OBJECTIVE 3: Access — The agencies establish and operate statewide an access system or protocols for Class Members and their families that timely identify, assess, and link them to the services/supports they need and are entitled to under the Agreement. The work of this Objective will be accomplished through the Services/Supports Workgroup, chaired by the IDHW. The work of operating an access process, as described in the following Strategies and Tasks will be described in the Practice Manual.

Expected Results of Accomplishing Objective 3: *Agencies have developed, adopted, and are consistently using the specified models, protocols, and tools necessary to identify, assess, and serve Class Members and their families. Agencies are communicating this process and are providing informative materials statewide to the community, stakeholders, and families. Class members, their families, and community stakeholders are informed about who is eligible for services under the Agreement, what services are available, and how to access services.*

Strategies to Accomplish Objective 3

A. Progressively implement use of the statewide Access Model to identify and move Class Members through the SoC. Full implementation of the Access Model will coincide with completion of CANS implementation by December 30, 2018. Creating transparency of the information pertaining to access, including additions, deletions and improvements to existing processes, products or authorities, will be accomplished through the Communication plan. The operations associated with this work will be addressed in the Practice Manual as relevant. Developing capacity and competencies for creating sufficient access to care will be addressed in the Workforce Development plan.
    1. Develop business flow diagrams that describe the existing pathways into, through, and out of the SoC for each agency's identification, screening, assessment, referral, planning, treatment, and transition process and policies.
    2. Identify Access Model requirements the agencies currently have in place including policy, administrative rules, and operations.
    3. Identify where agencies' responsibilities for serving Class Members intersect or overlap.
        a. Determine the specific functions of the agencies' programs that will operate in a coordinated manner to identify, screen, assess, refer, plan, treat, and transition Class Members across the agencies to meet requirements of the Access model.
        b. Design and adopt efficient business flow across agencies for ensuring a non-duplicative process of identifying, screening, assessing, referring and linking Class Members.

4. Administrators and directors of agencies provide the authority to develop and implement consistent agency-specific protocols necessary to operationalize the process described in Strategy A, Task 3.

B. Inform and guide the management and delivery of the services/supports by providers and contractors consistent with the Access Model and consistent with the PoC and PM by December 30, 2017.
    1. Review existing methodologies and contract requirements being followed across the agencies in relation to children and their families' access to services.
    2. Identify necessary and recommended changes to existing methodologies and contract requirements sufficient to support mental health providers and managed care contractors in delivering services consistent with Access Model and consistent with the PoC and PM.
    3. Under the direction of agencies' directors and administrators, develop a plan with timeline to make changes to policies, processes and contract requirements to align with the Access Model. This will be included in the Project plan described in Objective 1, Provide Services and Supports to Class Members, and in Objective 6, Governance and Interagency Collaboration.

C. Design and operate an identification and referral process that facilitates the identification of potential Class Members by child-serving entities including agencies, behavioral health providers, medical providers, county juvenile corrections, law enforcement, and educators, and for making referrals to the IDHW Assessment Process (described in Strategy D) by December 30, 2017. The identification and referral process will account for various levels of communication including face-to-face as well as telecommunications and will be described in the Practice Manual. The identification and referral process will be included in the training curriculums within the Workforce Development plan. The statewide dispersal of the information regarding the identification and referral process will be addressed in the Communication plan. The ongoing review and refinement of the identification and referral process will be addressed in the QMIA plan.
    1. Develop and use a defined set of indicators of potential class membership to be used for systemic screening or referral to the IDHW Assessment Process. IDHW will develop protocols for accepting referrals from other child-serving systems, agencies, or individuals including accepting self-referrals from youth and/or families.
        a. Describe the steps necessary for any entity or person to participate in the identification process of potential Class Members.
            i. Develop the Checklist, as described in the Agreement that can be used by any interested person and will serve as the

mechanism for the broadest possible entryway into the SoC. The Communication plan will describe the statewide dispersal of the Checklist, making it easily available to anyone seeking to use it. Dispersal methods may include mailings, websites, public service announcements, service directories, waiting rooms, etc. The Checklist itself will provide direction for its use and referral information.

ii. Identify process and qualified users of the Screening Tool that is to be derived from the CANS. This Tool may be used to identify potential Class Members who may have unmet mental health treatment needs. Regardless of the outcome of the screening, the process necessarily includes the screener providing referral information to the potential Class Member, Class Member and the family to appropriate services using the IDHW Assessment Process. The Communication plan describes the work for reaching specific child-serving entities who will qualify as screening entities. The Workforce Development plan includes curriculums for using the Screening Tool. The Practice Manual includes guidance on how to communicate screening results to the potential Class Members and their families consistent with the PoC and PM.

iii. Develop materials designed to inform potential Class Members, Class Members and their families about their right to request services (or self-refer) under the Agreement, including screening and assessment. These materials will be developed with input from youth, families, and other community stakeholders and made available statewide and in a variety of media. Such messaging and the process for achieving it will be described in the Communication plan.

iv. Design, describe and make publicly available, the information necessary for connecting potential Class Members with positive Checklists and/or positive Screenings to the IDHW Assessment Process (described in Strategy D).

2. Collaborate to determine what constitutes a positive Checklist and a positive screen as well as what constitutes a timely referral for screening and/or assessment. Such standards will be incorporated into the Idaho Behavioral Health Standards of Care.
3. Each agency will develop and use system-specific indicators to identify potential Class Members for referral to screening or to the IDHW Assessment Process.

D. IDHW will design, operate and maintain an Assessment Process to determine Class Membership status of children and youth referred to it beginning January 1, 2018. The Assessment Process will account for receipt of referrals from all sources as described in Strategy C above. The Assessment Process will be described in the Practice Manual. Standards for the provision of an Assessment will be incorporated into the Idaho Behavioral Health Standards of Care. The Assessment Process will be included in the training curriculums within the Workforce Development plan. The statewide dispersal of the information regarding the Assessment Process will be addressed in the Communication plan. The ongoing review and refinement of the Assessment Process will be addressed in the QMIA plan.

1. Define scope of Assessment Process, including incorporation of the CANS (see Strategy E for CANS implementation). Describe how the Checklist and Screening Tool are incorporated into the process to maximize opportunities to identify potential Class Members who are seeking services.
    a. Develop and implement a statewide protocol for linking children and their families to services following the Assessment Process. Among other things, the protocol will include:
        i. A process for referring and connecting children determined ineligible for services under the Agreement, and Class Members who choose not to participate in services available under the Agreement, to appropriate mental health and/or community services and supports.
        ii. A process for the assessor to link the Class Member and family to the entity responsible for engagement in the treatment planning process, described in Strategy E, consistent with the Access Model.
2. IDHW will describe sequential steps of the Assessment Process, the associated quality standards to be met in the Assessment, the minimum qualifications of assessors, and the required timelines for completion of the initial Assessment and reassessment and referral to services. In addition, IDHW will:
    a. Develop guidance for assessors to provide the full results of the Assessment and the corresponding clinical recommendations, including the determination of Class Membership, to assessed youths and their families, unless such disclosure is prohibited by law or regulation.
    b. Develop and implement a statewide protocol for determining ongoing eligibility for Class Membership and transitioning out of care consistent with the Access Model and the PM. This protocol will include a process

for determining when a Class Member no longer meets class membership requirements. This protocol will also include processes for recording and reporting determinations of ongoing class membership as data for use in the QMIA plan and for notifying Class Members and their families consistent with the due process requirements under the Agreement.

c. The guidance and protocol, described in a and b above, will be consistent with the PoC and PM and developed in collaboration with youth, families, and other community stakeholders.

E. Develop and use the CANS tool statewide, as described in the Agreement, to screen potential Class Members for unmet mental health needs, assess Class Members' individual and family strengths and needs, support clinical decision-making and practice including formulating treatment plans, measure and communicate client outcomes, and improve service coordination and quality beginning January 1, 2018. Use of the CANS tool and its purpose will be detailed in the Practice Manual. Standards for using the CANS tool will be incorporated into the Idaho Behavioral Health Standards of Care. Certification in use of the CANS tool and how it will be used in the identification, referral and assessment processes addressed above in Strategies B and C will be included in the training curriculums within the Workforce Development plan. The statewide dispersal of the information regarding the CANS deployment plan and the role of the CANS will be addressed in the Communication plan. The ongoing review and refinement of the use of the CANS tool will be addressed in the QMIA plan.

1. The following activities will be completed during the development and implementation of the CANS tool(s):
   a. Training by Dr. John Lyons or a CANS certified trainer;
   b. Develop valid CMH version of CANS through workgroup model of action;
   c. Develop Checklist and screening tool;
   d. Develop Class Member profile;
   e. Develop Intensive Care Coordination (ICC) profile.
2. Design and implement a process that makes use of the CANS tool(s) for identifying, screening and assessing potential Class Members, confirming Class Membership, identifying need for ICC and facilitating the creation of a treatment plan.
   a. Develop plan for deployment of CANS including a training plan for creating and maintaining statewide capacity for use of the tool, automation of the tool and descriptions of agencies' and providers' roles and responsibilities (Strategy A, Task 3 are dependencies.)
   b. Implement statewide CANS deployment plan.

F. Develop and begin implementing by January 1, 2017, a statewide Communication plan that includes outreach and education of the community, stakeholders, and families. The effectiveness and ongoing refinement of the products, processes and activities of the Communication plan will necessarily include the input of potential Class Members, Class Members and their families and providers of services/supports.

1. Establish and maintain products and outreach activities to provide easily accessible and publicly available descriptions or explanations of the Agreement, the Services/Supports, the PoC and PM, and the Access Model to Class Members, their families, and other stakeholders.
    a. Develop action plan for outreach activities. Examples of outreach activities include, but are not limited to, newsletters, participation in health fairs or other community events through staffing a vendor booth, distribution of information and products that include use of the new branding specifically developed for the children's SoC, providing speakers at public and professional events.
    b. Communications: Develop focused communications to specific stakeholder groups in the SoC. Examples of some of the recipients of these communications may include but are not limited to the State Planning Council on Behavioral Health, the seven (7) Regional Behavioral Health Boards, the Idaho Hospital Association, the Idaho Psychiatric Association, the Idaho Psychological Association, the Psychiatric Rehabilitation Association, the National Association of Social Workers-Idaho Chapter, the Idaho Counseling Association, the Idaho Primary Care Association, the Idaho Academy of Family Physicians, the Idaho Association of Community Providers, and the population of behavioral health professionals and paraprofessionals who provide publicly-funded behavioral health services. Additional examples of stakeholders include but are not limited to: legislators, law enforcement entities, Medicaid regional nurse reviewers, magistrates, probation officers, educators, IDHW navigators, public health nurses and public health community outreach workers.
    c. Social Marketing Communications: Engage community advocacy organizations such as, but not limited to, NAMI, Idaho Federation of Families on Children's Mental Health, Idaho Parents Unlimited and the Idaho Association of Community Providers for opportunities to partner in development of communication materials and events to promote awareness and interest in the SoC and how to access it. Examples include but are not limited to topic-specific email alerts, individual meetings with organizations, live webcasts – with interactive question

and answer sessions, webinars, summaries of state-sponsored planning meetings posted on state websites.

d. The Communication plan will include development and implementation of a schedule for creating and distributing communication products and conducting and hosting communication events based on the communications tasks described above.

3. Conduct initial and periodic review of printed and electronic materials to identify opportunities to improve the effectiveness of the communications.
   a. Solicit responses and input from Class Members, their families and other stakeholders regarding communication products, processes, and outreach activities to obtain feedback for finalization or improvement of the Communication plan, communication products, processes, and outreach activities.
   b. Finalize or update communication products and events.
   c. Develop and execute schedule of implementation for updated products, processes, and outreach activities.
4. Build a new website, hosted by IDHW, to be jointly managed by the agencies, dedicated to the SoC, in order to publicly provide relevant information including descriptions of the SoC as a whole, specific services, resources, and topics of interest to stakeholders, youth and families.
   a. Establish protocols and standards for content management.
   b. Include interactive features to provide public opportunity for making inquiries and obtaining responses that will directly answer the inquiry or provide information on where the answer can be obtained.
   c. Include calendar of events to provide public notice of related meetings and actions.
   d. Include relevant information requested by Class Members and their families.
   e. Post information about and link to the jointly managed dedicated website and on each agency-specific website.