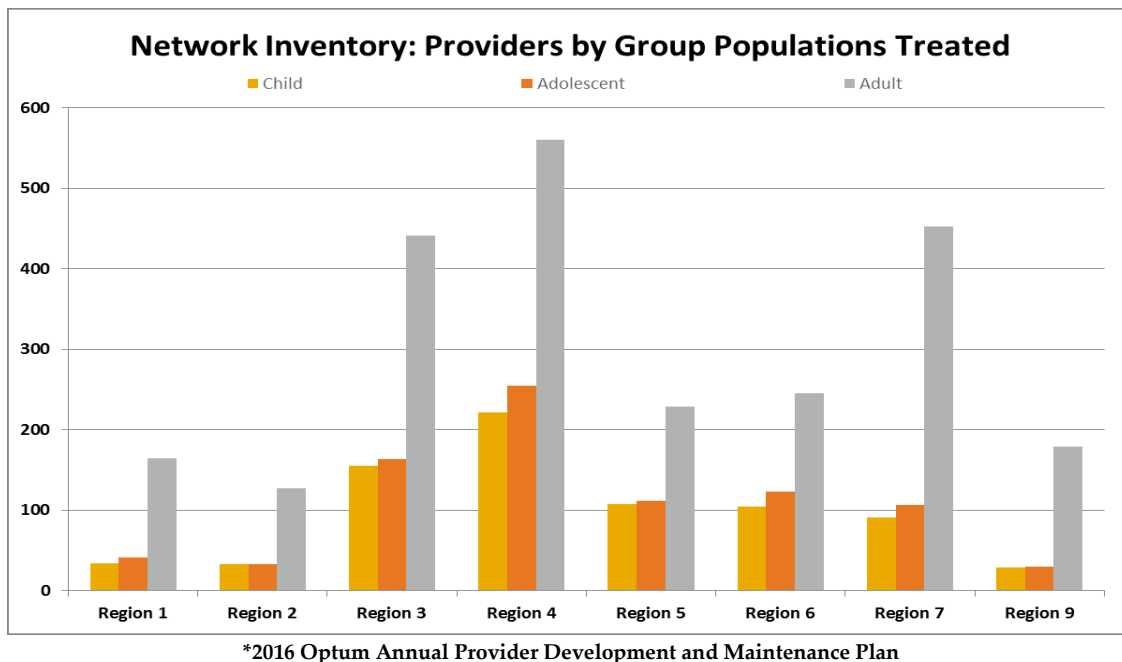
Medicaid Idaho Behavioral Health Plan (IBHP)

Behavioral health services are available for eligible Idaho Medicaid participants through a 1915(b) waiver that authorizes the Idaho Behavioral Health Plan, which was implemented September 1, 2013. Idaho contracts on a capitated basis with a single, statewide managed care entity, Optum Idaho, to administer behavioral health services to eligible Medicaid members. The contractor administers the outpatient plan of behavioral health services, including outpatient community-based mental health services, substance use disorder treatment, and case management services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), as well as any adults or children who have symptoms of mental illness.

Based on the 2016 Optum Annual Provider Development and Maintenance Plan, the IBHP offers services to a total membership (at the end of reporting period- August, 31 2016) of 291,227 eligible participants, with over 8% of the eligible membership receiving provider services.

According to the Optum report, an important area of development for Optum's network of providers is related to these children's services and specifically the 0-17 population. While the 0-17 population makes up the highest number of members accessing services in most regions of the state, the age group has the fewest number of providers available to render services.

Demographic Data: Members Served by Age Group Sep 2015 to Aug 2016

2016 Optum Annual Provider Development and Maintenance Plan
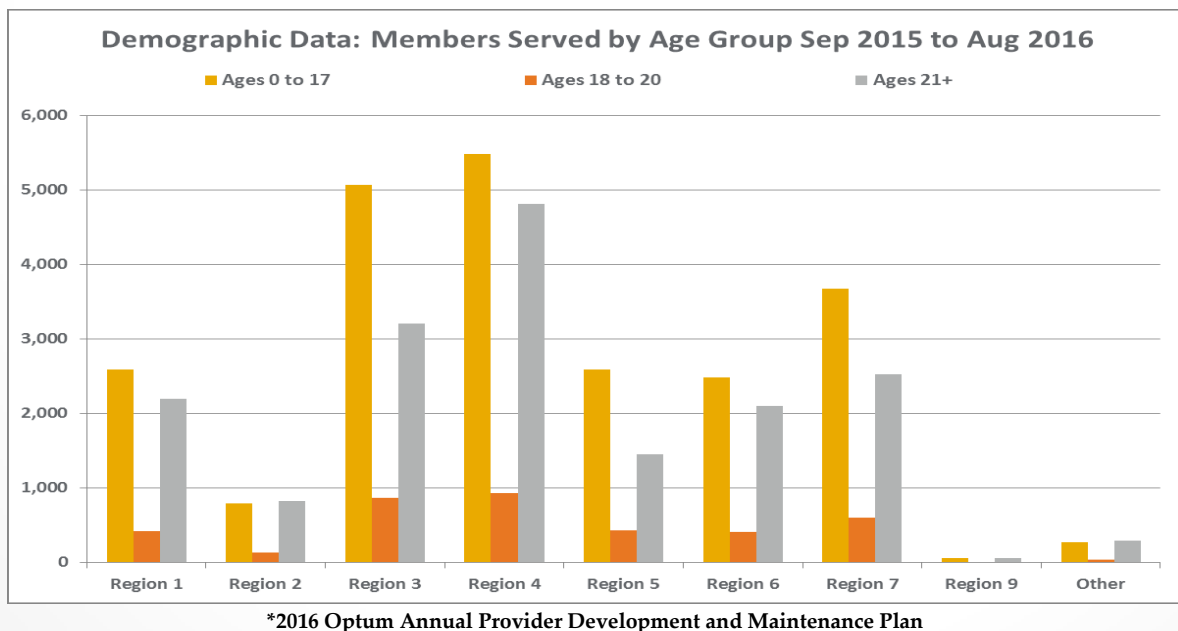
Optum credentials individual practitioners and agencies into the network. The most common license types Optum credentials are MD, PhD, Master level practitioners such as LCSW, LMFT, and LCPC as well as APRN and NP or PA with prescriptive authority. There are over 4,300 mental health providers and 700-800 prescribers between respective reporting years. The following table illustrates providers by service population.

Network Inventory: Providers by Group Populations Treated

2016 Optum Annual Provider Development and Maintenance Plan

Optum reports that providers identify with and serve 16 different ethnicities and 26 different languages. It is not known which of these providers serve children and if it is representative of the actual need.

According to the 2016 YES Capacity Analysis Report, the following metrics were used to estimate the number of Class Members who are not currently accessing services. The number of projected Class Members currently receiving services was multiplied by the prevalence rate and compared to the number of presumed Class Members currently being served.

Metrics:
- Estimated number of uninsured and Medicaid members under the age of 18 as of 2016
- Prevalence rate of 6.47% (as noted in the BSU Class Member analysis)
- Number of presumed Class members currently served

The results, per the table below, indicate that is likely that most of the Class Members may be accessing some type of mental health services. However, this result should not be interpreted as an indication that Class Member needs are being met. The only thing we know is the number of children and youth that currently have some contact with the outpatient mental services is close to the projected numbers who need those services. There needs to be more study of the use of services to assess the amount of service being delivered to individuals. This will include intensity and duration of services. Also as noted previously, it is unknown how many of those who are privately insured will access the public mental health system.

Table 5: 2016 YES Capacity Analysis Report

Total Population	Division of Behavioral Health (Uninsured)	Medicaid
# of Projected Class Members	17,984	208,687
# of Presumed Class Members currently served	1,164	13,502
Variance	+14	+202

*Data Source: DBH, Medicaid/Optum

As identified in the Yes Capacity Report, an additional analysis is needed for comprehensive assessment of the current capacity and estimated need to timely provide services and supports in appropriate scope, intensity and duration to Class Members. As well, a comprehensive study will be completed to assess provider demographics, competency, scope of practice, and training needs.

Primary Care and Pediatrics Providers
According to data gathered by Medicaid and cited in the 2016 YES Capacity Analysis Report, it is estimated that there are approximately 207,794 children under the age of 18 in the state of Idaho that are privately insured. Of those children it is presumed that approximately 6,446 are considered to meet the criteria to be a Class Member. Per the report, it is unknown how many youth or children will choose to utilize the public mental health system for mental health services. Primary care physicians are seeing a growing population of patients with mental health needs and have taken on a greater role in prescribing psychotropic medications.

According to a paper published by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry, approximately 70% of children and adolescents who are in need of treatment do not receive mental health services. Of those who seek treatment, only 1 in 5 children use mental health specialty services. Thus, approximately 75% to 85% fail to receive specialty services, and most of these children fail to receive any services at all. For the families that seek services, 40% to 50% terminate treatment prematurely because of lack of access, lack of transportation, financial constraints, child mental health professional shortages, and stigma related to mental health disorders. Only a small proportion of these children receive treatment from mental health professionals.

Trending nationally and here in Idaho, there is a recognition that behavioral health integration in family practice and in pediatric care is an opportunity to prevent and identify common emotional, behavioral and social problems over the course of childhood and adolescence. Often, it is through the trusting relationship with a primary healthcare provider that families and youth can seek needed referrals and treatment. To that, primary care and pediatric practices must have access, knowledge and training to effectively address behavioral health issues. Knowledge of generic and disorder specific screening tools, community referral resources, Evidenced Based Practices, and family engagement

strategies are critical and essential components of effective identification, referral and treatment.

Future System and Workforce Profile

As defined in the Settlement Agreement, a System of Care is an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving services and access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with a SED and their families. While in philosophy and practice, many providers of Children's Behavioral Health services may argue that they espouse the characteristics of a system of care, currently the various child-serving agencies work fairly independently to serve children. In the new system of care, child-serving agencies will collaborate to make sure that children who have SED will be identified as early as possible and will be routed to the pathway for assessment and referral to services.

Once published, the Practice Manual will serve to instruct, guide and facilitate access to services and supports based on the Principles of Care, the Practice Model and the Access Model. The Practice Manual is intended to provide direction to agency staff, community providers and other system and community stakeholders. It is through the development, implementation and adherence to the Practice Manual that will shape and sustain a new System of Care. Providers of children mental health services will require training and certification to the Practice Manual.

Description of New Services

Services and supports have been chosen to provide a home and community-based treatment approach to the delivery of services/supports in the least restrictive setting. These services/supports allow for a full continuum of care available to the family based on the child's strengths/needs. The child and family team provides support to access services based on medical necessity requirements.

Considerations to delivering these services include reasonable access to existing and new services required, the capacity of Idaho's current workforce to meet the demand, and the changing profile of skills needed to deliver services in the new System of Care. Clearly, a paradigm shift will need to occur as the workforce moves towards adopting the Principles of Care and more closely embrace the Child and Family Team approach. As well, the demand of adopting and using best practice interventions and a keener focus on outcome may present some additional challenges to the existing and emerging workforce.

There will be new services as well as improvements made to existing services. Appendix C of the Settlement Agreement lists services and supports that will be included in the continuum of care. Most of these will become Medicaid benefits and some will be offered through the Division of Behavioral Health. Services and supports include:

- Initial Assessment
- Evaluation & Testing
- Treatment Planning
- Case Management
- Intensive Care Coordination
- Medication Management

- Psychotherapy
- Skills Building
- Behavioral/ Therapeutic Aide Services
- Day Treatment
- Intensive Home and Community-Based Services
- Therapeutic after-school and summer programs
- Integrated substance use disorder (SUD) services
- Treatment Foster Care
- Residential Care
- Respite
- Transportation
- Psychoeducation & Training
- Family Support
- Youth Support
- Case Consultation
- Flexible Funds
- Crisis Respite
- Crisis Response Services
- Crisis Intervention Services
- Inpatient

As groups of existing and new services are rolled out, an evaluation of the training needs for providers will be assessed and training will be developed and delivered through DBH, agency partnerships and through contracted entities.

Introduction of CANS

One significant feature of the new system will include the incorporation of the Child and Adolescent Needs and Strengths (CANS). The CANS is a tool used in the assessment process that provides a measure of a child's or youth's needs and strengths. This is important and necessary information for the Child and Family Team to use to build an effective treatment plan. The information will help the Child and Family Team make decisions about what should be done to help the child and family in terms of mental health services and supports. The state will use the CANS to identify children and youth who may be Class Members. The tool will also be used to track the Class Member's progress in treatment. The CANS will replace the Child and Adolescent Functional Assessment Scale (CAFAS) that is currently used as an eligibility and outcome measure in youths qualifying for and receiving services from Children's Mental Health. To date, a number of DBH Children's Behavioral Health clinicians have been CANS trained with a regional pilot to begin in August 2017. In January 2018, a CANS pilot with providers will be initiated after a period of recruitment and training. By April 2019, training for all providers will be launched with full implementation targeted for July 2019.

Development of Core Competences in Children's Mental Health

Currently in Idaho, there are no established or recognized core competency standards for working with children, youth and families. Whether working in schools, clinics, in home, inpatient, residential or other community settings, establishing core proficiencies are a way to ensure a competent and qualified workforce. A new system of care will require knowledge, skills and abilities in cultural competency, child development, screening, assessment, referral, quality improvement, child and family teaming, community development and communication. It is envisioned that Idaho will move towards identifying and developing core competency standards in January 2018 in partnership with a contracted university with a plan for implementation the following year.

Capacity Analysis and Workforce Development

Overview of Capacity Analysis

The initial Capacity Analysis was published January 30, 2017 and is based on the requirements in the Jeff D Settlement Agreement and Idaho Implementation Plan. The YES Quality Management Improvement and Accountably (QMIA) Data and Reports Committee completed the initial system capacity assessment. The QMIA Data and Reports Committee is a workgroup, involving representatives from the Idaho Department of Health and Welfare (DHW) Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS), along with the Idaho Department of Juvenile Corrections (IDJC) and the State Department of Education (SDE), was formed to develop YES reports that are across the child serving systems.

One of the primary goals of the capacity analysis was to formulate initial recommendations to inform Object 4 of the Implementation Plan to support a sustainable workforce and community stakeholder development.

Over the next one to two (1-2) years more extensive analyses on the system capacity needs for Jeff D Class Members will be conducted and reported. The intent of further study into system capacity will be to uncover more in-depth information about child, youth and family needs, and how the system is able to meet those needs.

Recommendations for Workforce Development:

Based on the result of this initial Capacity Analysis the initial recommendations for Workforce Development to establish and maintain system capacity:

- Continue analysis of current capacity and assessing needed capacity on an on-going basis based on an in-depth need-based planning study
- Implement CANS and TCOM system which will provide useful data about child, youth and family outcomes to aid in system transformation
- Evaluate the cause of apparent capacity issues or gaps by region
- Set recruitment goals by region and by type of service needed
- Provide training to support expansion of the array of services to include all services in the Agreement
- Provide training on practices that are effective (evidence based, evidence informed an proven practices) but not utilized extensively
- Consider establishing staffing models by program type
- Work with local universities to ensure education is focused on areas of need throughout the state.
- Support primary integration by developing new models of integration and pilot them

Based on the recommendation from the YES Capacity Analysis 2017, particular attention will be given to these areas as outlined in Goal 1 of the WFD and Training Plan. Through a contract with an Idaho university, information will be gathered focusing on provider

types, delivery of Evidence Based Practices, levels of care provided, geographic coverage and evidence of lack of system coordination.

Quality Management Improvement and Accountability (QMIA)

The impact of the Workforce Development and Training Plan will be evaluated using the principles and strategies of Transformational Collaborative Outcomes Management and guided under the Quality Management, Improvement, and Accountability Plan (QMIA) Plan. Additionally, the WFD Plan will be monitored under the QMIA Council to ensure that the goals, objectives, tasks and timelines remain in track.

The QMIA Plan describes the development of a collaborative, cross-system, practice, performance monitoring and clinical quality improvement system. The QMIA Plan explains how Idaho's child serving systems will monitor, assess, and report on the progress toward the execution of the commitments set forth in the Jeff D. Settlement Agreement.

There are four primary components at the core of the QMIA Plan:

- Quality: An enhanced Quality Assurance (QA) infrastructure,
- Management: The use of performance metrics to monitor and assess the system,
- Improvement: Quality improvement through management action plans (MAP) and performance improvement projects (PIP), and
- Accountability: Monitoring the progress toward implementation and completion of the outcomes required by the Settlement Agreement

The QMIA Workgroup, which met during the Implementation Planning process, identified the key performance metrics that will be monitored, assessed and utilized in planning system improvement. The key performance metrics form the basic framework of the QMIA and are based on critical points in the care process, such as services and supports, the Access Model, or the Principles of Care and Practice Model.

The Key Quality Performance Management Indicators have been organized in to the following categories:

1 - Process: Interactions between children, youth and families and providers, this includes diagnosis, treatment, and the quality of care delivered.

Examples: referrals, screening, assessment, eligibility, service delivery, provider performance, and safety

2 - Child, Youth and Family Outcomes: The effects of mental health care on children, youth and families.

Examples: Engagement, effectiveness, child, youth and family perception of care, changes in strengths and needs (CANS scores).

3 - System Impact: The context in which care is delivered.

Examples: Access to and availability of resources, provider training, expenditures, development of core system and cross system administration and management competencies

Each of the key Quality Performance Management Indicators will be used to identify specific workforce development and training outcomes as outlined in Goal 5 of the WFD and Training Plan. Identification of these outcome measures will begin during Phase 1 (January 2017) of the WFD Plan with evaluation of those outcomes coming during Phase 2 (January 2018) and Phase 3 (January 2019).

<center>**Section III**</center>

<center>**Workforce Development Goals and Objectives**</center>

The WFD and Training Plan envisions transforming the lives of children and their families by creating a sustainable Idaho Children's Behavioral Health workforce that is professionally and culturally competent and diverse, in which the Principles of Care are the guiding foundations of education, training and practice.

To achieve this vision the WFD Plan outlines five (5) overarching goals that address developing the workforce, supporting the workforce and strengthening the workforce. Ideally, the goals of the WFD Plan, through its objectives, will be achieved over the course of the next 2-3 years by the timelines identified.

These goals speak to the overall outcomes of the WFD Plan.
-Identifying the gaps in the current system to deliver services and supports
-Identifying the future workforce needs of the new System of Care to include access, capacity and competencies
-Provide sustainable training, coaching and mentoring to the workforce
-Support families and youth as a critical and necessary part of the workforce
-Ensure the sustainability, quality and effectiveness of training and education

Workforce Development Goals and Objectives

> **Goal 1**. To enhance, develop, and strengthen a workforce that is guided by the System of Care philosophy and the Principles of Care.

To achieve this goal, the current system must carefully evaluate its workforce. This includes the capacity, accessibility and the competency of the workforce to deliver services and supports to class members. Once a thorough assessment has been conducted, priorities will be established, followed by a plan to address the gaps. Following, subsequent future priorities will need to be addressed.

When considering the competency of the current workforce, it is important to understand that while it is critical that the workforce have the clinical skills to deliver services, it is equally important that the workforce has a solid core competency base that is foundational to working with children, youth and families. To date Idaho has not adopted Core Competencies for delivering behavioral health services. As well, having effective leadership in a changing system is often assumed, but not always the case in practice. A changing system requires the development of leaders to expand their management knowledge, skills and abilities to include organizational change, community and partner building. This will involve developing core leadership competencies, expanded training initiatives, mentorship opportunities, and recognition and rewards. Leadership development initiatives should be formally evaluated and refined based on the resulting data regarding the impact of these efforts.

Objectives:
1. Assess the current workforce capacity to deliver Services and Supports to Class Members
2. Identify the current gaps (access, capacity and competencies) in workforce to deliver Services and Supports
3. Develop priority areas for addressing gap (access, capacity and competencies) to deliver Services and Supports
4. Conduct a provider Readiness Assessment
5. Develop an initial plan to address access and capacity gaps
6. Identify the Core Competencies needed for working with children and families needed to work within the new System of Care
7. Develop the infrastructure among partnering agencies to increase leadership competencies within the System of Care
8. Develop secondary priority areas for addressing gap (access, capacity and competencies) to deliver Services and Supports
9. Develop a plan for the implementation of Core Competency standards
10. Identify core leadership competencies needed to lead the system of care

Goal 2. To engage Idaho's communities in order to effectively meet the behavioral health needs of their most vulnerable children by creating sustainable education, training, and outreach.

Communities are a key in the development of a sustainable System of Care. It is important to engage stakeholders not only in the development of training, but in the delivery of training. As training, prevention, and treatment organizations attempt to address workforce issues, there is a notable tendency to do what is affordable rather than what is effective. System and agency managers are increasingly hungry for workforce tools of proven effectiveness, yet relatively few interventions or models are well described, portable, and easily adapted to different settings. A long term and sustainable approach to training will require agency and community partnerships to develop the infrastructure, resources and funding.

Objectives:
1. Engage stakeholders across youth and child serving systems in the development of a Phase 2 Workforce Development and Training Plan
2. Complete the initial version of the Practice Manual that will include the Access Model, the Practice Model and Principles of Care
3. Develop training and stakeholder priorities for Phase 2
4. Complete a Phase 2 Workforce Development and Training Plan
5. Explore various ways that technology can be used to enhance training and education
6. Develop initial curriculum that will be used to provide core training to providers, stakeholders and families
7. Develop a tiered provider, stakeholder and family training plan
8. Create Roll-Out and Training Schedule

9. Develop a comprehensive cross agency and stakeholder resource and funding plan that will support sustainable education and training
10. Create the infrastructure to provide ongoing education, training, coaching and mentoring to providers and stakeholders

Goal 3. Provide support and information to help families engage with the system, participate in meetings, and direct the care of their children as a respected and critical part of the treatment team.

Traditionally, the concept of viewing family and youth as part of the workforce is still relatively new. Yet, in the Child and Family Team approach, without the family at the core, there is no team. Family members and youth can best advocate for themselves by having access to the information they need to be an effective team participant. Training, advocacy, and leadership opportunities are just a few avenues to building an effective family/youth workforce. Additionally, increasing access to Family Support can help families and youth build the support and confidence needed to work with their treatment team.

Objectives:
1. Engage the Parent Network and other parent partners to participate in developing a plan for outreach and training
2. Create a youth and family focused engagement, information and education plan
3. Create opportunities for youth and families to engage in leadership training and to assume leadership roles
4. Develop shared decision making skills among youth receiving services, their families and providers
5. Expand Family Support services to families
6. Engage youth and families in roles as educators for other members of the workforce in provider training and education programs
7. Increase employment opportunities for family as paid staff in provider organizations

Goal 4: Strengthen the workforce by implementing systematic recruitment and retention strategies at the state and local levels.

Recruitment and retention of qualified professionals is multi-systemic problem. Not only does Idaho lack in trained individuals in many disciplines, it lacks the ability to adequately serve in rural and frontier communities. While recruitment and retention programs, such as loan repayment from the Health Resources and Services Administration serve to incentivize prospective employees, it is not a single effective strategy. As well, the clinical requirements for eligibility may be overly prescriptive and not always flexible. Recruiting for a culturally and linguistically diverse workforce presents its own challenges. Multiple strategies are needed at the state, local and community level.

Objectives:
1. Identify Idaho's professional shortage areas as they relate to Idaho's population, demographics and service location needs
2. Evaluate local, state and national programs currently being used in Idaho for recruitment and retention related to professional shortages
3. Identify workforce priorities for Phase 2, Phase 3 and beyond
4. Select recruitment and retention strategies for identified workforce priorities
5. Develop a plan to address workforce shortages in the priority areas identified
6. Evaluate recruitment and retention plan

> **Goal 5**: The impact of the Workforce Development and Training Plan will be evaluated using the principles and strategies of TCOM and consistent with the YES

The Quality Management, Improvement, and Accountability Plan (QMIA) Plan describes the development of a collaborative, cross-system, practice, performance monitoring and clinical quality improvement system. The QMIA Plan explains how Idaho's child serving systems will monitor, assess, and report on the progress toward the execution of the commitments set forth in the Jeff D. Settlement Agreement. Each of the key Quality Performance Management Indicators will be used to identify specific workforce development and training outcomes.

Objectives:
1. Implement the enhanced QMIA infrastructure identified in the QMIA Plan
2. Establish key outcome indicators that will be tracked to assess the quality of care delivered
3. Begin to develop quarterly QMIA reports that address the impact of the Workforce Development and Training Plan on child, youth and family outcomes, including all key decision points: screening, engagement, appropriateness, effectiveness and linkages
4. Evaluate the impact of the Workforce Development Plan on child, youth and family outcomes
5. Evaluate the impact of the clinician, supervisor, management and administrator training on child, youth and family outcomes
6. Continue development of QMIA methodology to assess identification of workforce gaps and training needs and implement Performance Improvement Projects
7. Implement monitoring processes to assess fidelity to the Access Model, the Principles of Care and Practice Model, and to Intensive Care Coordination (Wraparound)
8. Implement Quality Review process to assess child, youth and family perception of care

<h2 style="text-align:center">Goals and Objectives Timeline</h2>

The goals, objectives and tasks developed to accomplish the work of Objective 4 of the Implementation Plan to develop the workforce, support the workforce and strengthen the workforce is envisioned to be achieved over the course of the next 30 to 36 months. The work is broken into three (3) phases beginning January 2017 through 2019 and beyond. The table reflects the timeline for each phase and the corresponding goal and objective to be accomplished during the phase. Throughout each phase of the WFD Plan tasks, responsibility, target date for completion and deliverables will be more clearly articulated when more information is gathered and decision are made regarding next steps. It is expected that Phase 2 of the Workforce Development and Training Plan will be updated and delivered by December 2017.

Phase	Timeline	Goals	Objectives
I	January 2017-December 2017	1	1-4
		2	1-4
		3	1-2
		4	1-3
		5	1-3
II	January 2018-December 2018	1	5-8
		2	5-9
		3	3-6
		4	4-5
		5	4-6
III	January 2019-December 2019	1	9-10
		2	10-13
		3	7
		4	6
		5	7-8

Phase 1 Workforce Development Tasks

Goal 1- To enhance, develop, and strengthen a workforce that is guided by the System of Care philosophy and the Principles of Care			
Objective 1- Assess the current workforce capacity to deliver Services and Supports to Class Members Objective 2-Identify current gaps (access, capacity and competencies) to deliver services and supports Objective 3-Develop priority areas for addressing gaps (access, capacity, competencies) Objective 4-Conduct a provider readiness assessment			
Tasks	Who is responsible	Target Date	Deliverable
Complete a contract with an Idaho University (contractor) to address objectives 1-4	DBH	May 2017	1. Scope of Work 2. Signed contract
Contractor will conduct an analysis of workforce data currently available and a literature review	DBH Contractor	June 2017	1. Complete data and literature review 2. Complete the development of a provider survey
Contractor will complete a provider survey to gather information on access, capacity and competencies	DBH Contractor	October 2017	1. Deliver provider survey results 2. Identify gaps on access, capacity and competencies
Contractor will develop recommendations for addressing priority gaps in access, capacity and competencies	DBH Contractor	January 2018	1. Develop recommendations to address gaps and identify priorities
Develop and conduct a provider readiness assessment to identify competency and training needs	DBH Contractor	January 2018	1. Design and implement a readiness assessment 2. Incorporate information from the readiness assessment into recommendation for addressing gaps and priorities

Goal 2- To engage Idaho's communities in order to effectively meet the behavioral health needs of their most vulnerable children by creating sustainable education, training, and outreach.

Objective 1- Engage stakeholders across youth and child serving systems in the development of a Phase 2 Workforce Development and Training Plan
Objective 2- Complete the initial version of the Practice Manual that will include the Access Model, the Practice Model and Principles of Care
Objective 3-Develop training and stakeholder priorities for Phase 2
Objective 4-Complete a Phase 2 Workforce Development and Training Plan

Tasks	Who is Responsible	Target Date	Deliverable
Convene members of the WFD Workgroup	DBH WFD Workgroup Object Lead	June 2017	1. Identification of workgroup members 2. Schedule meetings through Phase 2
Practice Manual workgroup convenes	DBH WFD Workgroup Part 2 Object Lead	May 2017	1. Practice Manual Scope of Work and contract with Idaho university 2. Practice Manual content development
Completion of initial Practice Manual	Contractor DBH Objective lead	October 2017- December 2017	1. Practice Manual 2. Practice Manual curriculum for test training
Practice Manual Testing	DBH Contractor	December 2017- February 2018	1. Evaluation of testing and curriculum modifications
Contractor will develop recommendations for training priorities based on the stakeholder priority gaps in competencies	Contractor	December 2017- January 2018	2. Develop recommendations to address gaps and identify priorities

Goal 3: Provide support and information to help families engage with the system, participate in meetings, and direct the care of their children as a respected and critical part of the treatment team.			
Objective 1- Engage the Parent Network and other parent partners to participate in developing a plan for outreach and training Objective 2- Create a youth and family focused engagement, information and education plan			
Tasks	Who is Responsible	Target	Deliverable
Review the WFD and Training Plan with the Parent Network	DBH WFD Workgroup Chair	July 2017	1. Develop comprehensive review of WFD Plan and solicit participation in creating an family specific training plan
Convene family members and youth to develop a region specific training outline	DBH WFD Workgroup Chair Parent Network Chair	August-October 2017	1. Develop a family and youth focused training plan that spans through Phase 1 and Phase 2
Begin Region-specific training for families and youth	DBH Community Partners	December 2017	1. Deliver Foundational training concepts to family in youth in each region of the state

Goal 4: Strengthen the workforce by implementing systematic recruitment and retention strategies at the state and local levels			
Objective 1- Identify Idaho's professional shortage areas as they relate to Idaho's population, demographics and service location needs Objective 2- Evaluate local, state and national programs currently being used in Idaho for recruitment and retention related to professional shortages Objective 3- Identify workforce priorities for Phase 2, Phase 3 and beyond			
Tasks	Who is Responsible	Target Date	Deliverable
Complete a contract with Contractor to address objectives 1-3	DBH	May 2017	1. Scope of Work 2. Signed contract
Contractor will conduct an analysis of data currently available and a literature review related to recruitment and retention.	Contractor	July-August 2017	1. Complete data and literature review 2. Complete the development of a provider survey
Contractor will complete a provider survey to gather information on population, service and demographics	Contractor	October 2017	1. Deliver provider survey results 2. Identify gaps
Contractor will make recommendations related to workforce priorities for Phase 2	Contractor	January 2018	1. Deliver recommendations to DBH for incorporation into Phase 2 WFD and Training Plan

Goal 5: The impact of the Workforce Development and Training Plan will be evaluated using the principles and strategies of TCOM and consistent with the YES QMIA Plan
Objective 1- Implement the enhanced QMIA infrastructure identified in the QMIA Plan Objective 2- Establish key outcome indicators that will be tracked to assess the quality of care delivered Objective 3-Begin to develop quarterly QMIA reports that address the impact of the Workforce Development and Training Plan on child youth and family outcomes including all key decision point: screening, engagement, appropriateness, effectiveness and linkages

Tasks	Who is Responsible	Target Date	Deliverable
Convene the QMIA Council to review the WFD and Training Plan	DBH QMIA	June 2017	1. Establish priorities for WFD outcomes
Establish which outcome indicators will be tracked for Phase 1 of the WFD Plan	WFD Workgroup DBH QMIA QMIA Data/Reports	June 2017	1. Identify 3 key quality performance indicators for Phase 1
Identify data elements and reporting requirements for Phase 1 WFD Plan	DBH QMIA QMIA Data/Reports	August 2017	1. Data elements identified and report requirements developed
Develop 1st quarterly report for WFD Plan Phase 1	DBH QMIA QMIA Data/Reports	November 2017	1. Data report completed, reviewed and published

Workforce Training Plan

Specific to the Jeff D. Settlement Agreement, training content for the workforce is outlined as, but not limited to;

- o System of Care
- o Principles of Care
- o Practice Model
- o Access Model
- o Child and Adolescent Needs and Strengths (CANS)
- o Child and Family Team
- o Services and Supports

When considering the multiplicity of the provider network, child serving agencies, community stakeholders and family and youth, it is challenging to provide a "one size fits all" approach.   In the development of the Training Plan, a considerable stakeholder list was developed that reflected three primary groups of stakeholders. The first priority group was identified as having a direct role in the delivery of behavioral health services.

- o DBH staff, clinical, operations and administration
- o Medicaid Idaho Behavioral Health Plan Network Providers
- o IDJC and County Juvenile Probation
- o Family and Youth

The second priority stakeholder group was identified as being direct providers of medical and behavioral health services but not enrolled under the Idaho Behavioral Health Plan.

- o Primary Care Providers
- o Pediatricians
- o Other child serving behavioral health providers

The third priority group of stakeholders reflects those stakeholders considered to be entities that will fall under the Communication Plan. The Communication Plan will involve a number of outreach approaches. Some of these outreach efforts may include web based information and training, literature, public service announcements, community outreach and professional association trainings.

A phased approach to training development and training will begin January 2017 and continue into January 2020. The initial target audience for Foundational and Pilot Training will be primarily DBH Children's Behavioral Health staff, Medicaid Independent Assessors, IDJC, County Juvenile Probation and private providers who have been selected to participate in the CANS pilot.

Phase 1 (January 2017-December 2017) Foundational and Pilot Training
- System of Care
- Principles of Care
- Transformational Collaborative Outcomes Management (TCOM)
- Practice Model
- Child and Family Teams
- CANS (training DBH pilot)
- Wraparound

Phase 2 (January 2018-December 2018) Training
- CANS training for providers
- Practice Manual Training
  - Principles of Care
  - Transformational Collaborative Outcomes Management (TCOM)
  - Practice Model
  - Child and Family Teams
  - Wraparound
  - Wave 1 Services and Supports Training

Phase 3 (January 2019-December 2019) Training
- Wave 2 Services and Supports Training
- Practice Manual Training
  - Principles of Care
  - Transformational Collaborative Outcomes Management (TCOM)
  - Practice Model
  - Child and Family Teams

The Foundational Training and Pilot Training Roll-Out Timeline reflects the tasks and activities that will occur during Phase 1 of the plan having begun in April 2017 and ending December 2017. Sequentially, once the WFD and Training Plan is finalized, the development of the Practice Manual will begin with the establishment of the Practice Manual Workgroup and through a contracted entity. A Training Specialist for the Division of Behavioral Health will be hired in April 2017 which will initiate the organizational and content structure for the delivery of training for the Division of Behavioral Health, agencies and targeted providers that have agreed to participate in the CANS pilot project. Once the initial version of the Practice Manual has been developed, a companion curriculum will be developed and tested before the beginning of Phase 2 when comprehensive training to the Practice Manual will begin.

Foundational Training Roll-Out Timeline
Phase 1
February 2017-December 2017

Target Date	Event	Who is Responsible	Date of Completion
February 2017	WFD and Training Plan draft completed	WFD Workgroup	February 2017
May 2017	WFD and Training Plan finalized for Phase 1	DBH Medicaid	March 31, 2017
March 2017	Practice Manual development	Practice Manual (PM) Workgroup DBH Contractors	October 2017
May 2017	Hire Training Specialist for DBH	DBH	April 28, 2017
May 2017	Hire CANS Support and Training staff	DBH	April 28, 2017
July 2017	Develop content and contracts for Phase 1 Foundational Training	DBH	July 2017
July 2017	Develop schedule for Phase 1 Foundational Training	DBH	June 2017
August-September 2017	CANS Training for DBH Pilot	DBH	September 2017
August-September 2017	CANS training for Medicaid Independent Assessors	DBH	September 2017
June 2017	Hire Regional DBH staff for Wraparound Pilot	DBH Regional CMH Chiefs	July 28, 2017
July 2017	YES Foundational Training begins for DBH CO and Regional pilot staff	DBH Contractor	August 2017
September 2017	Wraparound Training for DBH pilot	DBH Contractor	October 2017
November 2017	Wraparound pilot for DBH	DBH	
November 2017	CANS Training and Certification for DBH Regional programs	DBH	December 2017
November 2017-January 2018	Curriculum development for Practice Manual Test	DBH Contractor	February 2018
January-February 2018	Practice Manual Test	DBH Contractor	March 2018
January 2018	Wraparound training for all DBH staff	DBH Contractor	March 2018

January 2018	Training for CANS for community provider pilot	DBH Contractor	February 2018
January 2018	Online Practice Manual available	DBH	January 2018

System of Care

Description: A system of care is a spectrum of community-based services and supports to improve the lives of children and youth with or at risk of serious mental health conditions. Systems of care build meaningful partnerships with families and youth, address cultural and linguistic needs and use evidence-based practices to help children, youth and families function better at home, in school, in the community and throughout life. The System of Care introduction training will serve to introduce the concepts and goals behind having a System of Care to stakeholders and partners who may work or identify children with SED.

Objectives:

1. Define System of Care
2. Identify the goal of System of Care
3. Identify how the System of Care works
4. Describe the System of Care Core Values
5. Define the Child and Family Team

Principles of Care

Description: In systems of care, the state, county, and local agencies partner with families and communities to address the multiple needs of children and families involved in child welfare, mental health, juvenile corrections, schools, and other service systems. At the heart of the effort is a shared set of guiding principles that are essential elements of any successful system of care. The implementation of these principles reflects the common goals of the agency, community, and family to ensure the safety, permanency, and well-being of children, youth, and families.

Objectives:

1. Define the purpose of the Principles of Care w/in a System of Care
2. Become familiar with the Principles of Care

Transformational Collaborative Outcomes Management (TCOM)

Description: Transformational Collaborative Outcomes Management (TCOM) is an approach 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 serviced). In health care, the shared vision is the patient; in the child servicing system, it is the child and family, and so forth. By creating systems that all return to their shared vision, it is easier to create and manage effective and equitable systems.

Objectives:

1. Describe the purpose of the TCOM
2. **Understand the philosophy of the TCOM**

Practice Model

Description: Children and families are best served through six key practice components (engagement, assessment, care planning and implementation, teaming, monitoring and adapting and transition) that make up an overarching Practice Model. Over the course of treatment and transition, the six practice components are organized and delivered in the context of an overall Child and Family Team (CFT) approach. Many of these practice components will occur throughout a child and family's experience in care and several will overlap or take place concurrently with other practice components. Consistent with the principle of individualized care, a child and family's experience of care should be guided by the Practice Model and tailored according to his or her individual needs and strengths.

Objectives:
1. What is the purpose of a Practice Model?
2. How does it relate to the System of Care, Child and Family teams and Wraparound?
3. What are the six components of the Practice Model

Introduction to CANS and E-CANS

Description: The Child and Adolescent Needs and Strengths (CANS) tool is used in the assessment process that provides a measure of a child's or youth's needs and strengths. This is important and necessary information for the Child and Family Team to use to build an effective treatment plan. The information will help the Child and Family Team make decisions about what should be done to help the child and family in terms of mental health services and supports. The state will use the CANS to identify children and youth who may be Class Members. The tool will also be used to track the Class Member's progress in treatment.

Objectives:

1. Understand the primary objective of using the CANS.
2. Describe how using the CANS can represent and communicate the shared vision for families.
3. Understand how the CANS help facilitate the linkage between the assessment process and the design of the individualized service plans.
4. Understand how the CANS can be used for safety planning.

Child and Family Teams (CFT)

Description: The CFT approach is a teaming process that brings together the family and individuals that the child and his or her family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals. These individuals may include informal community supports, such as extended family,

neighbors, friends, coaches, faith-based connections, and tribal members. CFT members may also include formal supports, such as providers and family peer support specialists, educational professionals, and representatives from other agencies providing services to the child and family.

Objectives:
1. What is a Child and Family Team?
2. What is the goal of the CFT?

Wraparound

Description: Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The Wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family.

Objectives:

1. What is Wraparound?
2. What are the elements of Wraparound?
3. Who can receive Wraparound services?
4. What takes place during the Wraparound process?
5. What specialized staff roles are needed for the Wraparound process with families?

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