Youth
Empowerment
Services

Practice Manual

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Contents

GETTING STARTED WITH YES

YES.idaho.gov

You have a variety of ways to determine if your child may benefit from mental or behavioral health services

1 TAKE THE FIRST STEPS

- Call the Idaho Behavioral Health Plan Managed Care Organization and talk to someone about getting help.
- Talk to a doctor about getting help and completing a mental health screener.
- Use the Youth Mental Health Checklist for Families available under "Parents" at YES.idaho.gov.

2 YOUR CHILD MAY BE ELIGIBLE FOR MEDICAID

To apply:

- Call 1-877-456-1233 **OR**
- Go to idalink.idaho.gov

NOTE: Medicaid income limits are higher for children with serious emotional disturbance (SED).

3 GET AN ASSESSMENT

- If you **previously applied for Medicaid and were not eligible**, call the Independent Assessor to schedule an assessment for SED.

YES Questions?
Call 1-800-352-6044

4 FIND A PROVIDER

- Call the Idaho Behavioral Health Plan Managed Care Organization for help locating services in your community.
- They can help even if your child is not eligible for Medicaid.

5 PARTICIPATE IN COORDINATED CARE PLANNING FOR YOUR CHILD

- Attend what is called "Child and Family Team (CFT) coordinated care plan meeting."
- Your child's mental health provider, other professionals, family, and friends can all participate in CFT meetings.
- Work with the members of your CFT to identify services, supports, and goals.

6 SET UP APPOINTMENTS WITH PROVIDERS WHO CAN PROVIDE THE SERVICES IN YOUR CHILD'S COORDINATED CARE PLAN

- Work towards the goals identified in the coordinated care plan.
- Celebrate milestones, goals, and successes.

RESOURCES

SED: Serious emotional disturbance refers to when youth under the age of 18 have both a behavioral health diagnosis and a functional impairment as identified by the Child and Adolescent Needs and Strengths (CANS) functional assessment tool.

Youth Mental Health Checklist: Find a copy at YES.idaho.gov under Getting Started - Parents in the top menu.

Independent Assessor
Liberty Healthcare
1-877-305-3469

Idaho Behavioral Health Plan Managed Care Organization: Magellan Healthcare
MagellanofIdaho.com or 1-855-202-0973

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Version Change History

Version 4:

Changes to this version of the practice manual are summarized below.

- Updated Practice Manual to update information per the transition from Optum Idaho as the managed care organization to Magellan of Idaho being the managed care organization in Idaho.

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Introduction

Overview

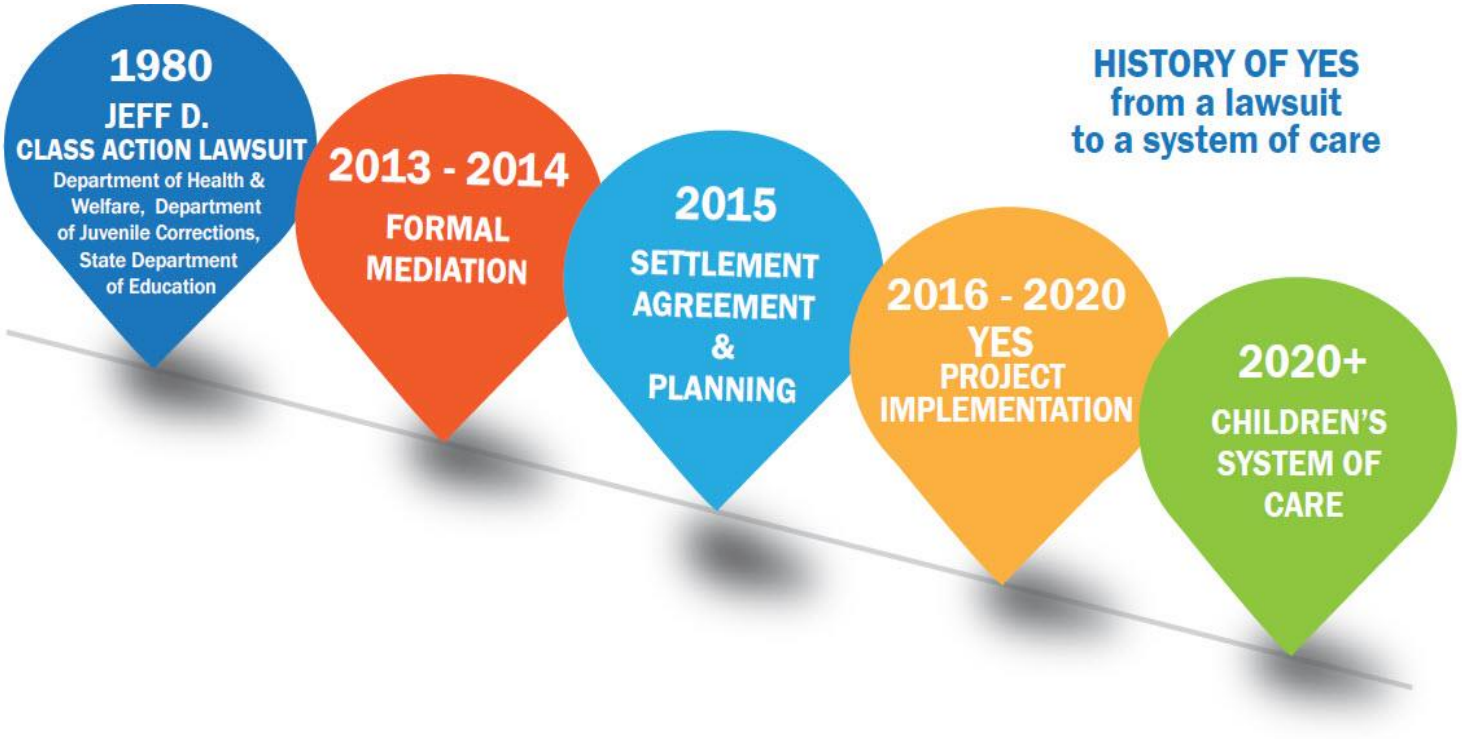
Youth Empowerment Services (YES) is the new mental health system of care in Idaho for youth with serious emotional disturbance (SED) — a term used to identify youth under the age of 18 who have both a mental health diagnosis and a functional impairment. YES uses a youth and family centered, team-based, strengths and needs focused approach for early identification, treatment planning, and implementation of care. Child and Family Teams create coordinated care plans with measurable goals that respect the youth's strengths, needs, community, and culture. Providers and agencies work together with the youth, family, and other supportive individuals in the youth's life to monitor and adjust the treatment plan as goals are met and needs change.

The Idaho Department of Health and Welfare, Idaho Department of Juvenile Corrections, Idaho State Department of Education, families, youth, and mental health professionals are working together to develop this system of care. The YES system of care began in 2019 and will continue to be monitored and improved to ensure the system is sustainable.

The introduction to the YES Practice Manual provides background information on the new system of care, introduces the YES system of care, and provides an overview of the rest of the YES Practice Manual.

Background

Idaho's new YES system of care grew out of the *Jeff D.* Class Action Lawsuit and Settlement Agreement. This lawsuit was filed in 1980 against the governor of Idaho, Idaho Department of Health and Welfare, Idaho Department of Juvenile Corrections, and Idaho State Department of Education for, in part, failing to meet the needs of youth determined to have SED. After many hearings and several attempts to implement an improved system of care, the plaintiffs and defendants came together to mediate an agreement. In 2015, all the parties signed the Jeff D. Settlement Agreement. The Agreement provides an outline for the system of care, a timeline to develop an implementation plan, and a timeline for the implementation of the new system of care.



The goals of the Settlement Agreement are to develop, implement, and sustain a family-driven, coordinated, and comprehensive children's mental health service delivery system that:

1. Identifies and screens youth who potentially have serious emotional disturbance and connects them to appropriate care according to a consistent statewide procedure, regardless of entry point or referral source.
2. Provides individualized services to youth with serious emotional disturbance consistent with the Principles of Care.
3. Communicates with youth and their families about the nature and purposes of services and how to access them.
4. Delivers a continuum of care that emphasizes high quality community-based services and supports in sufficient intensity and scope in the least restrictive environment appropriate to meet the youth's needs.
5. Coordinates delivery of mental health services among departments and agencies serving youth to reduce fragmentation of services for children and youth.
6. Measures and communicates treatment outcomes and system performance to improve quality of care and increase accountability to youth, their families, and stakeholders.
7. Supports engagement and involvement of youth and their families throughout the system of care, including treatment planning as well as system improvements and planning efforts.
8. Develops the workforce and infrastructure necessary to meet the need for availability and access to services and supports, and provides for education, training, and ongoing coaching of providers, youth, their families, and other stakeholders as applied to the system of care and its implementation.
9. Builds on existing strengths of the children's mental health system and uses state resources efficiently.
10. Fully accesses Medicaid and other federal funds maximizing opportunities for child serving agencies to work together on funding of common services.
11. Maintains a collaborative governance structure that includes state agencies, youth, their families, and other stakeholders.
12. Affords due process — procedures for youth and family to file complaints or appeals — to youth to ensure that they are not treated in an unfair, unsupported, or unreasonable way.
13. Leads to improved outcomes for youth and their families to:
    - Keep children and youth safe, in their own homes and in school.
    - Minimize hospitalizations and out-of-home placements.
    - Reduce potential risks to their families.
    - Avoid delinquency and commitment to the juvenile justice system to receive mental health services.
    - Correct or improve mental illness, reduce mental disability, and to restore functioning.

YES System of Care

The YES system of care is a continuum of community-based services and supports for youth with mental health needs. These services and supports are organized into a coordinated network that:

- Builds meaningful partnerships between providers, families, and youth to empower youth and families to make choices about the youth's care.
- Ensures a family's cultural and language needs are incorporated in the youth's care.
- Provides support to help youth function better at home, in school, in the community, and throughout life.

Implementing a system of care begins with a commitment on the local and state levels. It involves collaboration across agencies, families, and youth to improve access to care and expand available services and supports. It also requires an important cultural shift in the approach to delivering mental health care in the state of Idaho.

Idaho's mental health system was uncoordinated in the past. Access to services for youth with SED was limited, and youth and families did not have a say in treatment plans that were developed. YES puts a framework in place for a Child and Family Team to develop goals that guide all treatment plans and embrace 11 Principles of Care:

1. Family-centered
2. Family and youth voice and choice
3. Strengths-based
4. Individualized care
5. Team-based
6. Community-based service array
7. Collaboration
8. Unconditional
9. Culturally competent
10. Early identification and intervention
11. Outcome-based

In addition to these values, YES organizes the pathway to services, expands access to them, uses a coordinated care plan, and communicates goals across agencies and providers.

The YES website, yes.idaho.gov, provides information about the YES system of care, targeted information for youth, families, and providers, links to resources and links to YES partner agencies.

YES Practice Manual Overview

The YES Practice Manual, provides information on how the new system of care is used in practice. It is a guide for youth, families, and providers. Although the manual may be read from beginning to end, each individual part may also be read on its own. It may be referred to for answers to questions or to find specific information.

The manual contains seven chapters that explain the standards used in the YES system of care and the system as a whole. It also describes how state agencies and providers interact with youth and families to help them gain access to services and supports. Finally, the manual provides the structure for how youth and families can expect to move into, through, and out of care. The diagram shown below represents the YES system of care.

In the YES Practice Manual, chapters 1–6 each represent a part of the system of care. The seventh chapter contains information about the rights youth and families have to file a complaint or appeal a decision. The chapters in the manual are listed below.

1. Applying the Principle of Care and Practice Model
2. Identifying and Engaging Youth and Families
3. Assessing Youth and Determining Eligibility
4. Planning Coordinated Care
5. Exploring Services and Supports
6. Working Through Transitions
7. Filing Complaints and Appeals

In some places, the manual refers to other resources that may provide more complete or supplemental information. Links to these resources are embedded in the text, and a list of resources with information on how to obtain a printed copy is included in Appendix A.

The word “youth” is used throughout the practice manual to refer to anyone under the age of 18 except for in the “Tips for Families,” which uses “child” or “children.” The word “family” refers to birthparents, adoptive parents, guardians, extended family, family of choice, members of the family’s support system, and current caregivers.

Chapter 1: Applying the Principles of Care and Practice Model

Contents

Overview

The Principles of Care and Practice Model guide the delivery and management of mental health services and supports for youth in Idaho. These standards have been implemented throughout the state and are applied at every stage in the YES system of care.

This chapter provides a summary of each principle and an overview of the practice model.

For help getting started with YES, call one of the following numbers:

- **Magellan Member line 855-202-0973**
- **Liberty Healthcare 877-305-3469**

To learn unfamiliar terminology, refer to the Terms to Know.

Principles of Care

The Principles of Care are 11 values that are applied in all areas of mental health treatment planning, implementation, and evaluation.

1. Family-centered — emphasizes each family's strengths and resources.
2. Family and youth voice and choice — prioritizes the preferences of youth and families in all stages of care.
3. Strengths-based — identifies and builds on youth and family strengths to improve functioning.
4. Individualized care — customizes care specifically for each youth and family.
5. Team-based — brings youth, families, and informal supports together with professionals to identify the strengths and needs of the youth and family, and to create, implement, and revise a coordinated care plan.
6. Community-based service array — provides local services in the least restrictive setting possible and in a location chosen by the youth and family.
7. Collaboration — brings together families, informal supports, providers, and agencies to meet identified goals of the youth and family.
8. Unconditional — commits to achieving the goals of the coordinated care plan.
9. Culturally competent — considers the family's unique needs and preferences.
10. Early identification and intervention — assesses mental health early and provides access to services and supports when the need is first identified.
11. Outcome-based — contains measurable goals to assess change.

Each of these principles is described in greater detail in the following sections.

Family-centered

Family-centered care emphasizes each families' strengths, resources, and culture. Families are actively engaged in the process of creating and implementing a coordinated care plan for the youth, and their preferences, experiences, and perspectives are valued by all members of the Child and Family Team. Families formed through birth, foster care, adoption, and choice are respected and included.

Learn more about Child and Family Teams in Chapter 4.

Family-centered essentials

The most important parts of the family-centered principle are listed below: Team members support, value, and respect youth and families as essential members of the team.

- Family, providers, and other team members communicate in a respectful and honest manner.
- Members support youth and families, and encourage them to share their knowledge, opinions, and preferences throughout the process.
- Through active engagement, the members of the team learn about the youth and family members' perspectives on their strengths (like coping skills), needs (like behavioral or emotional challenges), and resources (like supportive relationships or informal supports.) The team uses what they learn to help the youth and family develop a coordinated care plan.
- Youth and family members lead the identification of short and long-term goals.
- The coordinated care plan focuses on increasing the strengths of youth and families to increase the likelihood of improvements in functioning.
- The team adapts the coordinated care plan as the needs of the family and youth change over time. These adaptations include transitions to lower or higher levels of care as needed.

Tips for families

Sometimes when you are getting help for your child, it feels like you are focusing on what doctors and therapists want. It can be overwhelming, especially if you do not feel heard. The Principles of Care are meant to guide providers so your family is always at the center of the care you receive. The following list provides important information you should remember about Child and Family Teams, the Principles of Care, and the Practice Model.

- You are the expert on your child and family, and the focus is on what works for you as a family. All assessments, treatment planning, and services and supports focus on your family's strengths and needs.
- Every family and child are different, which is why individualized care is important. You identify the goals that mean the most to you and your child and the services and supports that will help you achieve them.
- Service providers should listen to you and use your preferences to provide treatment that meets your needs. If the current treatment plan does not work for you, speak up and let them know.
- By collaborating with your team, you create a meaningful treatment plan, and you do not have to identify and reach goals alone.

Tips for families

- Providers should include you in all aspects of planning and implementing the coordinated care plan. If you feel left out or are unclear of the process, talk to your provider or the agency you are working with to help them do a better job engaging you and your family.
- While your family is the primary support for your child, a team of people who support you in your goals and participate as partners in decision making form an important support system your family can use throughout treatment.
- Your Child and Family Team is tasked with helping your child and family be successful. Use their individual perspectives and knowledge to create a better plan for your family.
- Your Child and Family Team is committed to your family and will help you until your goals are reached, even when goals are changed, services and supports are revised, or there are steps backwards on progress.
- The coordinated care plan is all about your family and child. You define the types of supports you need to meet your goals and how each service and support is going to help you meet them. Use your team to help you identify the supports you need. Sometimes supports are not mental health related, and that is okay.

- Members of the team identify the formal and informal supports the youth and family need. As the youth reaches the goals identified in the coordinated care plan, formal supports are transitioned to informal supports that are available in the family's natural setting.

Learn more about formal and informal supports in Terms to Know.

Family and youth voice and choice

The preferences of the youth and family are prioritized during all phases of the process, including engagement, assessment, teaming, coordinated care planning, implementation, monitoring and adaption, and during transition. All providers communicate openly and honestly with families in a way that supports their culture, dynamics, and personal experiences.

Family and youth voice and choice essentials

The most important parts of the family and youth voice and choice principle are listed below.

- The family and youth work with their provider to decide which individuals to invite to be on their Child and Family Team. Providers of services and supports are always part of the team.
- Team members engage the youth and family to learn about their strengths and needs.
- The youth and family provide input that is prioritized throughout the process of developing and implementing a coordinated care plan.
- The family and youth actively participate with the rest of the team to determine if goals are being met and identify any necessary changes to the coordinated care plan.
- The youth and family identify the most natural and convenient settings for services and supports to take place in.
- Team members recognize and value the cultural identities, primary language, and practices of the youth and family members. Cultural traditions and practices are integrated into care whenever possible.
- Members of the team understand that sometimes the youth and family members have different cultures they identify with and create plans to address any cultural differences that exist among family members.

Strengths-based

Services and supports are identified to build upon the strengths of the youth and family to improve the youth's functioning. The coordinated care plan focuses on strengths and competencies that address needs, and deficiencies and problems that create needs. Each service and support are delivered in a way that enhances the capabilities, knowledge, skills, and assets of the youth and family.

Strengths-based essentials

The most important parts of the strengths-based principle are listed below.

- Providers use the Child and Adolescent Needs and Strengths (CANS) tool to identify the strengths and needs of the youth and family. There is one CANS record for each youth that is shared among and updated by each of the youth's providers.

Learn more about the CANS Tool in Chapter 3.

- Members of the team learn about individual and family strengths and use them in the coordinated care plan to address their needs.
- The team includes ways to increase the individual and family strengths on the coordinated care plan.

Individualized care

Goals, services, supports, and the coordinated care plan are all customized to provide care specific to the unique strengths and needs of the youth and family. Each portion of the plan is monitored and adapted as necessary to meet the changing needs and goals of the youth and family.

Individualized care essentials

The most important parts of the individualized care principle are listed below.

- The Child and Family Team recognizes that every youth and family are unique and has specific needs, strengths, and family cultures.
- The youth and family work with the other members of the team to identify the services and supports that best utilize their strengths and address their needs.

Tips for families

- Your child's coordinated care plan has measurable, outcome-based goals that help your family know how you are doing. If a goal, a service, or a support is not working, you can work with your provider or team to change it so you are working on an outcome that meets your family's vision.
- The Child and Adolescent Needs and Strengths (CANS) captures the story of your family. Through this tool you can find out where you excel and where you need help. It is not about finding out what is wrong.
- When you acknowledge your strengths, you are more likely to use them to work towards your goals and improve your treatment experience. The CANS tool can help you identify these strengths.
- Services are designed to take place in the community whenever possible, but each community is different, so services in your area may look different than services in other communities.
- Being willing to adapt the goals, services and supports included in your plan allows it to grow with your child and family and to reflect the vision your family has of the future.
- Your child does not always need the same level of care throughout their lifetime, and it is likely that their needs will transition between higher and lower intensities as treatment continues.

Tips for families

- Your coordinated care plan provides information on how you know your child is done with treatment and what to do when your child ages out of the children's system.

Tips for youth

There are a lot of things that need to go into your Coordinated Care Plan, so it's good that there are principles to help make sure you know what's going on and have a voice in the process. Remember that this plan is for YOU, so make sure that it'll work and reflects who you are and what's going on in your life. Don't hesitate to speak up! Here are some tips to get ready for the process:

- The principles and practice model can help you figure out goals that deal with the struggles or challenges you're facing and think through how to accomplish them!
- You should feel like what you say and want guides the team, and not what another member of your team wants or feels. Bring it up if it feels like you're being talked over, or if what someone else comes up with won't work for you or your plan.
- Things in your life, or even you, will change over time. Make sure that your plan meets your current needs, because working on things that don't make a difference is frustrating and makes you feel like you're wasting your time.
- The team develops a coordinated care plan that includes the identified services and supports and is responsive to changes in strengths and needs.
- The team collaborates with youth and family members to evaluate and adjust goals, services, and supports in the coordinated care plan as needed to provide the best outcomes for the youth and families.

Team-based

Youth and families are brought together with informal supports (members of the family's community and social network), professionals, and individuals from child-serving organizations to create a team that develops a family-driven, strengths-based coordinated care plan. This Child and Family Team commits to supporting the youth and family throughout care.

Team-based essentials

The most important parts of the team-based principle are listed below.

- The family and youth bring together important people in their lives, such as extended family, friends, neighbors, coaches, and faith-based connections, with health care providers, educational staff, and child-serving agency representatives to create a Child and Family Team.
- The team members may change as the treatment goals are refined or when new services and supports are identified.
- The youth and family actively participate and are equal partners during this collaborative process.
- The other members of the team work together with the youth and family to develop a coordinated care plan based on a shared vision that builds on the youth's and family's strengths.
- The team members use their knowledge, skills, and different perspectives to provide valuable input about the youth's strengths and needs, and the services and supports to create meaningful treatment goals.
- The team works together to create a coordinated care plan that is agreed on by all team members.
- Members of the team work to revise and update the coordinated care plan when goals, strengths, and needs change. Changes are based on input from the youth, family, other team members, and information from ongoing assessments and data collection.

Community-based service array

A collection of community-based formal and informal services and supports are available to assist youth and families so they can reach the goals identified in their coordinated care plan. Community-based services take place in the youth's community or home as opposed to in a clinical setting. These services and supports are intended to help them use their strengths to address their needs and improve their functionality. Services and supports are provided in the least restrictive setting for the youth's identified needs.

Community-based service array essentials

The most important parts of the community-based service array principle are listed below.

- The Child and Family Team develops a coordinated care plan that includes services and supports in the least restrictive appropriate setting possible.
- Communities, including private and public agencies, develop and support local services to help youth and families reach the goals in their coordinated care plans.
- The youth and family members' preferences help the rest of the team decide when and where (e.g., home, schools, community centers, parks) services and supports are provided.
- The team identifies the desired services and supports based on the youth's strengths and needs and documents the available services and preferred setting in the coordinated care plan.

Collaboration

Youth and families work with any extended family, community members, health care providers, and individuals from local or state child-serving organizations and agencies to build the strengths and meet the needs identified in the coordinated care plan. For local and state child-serving agencies, this partnership occurs at the individual treatment planning level as well as within the governance structure.

Collaboration essentials

The most important parts of the collaboration principle are listed below.

- The systems a youth may be involved with (e.g. medical care, education, corrections, and child welfare) work together in the Child and Family Team to build on strengths and meet the identified needs of the youth.

Tips for youth

- It's important to feel like you're doing something. No one likes to do a bunch of stuff and feel like they're just spinning their wheels. Set goals you can measure through steps, specific dates, or another way. Work with your team to translate general goals into measurable ones.
- Just like how our needs change over time, the amount of support we need will change too. Sometimes our struggles aren't as serious as they had been, and sometimes they get harder. Working toward wellness isn't a straight line, and that's okay! Be open to getting care that will help you the most with the struggles you're facing right now.

Tips for providers

As you implement the Principles of Care and Practice Model in your practice, keep the following tips in mind.

- Help youth choose supportive and positive people to be a part of their team. The family involved in their team may be a non-traditional family that they choose.
- Share your perspective and listen to the perspectives of others on the team. This helps everyone broaden their view and see a more complete picture of the youth and family.

Tips for providers

- Encourage youth and families to have their own voice in the treatment process and to make their own choices. Help them prioritize their preferences so they buy into the process.
- Offer your professional opinion on services and supports, and encourage families and youth to consider all their options. Document service recommendations and any reasons why a service is refused.
- Work with other professionals to provide better care for youth. Additional perspectives provide different insights and can benefit everyone involved.
- Help youth identify with their own culture so they develop a sense of who they are and where they belong.
- Work with the youth and team to develop outcome-based goals, and use the CANS as a way to measure success. Positive outcomes are what everyone is working towards.
- Encourage youth to speak up to make sure they are getting what they want out of treatment. Try to put them at ease and encourage them to discuss what it is that they want. Remind youth that this process is for them.
- Offer suggestions and listen to what the youth and family would really like. Find out what's important to them and come up with ways to accommodate their wishes.

- Youth and families work with their providers and care coordinators to identify who to invite onto their team. Providers are always part of the team.
- Local and state agencies work together to further the treatment goals identified in the coordinated care plan and incorporate additional goals that need to be accomplished (e.g. Individual Education Plan goals, probation requirements, or youth and family case plans).
- Local and state agencies work together to develop rules, policies, procedures, and monitoring systems to ensure services are seamless for the youth and family regardless of where access starts (e.g. primary care doctor, school, or state agency) or how their needs change over time.

Unconditional

The Child and Family Team is committed to achieving the goals of the coordinated care plan regardless of the youth's behavior, placement, or family circumstances, and regardless of the availability of community-based services. The team remains in place through the transition from formal supports (trained professionals) to informal supports (members of the family's community and social network) and continues until the youth and family indicate the desire for the team to end.

Unconditional essentials

The most important parts of the unconditional principle are listed below.

- Members of the Child and Family Team work with the youth and family to achieve the goals of the care plan.
- The team prioritizes building the strengths of the youth and family while addressing the identified needs.
- Members of the team work to find appropriate services and supports for the youth and family regardless of the availability of formal community-based services. If there is a lack of progress, the team attempts to identify changing needs rather than assuming that the lack of progress is due to resistance or noncompliance with treatment.
- The team remains committed to assisting and supporting the youth and family members regardless of any challenges or difficult conditions the youth, family, or providers experience in their efforts to meet goals.
- All team members commit to working towards youth and family driven goals until the family agrees that the identified needs have been addressed.

Cultural competency

Learn more about services and supports in Chapter 5.

Services and supports are provided in a way that is understandable and relatable to the youth and family and in a way that is considerate of the unique cultural needs and preferences of the youth and family. Services also respect the individuality of each member of the family.

Cultural competency essentials

The most important parts of the cultural competency principle are listed below.

- In all phases of the Child and Family Team's work, cultural identities, primary languages, and practices of the youth and family members are recognized and valued. Cultural traditions and practices are integrated into care whenever possible.
- Members of the team are aware that the youth and family members may identify with different cultures and include plans to address any cultural differences that exist among family members.
- Team members respect and are open to learning about the cultural identities and practices of the youth and family. Cultural identity and practices include race, nationality, locality (where they are from), disability, language, ethnicity, religion, political beliefs, sexual orientation, gender identity, socioeconomic status, and other aspects of diversity.
- The team learns about the importance and role of cultural practices for individual youth and family members and integrates this understanding into the coordinated care plan and associated services and supports.
- If the culture of the youth and the family are different, the team accommodates both cultures in the coordinated care plan.

Early identification and intervention

Youth are given opportunities to learn about their mental health diagnosis and are given access to appropriate services and supports when their needs are first identified.

Early identification and intervention essentials

The most important parts of the early identification and intervention principle are listed below.

- Youth and families may use a checklist to determine if a meeting with a mental health professional would be beneficial.
- Family doctors complete a screening if they observe any potential mental health needs during routine appointments.
- Both personal use checklists and doctor screenings provide the youth and family with more information to help them decide if a full mental health assessment may be beneficial.
- A mental health provider conducts a full mental health assessment and CANS to identify the strengths and needs of both the youth and family.
- The Child and Family Team includes services and supports in the coordinated care plan at the appropriate level and intensity identified in the assessment.
- The team also recognizes that early intervention provides the most positive outcome.

Outcome-based

Coordinated care plans contain observable and measurable goals that are used to assess change rather than youth and family compliance. State agencies develop meaningful, measurable methods to monitor system improvements and outcomes.

Outcome-based essentials

The most important parts of the outcome-based principle are listed below.

- The Child and Family Team creates a coordinated care plan with services and supports based on measurable goals.
- Members of the team monitor the success of specific services and supports. Changes are made to the coordinated care plan when goals are reached or adjustments to the services and supports are needed to improve effectiveness.
- The team identifies any progress towards meeting the goals of the coordinated care plan with improvement in any functional impairment as noted by the family and the CANS tool.
- State agencies monitor outcomes for all youth and families receiving services and supports to ensure the agencies are providing effective and efficient services. State agencies make changes to address any systematic barriers to effective and efficient services and supports.

Practice Model

The six components of the Practice Model describe the experience that youth and families should expect to receive while in care. The six components are:

1. Engagement — actively involving youth and families in the entire process of mental health care, including identification, assessment and the creation and implementation of their coordinated care plan.
2. Assessment — gathering and evaluating information to identify the strengths and needs of the youth and family and to create, implement, monitor, and adapt a coordinated care plan.
3. Care planning and implementation — identifying and providing appropriate services and supports in a coordinated care plan.
4. Teaming — collaborating with youth, families, providers, and community partners to provide support for the youth and families and to create a coordinated care plan.
5. Monitoring and adapting — evaluating and updating the services and supports in the coordinated care plan.
6. Transition — altering levels of care and support in the coordinated care plan.

The following subsections describe each of these components in greater detail.

Engagement

Engagement is the process of mental health agencies, providers, and child-serving organizations empowering youth and families to take an active role in improving their own mental health. The providers commitment to engaging families motivates youth and families to recognize their own strengths, needs, and resources. Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, service providers, and other members of the Child and Family Team.

Engagement is a continuous process of communication and involvement used across all services and supports to gain input from youth and families. All the principles of care are adhered to during the engagement process.

Engagement principles include:

- Providing youth and families with respect, honesty, and transparency.
- Learning about the strengths and needs of the youth and family with the intent of helping them reach their goals.
- Using the family's primary language and avoiding jargon.
- Valuing and respecting cultural diversity.

Engagement essentials

The most important parts of the engagement process are listed below.

- The family, providers, and team members communicate in a respectful and honest manner.
- Youth, families, providers, agencies, and other team members build trusting relationships.
- Members of the team communicate their belief in the family's ability to succeed and listen to the youth and family without judgment or defensiveness.
- Members of the team use language that is accessible and familiar to all team members.
- Based on the family's preferred method of communication, the family, providers, and other team members determine how to maintain contact with each other throughout the period of time the youth is in treatment.
- In all phases of the team's work, they recognize and value the cultural identities, primary languages and practices of the youth and family members, and they integrate cultural traditions and practices into care whenever possible.
- Members of the team are aware that sometimes the youth and family members have different cultures they identify with and create plans to address any cultural differences that exist among family members.

Assessment

Assessment is the practice of gathering and evaluating information about youth with mental health concerns and their families to understand their strengths and needs. This discovery process may include a self-administered mental health questionnaire or a brief screening by a medical professional. Both tools identify youth who may have a need for mental health services. A more comprehensive assessment by a mental health professional can provide an in-depth evaluation of available strengths, underlying needs, functional impairment, specific mental health concerns, and risk factors. Assessment is a continuous practice and is not just performed at the beginning of the care process.

Learn more about assessments and the CANS Tool in Chapter 3.

A Comprehensive Diagnostic Assessment, which is a type of mental health assessment, and the Child and Adolescent Needs and Strengths (CANS) tool are both used during the assessment process. The CANS tool addresses the strengths and needs of the youth and family, and it aligns with the principles of care. It is individualized, family centered, and administered in a collaborative process. The Opeeka system is an application that is used to record CANS information.

Assessment principles include:

- Acknowledging families as experts on their youth and family, and youth as experts on themselves.
- Listening to families and ensuring they are heard and valued.
- Identifying individual and family strengths and considering them a vital part of understanding the youth and their needs.

Assessment essentials

The most important parts of the assessment are listed below.

- The assessment process continues throughout treatment and the CANS and assessments are updated as strengths and needs change.
- The screening process, whether completed by the youth, family, or by a medical professional, provides the youth and family with information to help them decide if a full mental health assessment may be beneficial. A screening is not required for an assessment. Providers recognize that youth and families are experts on their own experiences and place significant value on their input.
- Evaluators learn about the strengths of all family members as an important part of getting to know them and understanding how each person's interactions contribute to the strengths and needs of the youth and family.
- Families may choose to include other individuals in the assessment process who can add important details about both strengths and needs.
- Providers access CANS information in the Opeeka system as part of their information gathering process.
- New providers update the existing CANS in the Opeeka system. A youth should only have one record in the system.

- Once an initial CANS assessment is complete, the youth and family should not need to repeat sensitive information unless clinically necessary.
- The assessment process includes the identification of existing and potential informal supports for both the youth and family.
- The team identifies treatment plans from information gathered by the CANS tool and from the Comprehensive Diagnostic Assessment.
- Clinicians review and discuss initial assessment findings with the youth and family members to ensure transparency in the assessment process and agreement on the results.

Care planning and implementation

Care planning is the practice of identifying appropriate services and supports that are unique to the strengths and needs of each youth and family. The care plan should incorporate informal services and supports whenever possible, and formal services and supports should be delivered in the least restrictive setting and method to meet the assessed needs and strengths of the individual youth. The care planning process engages the youth, family, and other members of the Child and Family Team to develop a written coordinated care plan.

Learn more about services and supports in Chapter 5.

The coordinated care plan combines the strengths and needs identified by the CANS tool with all treatment plans from individual providers, if they exist, and informal supports into one comprehensive plan that helps the youth, family, providers, and informal supports focus on specific identified goals. These goals are designed to help the youth function better and reduce the impact of serious emotional disturbance. The coordinated care plan describes the youth's strengths and needs and short and long-term goals; addresses crisis, safety, and transitions to different levels of care; and specifies the strategies, resources, and time frames for implementation of services and supports.

Learn more about the CANS Tool in Chapter 3.

Care planning and implementation principles include:

- Providing youth and families written information about choices they have in their care planning and teaming process.
- Informing youth and families of any limitations due to agency involvement, access to services, and availability of resources.
- Providing youth and families both formal and informal services in the most appropriate and least restrictive settings.
- Making youth and family voice and choice the primary factors for decisions on intervention strategies.
- Finding community-based services and supports that can be accessed currently or as resources to expand in the youth's community.
- Focusing services on strengths and competencies that address needs, and not on deficiencies and problems that create needs.

- Planning services that are available, accessible, and provided in a time, location, and way that causes the least amount of additional strain to the youth and family.
- Identifying methods to measure the outcomes of goals and tasks to assess how a youth changes rather than just their compliance with treatment.

Care planning and implementation essentials

The most important parts of care planning and implementation are listed below.

- The team members prioritize family preference when deciding which strategies will work best to meet the goals.
- Members of the team write and develop the coordinated care plan to build upon the strengths of the youth and family to help improve the youth's functioning.
- The team revises and updates the coordinated care plan based on input from the youth, family, and other team members, and with information from ongoing assessments and data collection.
- The coordinated care plan includes short and long-term goals that:
    - Are clear to all team members.
    - Use the identified and potential strengths of the youth and family.
    - Address the unmet needs of the youth and family.
    - Are measurable. For example, goals track changes in the number or frequency of behaviors and improved levels of functioning.
    - Are used to assess change rather than assess youth and family compliance. For example, goals do not track missed appointments or incomplete tasks.
    - Address short-term improvements as well as long-term youth and family driven objectives to encourage the youth and family to work towards wellness and self-sufficiency.
- The coordinated care plan includes information from all provider treatment plans and any agency specific documentation, such as person-centered service plans, developmental disability plans, court ordered goals, or Family and Community Services plans. Members representing each group may be invited by the family to participate on the Child and Family Team.
- The coordinated care plan records decisions and progress made by the team.
- Families and youth fully engage in the care planning process by reviewing service options and limitations, and by ensuring the care plan is representative of the youth and family's preference.

Teaming

Teaming is the process of bringing a youth and family together with any extended family, community members, mental health providers, and individuals from child-serving organizations that are committed to helping the youth reach their treatment goals. These caring and invested individuals are invited by the family to work with and support the youth and family through a Child and Family Team coordinated care approach. The goal of this team is to include the perspectives of each member in order to create, monitor, and adapt a more informed and collaborative care plan for the youth and family. Youth that require a higher level of treatment planning may have an Intensive Care Coordinator to facilitate their team and to coordinate and monitor service delivery.

Teaming principles include:

- Ensuring youth and families have input about who is on their Child and Family Team.
- Engaging youth and families as full and active partners in the process.
- Creating a decision-making method that is a joint activity with the youth and family rather than a process where decisions are made by a "majority rule" of the team.

Teaming essentials

The most important parts of teaming are listed below.

- The youth and family actively participate and are equal partners on the Child and Family Team.
- The concerns, competencies, and perspectives of the youth and family inform all the decision making on the team.
- Team members commit to supporting the youth and family throughout care.
- Members of the team work collaboratively with the youth and family to develop, monitor, and adapt a coordinated care plan based on a shared vision that builds on the strengths of the youth and family.
- The family and youth work together with their provider to decide which individuals from the community are important to include on their team. Examples may include, but are not limited to:
    - Extended family
    - Friends
    - Neighbors
    - Coaches
    - Faith-based connections
    - Family doctors
    - Therapists
    - Service providers
    - Teachers or other educational staff
    - State and local agency representatives from child-serving organizations
- Members of the team who have different perspectives about the youth and family help improve the decision making and planning process by providing valuable input about the strengths and needs and the services and supports that will further meaningful treatment goals.
- The team identifies both formal and informal services and supports to help the youth and family reach the goals identified in the coordinated care plan.
- The teaming process does not replace the decision-making process for other agencies, and the team does not have the authority to change those agencies' planning documents. Examples of planning documents that may not be changed include, but are not limited to:
    - Individualized Education Plans (IEPs)
    - 504 education plans
    - Family and Community Services plans
    - Court plans
- The composition of the team will likely change as the needs of the youth and family change, however, some composition of the team remains in place for the duration of a youth's treatment, including during transitions to different levels of care, until the family determines the team is no longer needed.

Monitoring and adapting

Monitoring and adapting is the practice of continually evaluating the effectiveness of the coordinated care plan, continuously reassessing circumstances and resources, and reworking the plan as needed. The Child and Family Team is responsible for reassessing the youth and family's needs, applying knowledge gained through ongoing assessments and data collection, and adapting the plan in a timely manner.

Monitoring and adapting principles include:

- Identifying services, regardless of the youth's behavior, placement, family circumstances, and regardless of the availability of community-based services.
- Committing to never give up on the youth and family.
- Modifying the coordinated care plan to keep the youth and family safe.
- Understanding that setbacks may reflect the changing needs of the youth or family members, and not resistance.
- Recognizing the skills and knowledge of the family and youth are essential to the change process.

Monitoring and adapting essentials

The most important parts of the monitoring and adapting principle are listed below.

- The youth, family, and other team members continuously evaluate the coordinated care plan for effectiveness.
- The team reviews the coordinated care plan to ensure the plan is providing services regardless of the youth's behavior, placement, family circumstances, or availability of community-based services.
- Members of the team monitor services to ensure that providers are working towards the goals identified in the coordinated care plan and are mindful of keeping the youth and family safe.
- The team members adjust the coordinated care plan to ensure services and supports are effective and appropriate as the strengths and needs of the family change.
- The team adapts the coordinated care plan as the needs of the family and youth change over time. These adaptations include transitions to both lower and higher levels of care as needed.
- If there is a lack of progress, the team tries to identify changing needs rather than assuming that the lack of progress is due to resistance or noncompliance with treatment.
- Members of the team realize that the planning, monitoring, and adaptation processes are essential to accomplishing change.

Transition

Transition is the process of moving between levels of care and/or formal and informal services and supports. One goal of each coordinated care plan is to identify the appropriate level of care and find the correct balance of formal and informal supports that are needed to help the youth and family meet their goals. As goals are achieved, the Child and Family Team works to reduce the level of care supplied and the number of formal services a youth receives. Formal services are then replaced with informal supports. If a youth has an increase in needs and/or a reduction in strengths that are reflected in the Child and Adolescent Needs and Strengths (CANS) or in a mental health assess, the Child and Family Team may choose to transition to a higher level of care and an increase in formal supports.

The transition away from higher levels of care occurs when the assessment and CANS tool identifies that the youth has developed enough strengths to justify the change and appropriate formal and informal supports are in place for the youth and family. This transition is intended to help the family ensure long-term success.

Transition principles include:

- Recognizing that the youth and family are key in identifying available resources and supports.
- Viewing the community as the preferred resource for formal and informal supports.

Transition essentials

The most important parts of transition are listed below.

- The Child and Family Team is responsible for ensuring that transition and crisis planning is included in the coordinated care plan.
- When a youth meets a goal, the team identifies any level of care that can be reduced or formal services and supports that can be replaced with informal supports. The timeline for these transitions and any indicators (such as a change in CANS results or enacting a crisis plan), that a child may need to return to the more formal supports are included in the coordinated care plan.
- During the transition planning process, the youth and family collaborate with other team members to identify and engage informal community resources to provide sustainable support. Key considerations for these resources include:
    - Determining if an informal support is committed to meeting the ongoing needs of the youth and family.
    - Assessing the informal support's ability to enhance the youth and family's strengths.
    - Confirming that the informal supports are aware of the transition plans, are prepared to work with the youth and family to meet their identified needs, and have effectively engaged the youth and family.
    - Members of the team ensure that stable informal supports for the youth and family are in place before transitioning away from formal services. Transitions occur over time and are included in the coordinated care plan.

Summary

The Principles of Care and Practice Model define the care experience youth and families can expect to receive in the YES system of care. They are practice standards put into place to ensure that the system of care is family-centered, strengths-based, individualized, collaborative, culturally competent, out-come-based, and more. The Practice Model shifts the treatment approach to focus on Child and Family Teams built around the needs of each youth.

These standards are used throughout the entire system of care, starting with the identification of youth. Read more about identifying youth who can access care through the YES system of care in Chapter 3.

Chapter 2: Identifying and Engaging Youth

Contents

Overview

The first step in accessing the YES system of care is to identify and engage youth and families. This chapter provides information on different tools that may be used to help identify youth, how to get help, and how providers engage the youth and family from the very start of the YES process.

It is important to note that youth with Medicaid can always receive medically necessary mental health services through Magellan Healthcare and do not need to receive a screener before contacting Magellan Healthcare to access these services.

For help getting started with YES, call one of the following numbers:

- **Magellan Member line 855-202-0973**
- **Liberty Healthcare 877-305-3469**

Identifying Youth

To learn unfamiliar terminology, refer to the Terms to Know.

Youth may be identified for YES by anyone who knows them and is concerned about their mental health. This may include family members, teachers, coaches, primary care doctors, mental health providers, and probation officers. A checklist is available to help families with this identification. It contains a brief series of mental health statements the youth and family answer together to help them decide if the youth should participate in a full mental health assessment. This checklist is available on the YES website or may be provided by the youth's school.

If the family decides that they would like a mental health assessment, they can call one of the numbers below to get help:

- If the youth has Medicaid, the family can call the Magellan Member line at: 855-202-0973
- If the youth does not have Medicaid, the family can call Liberty Healthcare at: 877-305-3469

Additional information and resources are also available at www.yes.idaho.gov.

If family doctors or mental health providers believe a youth may benefit from the YES system of care, they may offer a screening. These screenings are designed to identify unmet mental health needs and provide an indication for a comprehensive mental health assessment. The sections below discuss some of the screening options that may be used.

Idaho Children's Mental Health Screener

Learn more about assessments and the CANS Tool in Chapter 3.

The Idaho Children's Mental Health Screener was developed from the Child and Adolescent Needs and Strengths (CANS) tool and is designed to help identify youth with unmet mental health needs. Family doctors, mental health providers, probation officers and others may use the screener if there is an indication that the youth may need help with their mental health. The screener cannot be used in place of a complete CANS. It is one of many tools a provider can use to identify unmet needs and is not billable as a separate service

The Idaho Children's Mental Health Screener looks at the following four areas and rates them:

- Behavioral or emotional needs
- Life functioning
- Risk behaviors
- Caregiver resources and needs

Results of the screener are given both verbally and in writing to the youth and family.

The screener is available in a printable paper version and an online version at www.IdahoCMHScreener.com.

Physician screenings

There are a variety of screening tools physicians may choose to use to screen for mental health problems. These screenings are typically short and results are given during the exam. If the screening indicates the youth has unmet needs the family is directed to Liberty Healthcare, Magellan of Idaho to get help.

Getting Help

After a screening, families will be directed to contact one of the resources below for a full mental health assessment.

- Liberty Healthcare for a mental health assessment
- Magellan Healthcare (if the youth has Medicaid) to find a provider

The sections below describe what happens when the family calls Magellan Healthcare or Liberty Healthcare.

Magellan Healthcare Youth who are Medicaid members have access to mental health providers through Magellan Healthcare . The family can call the member line at 1-855-202-0973 to find a provider and schedule an appointment.

Once a youth has a mental health provider, the provider can help the family by:

Tips for youth

Do you feel hopeless, depressed, or anxious? Are you struggling with negative thoughts or fears that won't leave you alone? Is it hard to find the motivation to get out of bed?

- Talk about it with people in your life you trust. This can be your parents, teacher, a friend's parent, a school counselor, or a youth group leader.
- Most people in your life will help if you ask, even if you think they don't care.
- Mental Health Providers can be awesome. Their whole job is to listen to what's going on in your life and help come up with solutions. They wouldn't do their job if they didn't care at least a little. Plus, almost everything you talk about with them must be kept completely private!
- Everyone struggles with negative feelings or harmful behaviors at some point in their life. Make talking about what's going on in your life a normal part of hanging out with your friends. If you're there to support them when they're having a hard time, they'll be there for you.
- Always bring up serious stuff that may be happening with you or a friend with a support person in your life.

Tips for families

If you think your child would benefit from mental health services, you can:

- Call one of the numbers below for help:
  - Magellan Member line at 855-202-0973
  - Liberty Healthcare at 877-305-3469
- Talk to other people in your child's life to see if they see the same things you do. This could be a teacher, coach, friend, religious leader, or any other important person in your child's life.
- Schedule a mental health screening with your child's doctor, or a full mental health assessment with a mental health provider.

Tips for providers

It is important for providers to engage youth and families throughout YES, including in the identification and referral phase. You can do this by:

- Explaining the YES system of care to youth and families.
- Asking the family to "tell you about it" regarding specific experiences or behaviors that concern them so that you can understand the parts of the story that are important to them.
- Ensuring you follow-up with youth and families to make sure they are engaged.
- Answering questions, listening to the youth and family's story, guiding conversations with them, and gathering information to complete a mental health assessment, also known as a comprehensive diagnostic assessment.

Learn more about assessments and the CANS Tool in Chapter 3.

- Working collaboratively with the youth and family to complete a CANS.

Learn more about assessments and the CANS Tool in Chapter 3.

- Developing a treatment plan with the youth, family, and their supporters that captures the youth and family's vision and goals.

Learn more about care planning in Chapter 4.

Liberty Healthcare

Families can call Liberty Healthcare at 1-877-305-3469 to schedule a mental health assessment. During this phone call, a YES customer service specialist gathers some basic information from the family. A provider calls the family back within one business day to set up a time for the assessment. The family and provider discuss the assessment process and set a time and location for the assessment. A few important things to note about this conversation are listed below:

- The family chooses the location for the assessment. This can be a place where the youth and family feel comfortable and can speak freely. It can be in their home or in another community-based location where their confidentiality can be kept.
- This is a good time to speak about any sensitive information the family would like to discuss without the youth present.

During the assessment, the youth and family share their story with the provider. The youth does not need to be present for this entire conversation and may leave for parts of the discussion. The youth may also ask to speak to the assessor in private. The assessor follows up with the family after the appointment to provide them with a diagnosis and SED determination.

Engagement

Engagement is the process mental health agencies, providers, and others use to empower youth and their families to take an active role in improving their own mental health. It is the foundation to building trusting and mutually beneficial relationships. Providers involve youth and families in every aspect of their care and motivate them to recognize their own strengths, needs, and resources. Families are recognized as the expert on their experience, and the information they share about their experience is vital to success.

Learn more about Engagement in Chapter 4.

Engagement starts during the identification and referral process and continues throughout the youth and family's entire experience with the YES system of care. Youth and families are always welcomed, treated with respect and honesty, and their feelings and experiences are sought out and validated. They are given choices and their opinions and preferences are included at every decision point.

Tips for providers

- Providing information about the Liberty Healthcare assessment process for youth who:
  - Have Medicaid and would benefit from Respite.
  - Might qualify for Medicaid with an SED determination.
  - Are unsure if they have mental health needs.

Summary

Anyone may identify a youth as someone who may benefit from the YES system of care. There is a checklist available on the YES website and through some schools that can help families decide if the youth should seek care. Some youth may be identified by a primary care physician, mental health providers, or probation officer through a screening tool. Youth may be directed to Liberty Healthcare for an assessment, and youth with Medicaid may be directed to the Magellan Healthcare provider network to start receiving care.

Engagement is one of the most important shifts in the new system of care. Through active engagement, youth and families are empowered to make choices and give their opinions about the care the youth receives. This process starts during identification and continues throughout the system of care.

Go to Chapter 3 to learn about the assessment and eligibility process.

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Chapter 3: Assessing Youth and Determining Eligibility

Contents

Overview

This chapter provides information on mental health assessments, the Child and Adolescent Needs and Strengths (CANS) tool, and eligibility for the YES system of care. A mental health assessment and the CANS tool are used for treatment planning and progress tracking. They may also be used to determine if a youth has a serious emotional disturbance (SED). In Idaho, SED is defined as the combination of a mental health diagnosis and a substantial functional impairment.

For help getting started with YES, call one of the following numbers:

- **Magellan Member line 855-202-0973**
- **Liberty Healthcare 877-305-3469**

Mental Health Assessments

A mental health assessment begins with a conversation between a mental health provider, a youth, and their family. During this conversation, the youth and their family tell their story so the provider can combine their history with other elements of the assessment and provide a diagnosis. The youth may ask to speak to the assessor without their family present. They also do not need to be present for the entire conversation if the family feels there is some information that is best discussed without the youth in the room. It is important for the family to talk about how the youth would or does function without any services or supports, such as medications, accommodations, or therapies so the assessor can get a full picture of how those supports help the youth. This type of information can also help the assessor in their initial diagnosis.

To learn unfamiliar terminology, refer to the Terms to Know.

Learn more about respite care in Chapter 5.

The mental health provider guides the discussion by exploring the following topics with the youth and family:

- Mental health symptoms including feelings, thoughts, actions, experiences, any past diagnosis, and any family history of mental illness
- Physical health and wellbeing
- Social and family relationships
- Culture and ethnic background
- Drug or alcohol use
- Relevant recent events such as a death, divorce, or trauma
- Strengths and skills
- Hopes and goals for the future

Liberty Healthcare assessments can take place in a location the youth and family choose, such as a youth's home or another private location where they feel at ease. Other assessments typically take place in a provider's office and occur as the youth's mental health needs change.

Families should receive a copy of the assessment when it is complete and can ask for one if they do not automatically receive it.

The CANS Tool

The Child and Adolescent Needs and Strengths (CANS) is a tool that uses the information gathered during an assessment to create a record of the strengths and needs of the youth and their family. Strengths are areas of the youth's life or family's life where they are doing well, have an interest, or ability. Needs are areas where the youth or family needs support. This record is used by all providers servicing the youth and family so they do not need to tell their story multiple times to various providers.

In addition to identifying strengths and needs, the CANS is used to:

- Capture information about the youth's ability to function within their family and community.
- Determine if the youth has a functional impairment.
- Create meaningful care plans.
- Monitor the outcome of services.
- Provide a common language for providers, youth, and families to use when discussing strengths and needs.

Completing a CANS

The CANS is organized into individual and family life domains (areas). Each domain contains items that specifically relate to that area. The provider, youth, and family use the information gathered during the assessment to work through each item in the CANS. They discuss items and collaboratively decide how to rate the items on a 4-part scale. Through this work the provider, youth, and family can identify the strengths and needs of both the youth and family.

The ratings, as determined by the provider, youth, and family, are then used to help determine the amount of support the youth and family need. After the provider and family complete the CANS, the provider talks to the youth and family about the results to make sure they are accurate and reflect their story before they save and finalize the CANS. The family should receive a copy of their CANS so they can review and refer to it during care planning.

Tips for youth

To get help from a mental health professional, you need to do what's called an assessment. The questions and topics that come up can be hard. Here are some tips to help get ready:

- Think about what's important for a mental health provider to know about you and your life. Make a timeline or some bullet points on paper or in your head, then practice getting more comfortable talking about it.
- Talk to a trusted person in your life about your story before going to the assessment. Each time you tell your story it gets easier to talk about.
- If there are any really hard things that you don't want to hear or say, you can have your family talk about them while you take some space outside the room.
- If there is anything you don't want to talk about in front of your family, you can ask to talk to the provider alone.
- The person doing the assessment may not be the person that ends up working with you regularly. Think of this as more of an interview where they're trying to get an idea of who might be the best person to be on your team.
- Remember that the provider is there to help YOU. They're on your team and won't judge you for what's going on.

Tips for families

The assessment process, including the CANS, can be a powerful experience for you and your child. Here are some things to keep in mind:

- You are the expert on your child and on their needs and strengths. By participating in the assessment process, you help the provider understand your child's experiences and needs.
- You may need to talk about sensitive topics that are difficult to discuss and there may be things you do not want to talk about in front of your child. It's okay if your child needs to leave the room.
- Your child may want to discuss sensitive topics with the provider without you present. It is important to give them that opportunity.
- The provider may ask for copies of previous assessments. Having these assessments with you will help during this process.
- It's important to talk about the strengths and needs your child has without services and supports like medication or therapy.
- Keep an open mind about the assessment process.
- Make sure you go over the CANS findings, including the narrative, with the provider before it is finalized.
- Make sure you receive a copy of the complete finalized CANS, including the narrative.

The levels of care are listed in the table below.

Recommended Levels of Care	
Levels	Description
3	SED identified. Youth is considered to have high treatment needs and is at risk of out-of-home placement or may already be out of the home.
2	SED identified. Youth may be involved in multiple systems and require extensive service collaboration.
1	SED identified. Services should be coordinated, but functioning is stable.
0	SED eligibility criteria not met. Youth is referred to community services.

Some of the domains identified in the CANS are not considered in other types of functional assessments and are part of what makes the CANS unique. The core CANS domains, and some examples of the items under the domain, are listed below:

- Exposure to Potentially Traumatic/Adverse Childhood Experiences domain
  - Sexual abuse
  - Physical abuse
  - Emotional abuse
  - Neglect
- Strengths domain
  - Family
  - Interpersonal skills
  - Talents/interests
- Life functioning domain
  - Living situation
  - Social functioning
  - Resourcefulness
  - Sleep

- Cultural domain
    - Language
    - Identity
- Behavioral/emotional needs domain
    - Emotional and/or physical regulation
    - Attention/concentration
    - Depression
    - Anxiety
- Risk behaviors domain
    - Suicide
    - Self-harm
    - Danger to others
- Caregiver resources and needs domain
    - Physical health
    - Mental health
    - Substance use
    - Involvement with care

Tips for providers

Listed below are some tips you can use to help organize, plan, and facilitate an assessment and CANS.

- Use the CANS to organize your assessment questions. This can help facilitate the conversation so it flows more naturally.
- Teach the youth and family about the CANS rating scales so they understand them and can contribute to discussions.
- At the end of your discussion, ask a few open-ended questions to make sure there isn't any additional information the family would like to share.
- Make sure the family understands what the next steps will be and preview the planning process for them.
- Check to see if an OPEEKA record exists or ask the family if a CANS has been completed.
- If the youth has an OPEEKA record, update the existing CANS.
- Review the entire CANS and narrative with the family prior to finalizing it in the OPEEKA system to ensure agreement on the CANS.
- Make sure the CANS is complete in the OPEEKA system before exiting.
- Provide a complete copy of the finalized CANS to the family when you are done.

Using the CANS

The CANS is used in care planning for measuring outcomes and as a communication tool.

Learn more about care planning in Chapter 4.

Care planning

One of the most significant ways the CANS is used is to inform care planning. When the Child and Family Team meet to plan the youth's treatment, they discuss the CANS ratings to make sure that the strengths and needs of the youth and family are included in the plan. Sometimes a plan may focus on a subset of the strengths and needs.

Learn more about Child and Family Teams in Chapter 4.

- Need items identified within the CANS with a 2 or 3 rating should be considered when determining the youth's goals for improvement.
- Strength items identified within the CANS with a 0 or 1 indicate a strength that can be used throughout treatment.

Measuring outcomes

Youth and families' needs and strengths may change over time due to mental health services and supports, and the CANS should be updated to reflect these changes. One of the ways to determine if services and supports are helping is to revisit the CANS and track changes. This may be done upon request or when there is a substantial change that indicates the need for re-assessment outside of the standard 90-day update schedule. The youth's plan can then be updated to reflect their current strengths and needs more accurately.

Communication tool

The CANS provides a common language for providers, youth, families, and their formal and informal supports to use when discussing the youth's mental health. It can also provide a picture of the progress that's been made and can help with recommendations for future care.

Eligibility

Youth under the age of 18 who are determined to have SED can access the YES system of care and may be eligible for services through the Division of Medicaid or the Division of Behavioral Health.

Learn more about respite care in Chapter 5.

Division of Medicaid

Want to apply for Medicaid?
http://idalink.idaho.gov
1-877-456-1233

Youth already enrolled in Medicaid can access mental health care without going through the assessment process for an SED Determination, unless they need respite care. The family can contact the Magellan Healthcare member line at 855-202-0973 for access to mental health services.

Youth who do not have Medicaid, or youth who need respite care, should go through the assessment process with Liberty Healthcare. If the youth is determined to have SED, they may be eligible for Medicaid because the income limits for Medicaid are higher for youth with SED. Families can apply for Medicaid for their youth with SED by visiting http://idalink.idaho.gov or by calling 877-456-1233. When the family receives the youth's Medicaid eligibility letter, they can contact Magellan Healthcare to begin accessing services.

A premium, which is sometimes referred to as cost share, is a fee the family is required to pay the state to get Medicaid healthcare coverage for the youth. The premium is $15 per month per YES youth for families who have income in the 185-300% income bracket. If the youth is on CHIP or KB, they will pay those premiums rather than YES.

Important: The youth must have an SED determination from Liberty Healthcare before applying for Medicaid to qualify with the higher income limit or to receive respite care.

The online Medicaid application displays a preliminary eligibility decision. This decision may not be accurate because a manual review is required to confirm the youth's SED status and higher income level. The family will receive a letter within five business days with their actual Medicaid eligibility determination.

Summary

An assessment starts with a conversation between the youth, family, and a provider during which the youth and family tell their story. Their information, combined with the rest of the assessment process, leads the provider to a diagnosis and is used to complete the CANS. The CANS is used to determine functional impairment and to identify the strengths and needs of the youth and family.

Youth with Medicaid may access mental health services immediately by contacting the Magellan Healthcare member line. If the family wishes to apply for Medicaid for their youth under the increased income limits, an assessment is required to determine the youth has SED. If the family does not qualify for Medicaid [illegible]. After the youth has an SED determination and is enrolled in Medicaid or cost [illegible], the youth and family begin the care planning process. Refer to Chapter 4 to learn more.

Chapter 4: Planning Coordinated Care

Contents

Overview

Care planning is a process that utilizes Child and Family Teams to create a coordinated care plan. Coordinated care plans can take many forms, but there are some plans that have specific criteria and requirements. This chapter provides information on how Child and Family Teams work together and explains the types of coordinated care plans the Child and Family Team develops.

For help getting started with YES, call one of the following numbers:

- **Magellan Member line 855-202-0973**
- **Liberty Healthcare 877-305-3469**

To learn unfamiliar terminology, refer to the Terms to Know.

Child and Family Teams (CFTs)

All youth involved in the YES system of care should have access to a Child and Family Team (CFT) — a group of individuals the youth and family select to help and support them while the youth receives treatment. At a minimum, the team includes the youth, family, and their primary mental health providers, but may also include friends, neighbors, coaches, instructors, religious leaders, and other community members. This team works together to:

- Recognize and encourage the youth and family's strengths.
- Identify the needs of the youth and family.
- Learn what the youth and family want to accomplish.
- Set realistic short and long-term goals.
- Find solutions that build on the strengths of the youth and family and lead to necessary changes.

Child and Family Teams are formed during the care planning process and continue while the youth is in treatment. The size and involvement of team members is driven by the needs and desires of the youth and family, and as those needs change, members may be added or removed from the team. Each Child and Family Team works through the six components of the Practice Model and uses the Principles of Care in all the phases of the Practice Model.

Child and Family Teams may operate differently based on the needs of the youth. The frequency of team meetings and intensity of work depends on the needs of the youth and family. In cases where more support is needed, the care coordinator may recommend involving a Wraparound coordinator.

All members of the Child and Family Team are responsible for attending and participating in meetings, collaborating with other team members, and listening to and respecting the opinions of others. Additional roles and responsibilities for team members are listed below.

Facilitator:

- Engages the youth and family.
- Works with the youth and family to identify formal and informal supports.
- Collaborates and coordinates with other providers and informal supports.
- Contacts supports and schedules meetings.
- Pulls together important information and documents.
- Develops a decision making and conflict resolution process for the team.
- Ensures the services provided are appropriate and meet the needs of the youth.
- Sets expectations.
- Documents information.
- Performs administrative tasks necessary to support the team.

Youth and family:

- Identify and select individuals in their life to be their informal and formal supports.
- Actively participates.
- Speak up about choices and preferences.
- Set goals.
- May lead the team.

Informal Supports:

- Listen to the preferences of the youth and family.
- Help identify strengths to address the needs of the youth and family.
- Listen to the youth and family and provides support for them.
- Communicate progress that has been made towards goals.

Formal Supports (Providers):

- Listen to the preferences of the youth and family.
- Help identify services to address the youth and family's needs.
- Share treatment goals that have been developed with the youth and family.
- Communicate progress that has been made towards goals.

Teaming process

There are three primary phases that the Child and Family Team work through together:

Phase I — Team formation

The Child and Family Team facilitator engages the youth and family to identify people in their lives who can help and support them. The facilitator reaches out to these individuals to invite them to participate on the Child and Family Team.

Phase II — Plan development, implementation, and modification

This phase can be short or long depending on the strengths of the youth and family. The team works to develop and adopt a strengths-based coordinated care plan that includes both formal and informal services and supports.

One of the team's first tasks is to develop a crisis plan. This plan is designed to help youth and families avoid a crisis by addressing safety concerns, predicting potential areas of crisis, and identifying ways to minimize a crisis. This plan should be reviewed routinely to make sure it is kept up to date.

Phase III — Transition planning

The team plans for transitions to ensure that youth move appropriately between levels of care and eventually out of the YES system of care, either because goals are met, or they need to transition to adult care.

Child and Family Team meetings

Child and Family Team meetings are where the work of the team gets done. Community-based settings that promote openness, confidential discussion, and decision-making are the best place for Child and Family Team meetings. An office setting may not be the best location as some people do not feel comfortable in them.

The team decides where and how often to hold meetings based on the needs of the youth and family. Meetings occur more frequently during the initial plan development, when there are changes in goals or needs, and during transitions. A meeting may be scheduled when:

- A parent or youth requests a meeting.
- The identified strengths and needs change.
- The existing services and supports are not working as expected.
- New resources are available.
- The progress towards a goal is slower than expected.
- The goals are met and new goals need to be identified.
- There is a decrease in safety or a risk of crisis.

Coordinated Care Plans

A coordinated care plan is the result of the Child and Family Team's effort to coordinate care from all providers involved in a youth's treatment and may take many forms. Regardless of the form, the coordinated care plan is developed to connect plans developed by multiple service and support systems and to decrease redundancy and gaps. For youth in the Children's Developmental Disabilities Program, the coordinated care plan is written and combined with the youth's existing plan to form one plan of service.

In a few situations, a specific plan with defined requirements is developed. These plans include:

- Person-centered service plans
- Wraparound plans

Some examples of plans that can be integrated into a coordinated care plan are:

- Idaho Department of Juvenile Corrections plans
- Educational plans

Each of these plans are described in greater detail in this section.

Person-Centered Service Plans

A person-centered service plan is one form of a coordinated care plan and is a requirement for youth who receive a serious emotional disturbance (SED) determination through the Liberty Healthcare assessment process and want to access mental health services through Medicaid.

Person-centered service plans must meet federal requirements. To do so, the Principles of Care and Practice Model are used to meet the criteria listed below:

- The youth and family lead the process as much as possible.
- The planning process is timely and occurs in a location convenient for the youth and family.
- The plan includes cultural considerations for the youth and family members.
- Guidelines are included to resolve conflicts and disagreements.
- The plan includes strengths, preferences, needs, and goals that the youth and family identify.
- The youth and family are given access to medically necessary services, supports, and options for providers who offer them.
- The plan identifies risks and includes a plan to minimize them.
- The youth’s signature and the signatures of the family, providers, and other Child and Family Team members are on the plan.

The process for person-centered service planning is outlined in the following section.

Planning process

The person-centered service planning process begins after a youth receives an SED determination from Liberty Healthcare and is Medicaid eligible. After the family receives the youth's Medicaid eligibility information, they initiate the person-centered service planning process as described below.

Note: If the youth has a developmental disability and an SED determination, the youth's developmental disability case manager develops their person-centered service plan.

1. The family goes to the Magellan Idaho website or calls the member number at 855-202-0973 to locate a Targeted Care Coordinator.
2. The family calls the Targeted Care Coordinator and schedules an initial meeting.
3. During the first meeting, the Targeted Care Coordinator facilitates the process and may discuss the following topics:
    - Provides a definition of person-centered service planning
    - Explains the role of a Child and Family Team
    - Empowers the youth and family to identify individuals they want to be on their team
    - Tells the family about any information or documentation they should bring with them to the meeting
4. The Child and Family Team meet several times, and the Targeted Care Coordinator facilitates work on the plan. During these meetings, the team:
    - Gets to know as much about the youth and family as possible.
    - Reviews the strengths and needs captured on the youth's CANS to make sure both are included on the youth's plan.
    - Discusses types of treatments and options for the youth and family.
    - Makes decisions about what to include on the plan.
    - Goes through the person-centered service planning form to capture all the required information.
5. When the plan is complete, the Targeted Care Coordinator gives the family a copy of their person-centered service plan.
6. The Targeted Care Coordinator submits the plan to Magellan for approval.

The person-centered service planning process does not end once the plan is approved. The plan is used to guide treatment and is revisited and updated as the youth's strengths, needs, and general level of functioning changes. At a minimum, an annual review and update with the Child and Family Team is done.

Wraparound planning process

Wraparound is a coordinated planning process for youth and families with intensive needs. When high needs are identified on the CANS and by the youth and family, they may benefit from a planning process such as Wraparound.

Wraparound is a team-based, collaborative, principles-driven process that is used to create one overarching plan of care for the youth and family. The principles of Wraparound are very similar to the Principles of Care and are used to ensure that the Wraparound plan builds on the strengths of the youth and family to develop a larger informal support system to compliment any formal supports. The Wraparound principles are summarized in the blue sidebar.

Wraparound team

A Wraparound team includes a Wraparound Coordinator, the youth and family, natural or informal supports, formal supports, and youth and family partners. If the youth had a Child and Family Team prior to the Wraparound planning process, those team members are included in the formal Wraparound planning process. The team listens to the youth and family, provides support for them, and collaborates to develop the Wraparound plan.

Wraparound planning process phases

There are four phases in the Wraparound planning process:

- Engagement and team preparation
- Initial plan development
- Plan implementation
- Transition

Wraparound is a structured planning process with distinct facilitation activities and components for each phase that support the youth and family so they can achieve their goals and vision. The Wraparound Coordinator facilitates this process by helping the youth, family, and rest of the Wraparound team prioritize needs, establish outcome measures, identify strategies to meet the needs, and assign action steps to all team members.

Wraparound principles

The guiding principles for Wraparound are:

- *Family voice and choice:* The youth and family's opinions matter and their care preferences are prioritized.
- *Team-based:* The youth, family, and supports work together to reach agreement.
- *Natural supports:* People and programs in the youth and family's life provide support for them. Natural supports are sometimes called informal supports.
- *Collaboration:* Team members contribute ideas and take responsibility for the action steps in the plan.
- *Community-based:* The services and supports on the youth's plan are delivered where the youth lives.
- *Culturally competent:* The youth and family's unique cultural needs and preferences are taken into consideration.
- *Individualized:* Care is customized specifically for the youth and family's strengths and needs.
- *Strengths-based*: The strengths of the youth and family are identified and built on to improve functioning.
- *Outcome-based*: Plans contain measurable goals to assess change rather than compliance.
- *Persistence:* All team members commit to achieving the goals of the Wraparound plan.

Wraparound Intensive Services (WInS) Idaho

Wraparound Intensive Services (WInS) is the current Wraparound model implemented by the Division of Behavioral Health, Children's Mental Health. In WInS, the Wraparound coordinator is consistent in implementing the four Wraparound phases, activities and facilitation components of Wraparound, and in applying the Wraparound guiding principles. Wraparound coordinators receive ongoing individual and group coaching and work collaboratively with a supervisor who is trained in Wraparound to address any clinical issues. This coaching and supervision help coordinators practice Wraparound at an expert level (to fidelity) and ensure high quality.

In addition, WInS uses a fidelity tool to measure how the process and plan are working for the youth, family, and their team. This feedback is used to adjust the Wraparound process and assist in quality improvement.

Additional information

To learn more about Wraparound, refer to the resources listed below:

- Review the “What is Wraparound” video Wraparound Intro Video_Final with link (screencast.com)
- Visit the YES website for additional contacts and resources.

Idaho Department of Juvenile Corrections plans

If a youth is in the custody of the Idaho Department of Juvenile Corrections (IDJC), they receive mental health treatment planning under a model unique to the mission of the department. Juvenile Services Coordinators oversee treatment planning and implementation and actively work with the family, team members and community providers, as appropriate, during care, aftercare, and reintegration planning. Before the youth returns to the community, the CANS is administered, and they are connected with an Intensive Care Coordinator to ensure a continuum of care and to prevent gaps in services. When a youth is working towards reintegration back into the community and/or home, the Idaho Department of Juvenile Corrections accesses community reintegration providers for mental health services until the youth is released from custody. To learn more about Idaho Department of Corrections plans and services, visit their clinical services web page.

Educational plans

Educational plans, such as the Individualized Education Plan (IEP) and 504 Plan, are governed by federal and state regulations that are not part of the YES system of care. While staff members from a youth's school or district may participate on a Child and Family Team, they do not have the authority to modify an educational plan without following the procedures associated with those plans. If a youth or family needs help to create or change an educational plan to support their mental health needs, they may contact their school to discuss the required steps.

Summary

The Child and Family Team use the Principles of Care and Practice Model to work with formal and informal supports to develop a coordinated care plan based on the strengths and needs of the youth and family.

Coordinated care plans are created in a variety of ways, including through the person-centered service planning or Wraparound process. Treatment plans created for involuntary mental health services, such as those delivered by the Idaho Department of Juvenile Corrections are not governed by the YES system of care. Educational plans that may include services and supports for mental health needs are required to follow federal and state guidelines and are not subject to the requirements of the Principles of Care and Practice Model.

Chapter 5 provides information on the services and supports available for youth involved in the YES system of care.

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Chapter 5: Exploring Services and Supports

Contents

Overview

The services and supports described in this chapter are available to youth based on their individual assessed strengths and needs. The Child and Family Team works together to determine what services should be part of the youth's plan. The team facilitator coordinates care to ensure all the youth's providers and supports are working towards the same goals.

Publicly funded services and supports may be provided by different YES partners, including:

- Division of Medicaid
- Division of Family and Community Services
- Idaho Department of Juvenile Corrections
- Idaho State Department of Education

The roles each of these partners have in providing services are described in the sections below. All the services and supports available to youth are listed and defined at the end of this chapter. In addition to the services listed in this chapter, youth with private insurance may also contact a private provider to receive information about their covered care.

For help getting started with YES, call one of the following numbers:

- **Magellan Member line 855-202-0973**
- **Liberty Healthcare 877-305-3469**

To learn unfamiliar terminology, refer to the Terms to Know.

For YES background information, refer to the Introduction.

Division of Medicaid

Medicaid outpatient mental health services are managed by Magellan of Idaho. Magellan of Idaho manages a network of providers who offer services and supports, and they help connect Medicaid members to these providers, authorize services, and process providers' claims.

All youth with Medicaid are able to receive medically necessary Medicaid services and supports. Providers use their expertise, along with The Magellan of Level of Care Guidelines, to help them decide what is medically necessary. These guidelines are based on the following principles:

- Care should promote the youth's wellness and resiliency
- Care should be effective.
- Care should be accessible.
- Care should be appropriate.
- Care should be available in the least restrictive setting for the family.

Additional information about the Level of Care Guidelines and the services and supports provided by Magellan of Idaho can be found in the following resources:

- Magellan of Idaho Member Handbook
- Magellan of Idaho Provider Manual

Can't find a service or support?
Call: 1-855-202-0973

Learn more about Child and Family Teams and crisis planning in Chapter 3.

The Child and Family Team meets to identify services and supports and documents them in the coordinated care plan. Team members help connect the family with agencies for the services identified.

Medicaid covers inpatient mental health services directly. These services may be requested through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) component of Medicaid.

Children's Medicaid

If a youth needs medically necessary services that are not specifically included in the Idaho Medicaid State Plan, the services may be authorized by Children's Medicaid, also known as EPSDT. The service request must be submitted by either the youth's primary care provider or a specialist physician who determines that the youth has a need for the requested treatment. Service providers must coordinate services with the youth's primary care physician. Submit service requests as follows:

- For outpatient service requests, submit the request to Magellan of Idaho. For additional information, refer to the Magellan of Idaho Member Handbook.
- For inpatient service requests, submit the request to Medicaid. For additional information, refer to Medicaid's EPSDT Information.

Children's Medicaid in Idaho entitles youth to receive any treatment or service if that treatment or service is necessary to correct or help defects, physical and mental illnesses or conditions, and is specified as a Medicaid-covered service in the Social Security Act. This includes:

- Physician, nurse practitioner and hospital services.
- Physical, speech/language, and occupational therapies.
- Home health services, including medical equipment, supplies, and appliances.
- Treatment for mental health and substance use disorders.
- Treatment for vision, hearing and dental diseases and disorders.

This broad coverage requirement results in a comprehensive, high-quality health benefit for children enrolled in Medicaid.

Division of Family and Community Services (FACS)

Two programs under the Division of Family and Community Services — the Child Welfare Program and Children's Developmental Disabilities Program – provide case management services for:

- Youth in foster care.
- Youth who were adopted.
- Youth with both SED and a diagnosed developmental disability.

In addition, Children's Developmental Disabilities staff who are certified to administer the CANS.

For additional information on case management and the CANS, refer to the Services and Supports section.

Idaho Department of Juvenile Corrections (IDJC)

Youth in custody with the Idaho Department of Juvenile Corrections receive mental health services under a model unique to the mission of the department, as identified in the Jeff D. Settlement Agreement. These services are provided through the Clinical Service Bureau, which is staffed by clinicians and social workers. These providers develop treatment plans, provide counseling, and arrange for other services. The CANS is administered prior to youth returning to the community, and they are then connected with an Intensive Care Coordinator to allow for continued care and to prevent gaps in services. When a youth is working towards reintegration back into the community and/or home, the Idaho Department of Juvenile Corrections accesses community reintegration providers for mental health services until the youth is released from custody. For additional information on these services, refer to the Clinical Services page on the Idaho Department of Juvenile Corrections website.

Idaho Department of Education (IDE)

Not all youth involved with the YES program qualify for special education programs, but through the Child Find system, the Idaho Department of Education helps districts identify and provide services to those youth who do qualify. Child Find activities are run to create public awareness of special education programs, to advise the public of the rights of students, and to alert community residents of the need to identify and serve students with disabilities. To be eligible for services under the Individuals with Disabilities Act (IDEA), a student must have a disability that:

1. Meets the Idaho state disability criteria as established in the Idaho Department of Education - Special Education Manual.
2. Adversely affects educational performance.
3. Results in the need for specially designed instruction and related services.

In addition to special education services, some school-based services provided for children with IEPs are reimbursed by Medicaid.

For additional information on special education services, refer to the following websites:

- Idaho Department of Education - Special Education
- Idaho Training Clearinghouse

Services and Supports

All services and supports currently available through YES are described in the following section.

Services and Supports	Provided by
Assessments and Planning	
Assessment	• Magellan of Idaho (Division of Medicaid)
Case Management	• Child Welfare Program (Division of Family and Community Services) • Children's Developmental Disabilities Program (Division of Family and Community Services) • Magellan Healthcare (Division of Medicaid)
Child and Adolescent Needs and Strengths (CANS)	• Children's Developmental Disabilities Program (Division of Family and Community Services) • Magellan Healthcare (Division of Medicaid)
Child and Family Team	Magellan Healthcare (Division of Medicaid)
Comprehensive Diagnostic Assessments	Magellan Healthcare (Division of Medicaid)
Psychological/Neuropsychological Testing	Magellan Healthcare (Division of Medicaid)
Targeted Care Coordination	Magellan Healthcare (Division of Medicaid)
Treatment Planning	Magellan Healthcare (Division of Medicaid)
Wraparound	Magellan Healthcare (Division of Medicaid)
Crisis Services	
Crisis Intervention	• Magellan Healthcare (Division of Medicaid) • School-based Services (Division of Medicaid)

Services and Supports	Provided by
Crisis Response	• Magellan Healthcare (Division of Medicaid)
Support Services	
Family psychoeducation	• Magellan Healthcare (Division of Medicaid)
Family support	• Magellan Healthcare (Division of Medicaid)
Respite	• Magellan Healthcare (Division of Medicaid)
Transportation	Division of Medicaid
Youth support	Magellan Healthcare (Division of Medicaid)
Treatment Services	
Behavioral Modification and Consultation	• Magellan Healthcare (Division of Medicaid) • School-based Services (Division of Medicaid)
Day Treatment	Magellan Healthcare (Division of Medicaid)
Intensive Home & Community Based Services Programs	Magellan Healthcare (Division of Medicaid)
Intensive Outpatient Programs	Magellan Healthcare (Division of Medicaid)
Medication Management	Magellan Healthcare (Division of Medicaid)
Psychiatric Residential Treatment	Division of Medicaid
Psychotherapy	Magellan Healthcare (Division of Medicaid)
Skills Building/Community Based Rehabilitation Services	• Magellan Healthcare (Division of Medicaid) • School-based Service (Division of Medicaid)
Therapeutic After School and Summer Programs	Magellan Healthcare (Division of Medicaid)

Assessments and Planning

Assessments

Mental health assessments are completed by the provider using a variety of methods including, but not limited to, conversations with youth, family, and other members of their natural support system, observations of behaviors and interactions with others, a review of relevant assessments and other historical documents, and coordination with other service providers.

Learn more about assessments in Chapter 3.

There are different names for assessments depending on who provides the assessment. Liberty Healthcare, and Magellan of Idaho's providers can all provide assessments.

Case management

A service provided by a mental health professional to help the youth and family learn how to coordinate and access their medical, mental health, and community-living needs.

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a tool used to identify the strengths and needs (including functional impairment) of the youth and family to assist in treatment planning and to monitor the outcomes of services.

Learn more about the CANS in Chapter 3.

Child and Family Teams

A meeting with the youth's informal and formal supports to develop, change, review, and monitor the youth's coordinated care plan. The team is responsible for reviewing the services on the plan and the progress towards the youth's goals.

Comprehensive diagnostic assessment (CDA)

A licensed mental health clinician conducts an assessment by gathering historical and current clinical information through a clinical interview and from other available resources to identify the youth's strengths and unmet mental health needs. The results are recorded and include the youth's background information, the results of a mental health status exam, and the diagnosis.

Tips for youth

Listed below are some tips for you as you start behavioral health services.

- Including supportive people and family members in your care can help you achieve your goals.
- Learning about your strengths and the strengths of your family can help you feel supported during treatment.
- Sharing in a group setting can be powerful because the other group members can relate to you. Helping someone else in your group through a tough time can help you reach your own goals.
- Medications can be an important part of healing, but some may not be right for you. Be sure to talk to your provider to make sure you understand any possible side effects.
- Your voice matters. Be sure to communicate with your provider and team to help make a plan that works for you.

Tips for families

Listed below are some tips for you to think about as your child receives mental health services.

- Allowing your child time to process what they are learning in therapy and listening to their experience can help you understand how to help them reach their treatment goals.
- Improving family relationships can be an important part of behavioral health treatment because having strong supports improves the chance of success in treatment.
- Keeping a list of the medications your child is on, any changes in their health, and questions to discuss during visits can help when you meet with providers.
- Giving your child the opportunity to practice skills learned through skill building and community based rehabilitative services can help them reach their goals.
- Learning more about how your child's SED impacts their attitudes and behaviors can help you better understand their strengths and needs and can improve their treatment.
- Let's be real here: The things we do for ourselves are most often the things we give up first when our children are struggling. Taking time to do the things that build you up and give you rest are vital to helping you continue to be your child's best advocate and can help you gain perspective.

Psychological/neuropsychological testing

Written, visual, or verbal tests that are given by a psychologist to measure the youth's thinking, behavior, and daily functioning. This also includes observations of the youth to analyze their strengths and weaknesses to provide appropriate recommendations that take into consideration a variety of factors including age, culture, and living environment.

Targeted Care Coordination (until December 2024)

The Targeted Care Coordinator is responsible for ensuring that services are accessed, coordinated, and delivered in a strength-based, individualized, and relevant manner, and that services and supports are guided by family voice and choice. They serve as a care navigator for the family and are responsible for promoting integrated services with links between child-serving providers, systems, and programs.

If a youth and family have a targeted care coordinator, this person is responsible for coordinating and facilitating Child and Family Team meetings. During these meetings the team develops, implements, and monitors an outcome-focused, strengths-based, person-centered service plan that includes both formal and informal services and supports.

Treatment planning

The Child and Family Team, including youth, family, and mental health providers collaborate to develop a plan for treatment that includes the youth's mental health goals and the steps the youth and family want to take to meet those goals. This service supports the care planning described in Chapter 4.

Wraparound Service

Coordination of care and services for youth and families with intensive needs. For additional information on this service, refer to the Wraparound section in Chapter 4.

Crisis Services

Crisis intervention

During a crisis, a mental health provider works directly with the youth and family to deescalate the situation. The provider remains with the family until the crisis is resolved or other services and supports are in place to manage the crisis. This service is provided face to face in the community 24 hours a day, 7 days a week.

Crisis response

If a youth has a sudden and severe mental health problem, the youth or family can talk with a mental health professional on the phone to help them figure out what to do. This phone service is available 24 hours a day, 7 days a week. This service is not meant to replace emergency assistance. In a life-threatening emergency call 9-1-1.

Support Services

Family psychoeducation

This service teaches the youth and family about their mental health needs and strengths. In addition, they learn ways to manage their medications and mental health so the youth can function better at home, school, and in the community. The youth and family may attend a session with just their family or with a group of other families.

Family support services

A parent with lived experience raising a youth with mental health concerns meets with families to help them navigate the unique needs of raising children with mental health issues.

Respite

Short-term or temporary care for a youth with SED that is provided by someone other than the youth's primary care giver. This service can take place in the youth's home or in an appropriate community location, and may be offered as an individual or group service. Respite can be used if the youth is not experiencing a mental health crisis.

Respite services are available through Medicaid.

Medicaid Respite

Medicaid respite services are available through Magellan of Idaho to youth who go through the Liberty Healthcare assessment process and may be accessed immediately. However, once a youth has an approved person-centered service plan, respite must be included on it.

Tips for providers

Working with mental health services and supports may be a new experience for many youth and families. Listed below are some tips to keep in mind.

- Take time to describe any unfamiliar terms to the family, as well as potential positive and negative impacts of each type of intervention (both short and long term), so the youth and family can make a fully informed decision on which types of services and supports they would like to engage in.
- Take time to explain options, goals, and your process to youth and families.
- Help families understand their child's needs in the therapy process.
- Youth and family voice and choice are an important part of the YES principles of care. Help families understand the options they have and answer their questions so that together you can select services that help the youth reach their goals.
- Monitor the success of the coordinated care plan created by the CFT and help the team make changes if the services included are no longer working, or other services may be more appropriate.

Transportation

Youth and one additional rider (a parent or guardian) can be transported to appointments for treatment like psychotherapy or skills building. Any additional riders are handled on a case-by-case basis and need prior coordination. Transportation services are not covered for respite or for Child and Family Team meetings.

Youth support

A young adult who has personal experience with SED assists and provides support for the youth involved with YES. This person helps the youth understand their role in accessing services and in becoming an informed self-advocate. Youth support may include, but is not limited to, mentoring, advocating, and educating through youth support activities.

Treatment Services

Behavioral modification and consultation

The design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. Behavioral strategies are used to teach the youth alternative skills to manage targeted behaviors across social and learning environments.

Day Treatment

A structured program available to youth who have severe mental health needs. These services typically include various treatments that may include skills building, medication management, and group, individual, and family therapy. Youth participate in the program at least three (3) hours a day, four to five (4-5) days per week.

Intensive home and community-based programs

A short-term, individualized program that identifies, coordinates, and monitors various services provided in the youth's home and community. This program is for youth who have severe needs and provides them and their families with support to keep the youth at home rather than in an out-of-home placement.

Intensive Outpatient Programs

Intensive outpatient programs provide a structured care environment to youth who are experiencing mental health and/or substance use disorders, and who are experiencing moderate behavioral health symptoms The program may function as a step-down program from psychiatric hospitalization, partial hospitalization, or residential treatment and may also be used to prevent or minimize the need for a higher or more intense level of care.. These programs are appropriate for youth who live in the community without the restrictions of a 24-hour supervised treatment setting during non-program hours.

Medication management

A doctor or nurse meets with the youth and family to talk about the youth's symptoms and determine if medications are appropriate. They also meet to monitor the medications they are currently taking, the effect of the medication, and any side effects to the medication.

Psychiatric residential treatment

Comprehensive mental health treatment that takes place at a live-in facility, often referred to as a PRTF. These facilities offer intense, focused mental health treatment to promote a successful return to the community. While in residential treatment, youth must receive services to address all their identified therapeutic needs, developmental priorities, and personal strengths and needs. Providers will also assess the potential resources of the youth's family and involve the family in the therapeutic process. Appropriate transition and discharge planning must be included as part of treatment.

Psychotherapy

The youth talks with a provider about mental health challenges as well as functional impairments and learns methods to build upon their strengths. There are three types of psychotherapy available:

- Individual psychotherapy includes either a youth and therapist, or a parent and the youth's therapist.
- Family psychotherapy includes the youth, family, and a therapist.
- Group psychotherapy includes a group of people with similar emotional problems and/or functional impairments and a therapist.

Skills building/community based rehabilitative services

Services that help youth learn and use life skills so they can take care of their lives independently. A mental health provider and skills building worker help the youth and family come up with goals that are important to the youth. The skills building worker helps the youth learn and use skills to meet their goals.

Therapeutic after school and summer programs

This structured treatment program includes clinical, recreation, and education activities provided at school and in other community settings. The program uses a strengths-based and family-centered model to deliver specialized and supportive services. All treatment, care, and support services must be provided in a context that is child-centered, family-focused, strengths-based, culturally competent, and responsive to each youth's psychosocial, developmental, and treatment care needs.

Summary

YES partners play different roles in providing services and supports to help youth with mental health needs.

- Medicaid provides health care coverage for eligible youth who may have a variety of healthcare needs. Most of Medicaid's mental health services are managed by Magellan of Idaho.
- Youth in Juvenile Corrections receive treatment plans, counseling, and other services through the Clinical Service Bureau.
- The State Department of Education provides special education services for youth who qualify under the Individual's with Disabilities Act. Not all YES participants will quality for these services.

To learn more about the services and supports available, refer to the resources listed below:

- Magellan of Idaho Member Handbook
- Magellan of Idaho Provider Manual
- State Department of Education Special Education

Chapter 6 describes transitions youth may go through within the YES system of care.

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Chapter 6: Working Through Transitions

Contents

Overview

In the YES system of care transitions are an important part of care. Transitions refer to the changing levels of care and appropriate services and supports needed by youth and families throughout their involvement with YES. Transitions can also refer to movement between systems, such as aging into the adult system or accessing care through specific child-serving agencies. Mental health providers and child-serving agencies provide discharge and transition planning to ensure the youth and family receive coordinated care as they move through different levels of care, between providers, across child-serving agencies, into the adult mental health system, and out of care.

For help getting started with YES, call one of the following numbers:

- **Magellan Member line 855-202-0973**
- **Liberty Healthcare 877-305-3469**

Transition points are identified and planned for by the Child and Family Team, so connections can be built to other services and supports that are needed during care and during transitions. This identification and planning helps youth and families as they move between levels of care, and out of care, based upon their changing needs, changing circumstances, and treatment goals. The overall goal is to ensure that the achievements the youth and family made during care are meaningful, durable, and sustainable.

To learn unfamiliar terminology, refer to the Terms to Know.

Learn more about the CANS tool in Chapter 3.

While some transitions are unforeseen, others can be planned in advance or worked towards. One of the signals for transition occurs when the Child and Family Team begin to examine the strengths a youth has built in treatment. These strengths include the youth's internal strengths, family strengths, and community strengths. The Child and Adolescent Needs and Strengths (CANS) tool is used to measure these strengths, and used with a clinical assessment, is an important part of transitions planning.

The sections below identify transition points and provide information on transition planning.

Transition Points

Although there are many transitions youth and families may go through while in treatment, the seven transition points listed below have been identified in the YES system of care. These transitions occur when the youth:

- Is functioning at a higher level and no longer has a functional impairment or SED as identified by a Comprehensive Diagnostic Assessment and the CANS.
- Requires a different level of care.
- Ages out of the system.
- Experiences a change in insurance, including:
    - Loss or gain of Medicaid.
    - Loss or gain of private insurance.
- Leaves a residential placement.
- Leaves Idaho Department of Juvenile Corrections (IDJC) facility or county detention.
- Has left care and needs re-entry to YES.

Communication and collaboration between agencies and providers at the beginning of treatment, during treatment, and at transitions promotes engagement and helps maintain the gains a youth and family have made during treatment. When going through transitions, the youth and family work with their Child and Family Team. The members of their team help by making referrals and linking the youth and family to other informal and formal mental health and community resources.

Transition Planning

Transition planning is a collaborative part of the teaming process. The Child and Family Team meets to identify, discuss, and develop a shared vision of future success as defined by the youth and family. The resulting plan includes the transition points that are consistent with success. By planning for these transitions and being aware of their role during a transition, the Child and Family Team members help create a smoother process for the youth. The roles and responsibilities for Child and Family Team members can be found in Chapter 4: Planning Coordinated Care In general, members of the Child and Family Team are responsible for the following activities during a transition:

Youth/Family:

- Communicate with the provider about strengths and needs to make sure the CANS and Comprehensive Diagnostic Assessment accurately reflects them.
- Advocate for the youth (family).
- Participate in the planning process.
- Work with other members of the Child and Family Team to identify services, supports, and to create a crisis plan.
- Provide information to support decision making and inform planning.
- Engage in treatment and support for the youth.
- Guide the Child and Family Team.
- Ensure youth provide input on goals and strengths.

Providers, including Case Managers:

- Help the family seek care from additional sources, if necessary.
- Make care recommendations.
- Provide treatment.
- Participate in planning meetings.
- Prepare and engage the youth and family in treatment.
- Engage with the family regarding expectations.

Idaho Behavioral Health Plan (IBHP) Care Coordination Team (Intensive Care Coordinators or other care management team members), Developmental Disability Case Mangers, and/or Wraparound Coordinators:

- Provide youth access to behavioral health services if they have SED
- Provide info on eligibility groups, on how to transition between programs, and on how to access services
- Help family see care from additional sources if necessary

Other team members:

- Be a source of support of the youth and family.
- Identify services and informal supports that can help the youth and family.
- Help the youth and family make decisions about services and supports.
- Help identify additional resources for care.
- Participate in planning.

There are also some activities that are only done during specific transitions. These transition specific tasks are listed below:

- When the youth no longer has a functional impairment or SED:
  - The youth and family work with the rest of the Child and Family Team to prepare for the transition away from formal services.
  - Providers help the family prepare to move away from formal services and provide them with information and contacts in case they need to re-enter YES.
- When the youth ages out of YES:
  - The youth and family:
    - Work with the Child and Family Team to prepare for the transition away from YES.
    - Work with the youth's provider and state agencies to determine if the youth may be eligible for adult mental health services.
    - Applies or helps the youth apply for social security income, if necessary.
    - Applies or helps the youth apply for Medicaid if the youth will qualify as an adult under the regular income limits.
- When the youth's YES eligibility changes:
  - The youth and family can:
    - Contact Idaho Self-Reliance at 2-1-1 to determine options for eligibility.
    - Work to identify providers who accept the youth's insurance.
  - The provider should:
    - Work with the family to identify other resources for care or other payment options.
    - Help transition the youth out of services, if necessary.

- When the youth leaves residential treatment:
    - The Child and Family Team:
        - Communicates with the facility to determine what supports are needed for the youth in the community and ensures that these supports are available to the family immediately upon discharge.
        - Creates an updated crisis and safety plan.
    - The family:
        - Supports the development of a transition plan.
        - Participates in interventions as clinically appropriate to help support the youth in the transition home.
    - The provider:
        - Ensures an updated CANS is completed before the transition home.
        - Accepts appropriate releases and clinical documentation from the facility and communicates with the facility.
        - Provides adequate clinical support based on the recommendations of the Child and Family Team.

- When the youth leaves the Idaho Department of Juvenile Corrections or County Detention:
    - The provider coordinates with the court system, parole officer and family to structure planning and treatment expectations and requirements.
    - The Idaho Department of Juvenile Corrections:
        - Sets up an assessment with the independent assessor 90 days prior to release.
        - Makes referrals for services.
        - Ensures a comprehensive reintegration plan has been developed.
        - Ensures access to services is in place.
- When the youth needs to re-enter YES:
    - If the youth has Medicaid, they can contact their former provider to start planning care. If the youth does not have Medicaid:
        - The family can apply for Medicaid to see if they qualify with their current income.
        - The youth can go through the independent assessor process, and based on their SED determination, apply for Medicaid.
        - The family can contact Magellan Healthcare.

Summary

Transition is a change in care or circumstance that occurs as the youth and family move into, through, and out of the YES system of care. The YES system of care has identified seven transition points the youth and family may experience. The Child and Family Team helps the youth and family plan for transitions and progress through the transition. Most of the work they do during a transition is the same regardless of the transition type, but there are some activities that members of the team perform only for specific transitions. Planning for transitions and being aware of their role during a transition, the Child and Family Team makes the process go more smoothly for the youth and family.

The final chapter of the YES Practice Manual provides information on the complaints and appeals process. Go to Chapter 7: Filing Complaints and Appeals to learn more.

Chapter 7: Filing Complaints and Appeals

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Filing Complaints

When a youth, family member, or guardian is not satisfied with any part of their care within the YES system of care, they may file a complaint. The complaint may be about the quality of care received, access to services, a provider, an employee of a provider or state agency, a state agency involved in the YES system of care, the system of care in general, or any other issue including a complaint about an appeal.

Complaints are a valuable and important part of the state being able to identify gaps and needs within the system of care. All complaints are taken seriously. Youth and their families should not be penalized or retaliated against for filing a complaint. It is possible to submit a complaint about the YES system of care anonymously, if a youth or family wishes to.

If possible, complaints should start with the youth's provider, school district, case manager, or any other care provider. If the family is not satisfied with how the complaint is addressed or the family would rather file the complaint with the state or its contractor(s), follow the steps in the sections below.

Idaho Department of Health and Welfare complaint process

To file a complaint about the YES system of care or the Idaho Department of Health and Welfare, use the table below to locate the correct contact information. Complaints may be received in any format (phone, email, mail, fax, or an online submission, when available) and do not have any specific requirements.

Youth Empowerment Services (YES) Centralized Complaint Team	
YES System of Care *The Department of Health and Welfare coordinates the investigation of and responses to all YES System of Care complaints received.*	Phone: 208-364-1910 or 800-352-6044 Email: yes@dhw.idaho.gov Mail: IBHP Governance Bureau Attn: YES Centralized Complaints PO Box 83720 Boise, ID 83720-0009 Online Complaint Submission Form: https://app.keysurvey.com/f/1391131/5d8d/
Idaho Behavioral Health Plan (IBHP)	
Magellan Healthcare *Magellan Healthcare is the contractor that manages the IBHP for Medicaid members and other eligible members.*	Phone: 855-202-0973 Fax: 888-656-9795 Email: IDAC@magellanhealth.com Mail: Magellan Healthcare, Inc Attn: Idaho Quality Department PO Box 2188 Maryland Heights, MO 63043
IBHP Governance Bureau *Manages the contract with Magellan Healthcare to provide IBHP services, including YES services and supports.*	Phone: 866-681-7062 Email: IBHP@dhw.idaho.gov Mail: IBHP Governance Bureau PO Box 83720 Boise, ID 83720-0009
Division of Medicaid	
Medicaid ***Healthy Connections Team - Customer Service*** *Complaints about Medicaid contractors, Medicaid staff, Medicaid providers, Medicaid services outside of the IBHP and YES, etc. can be submitted to Medicaid Administration.*	Phone: 888-528-5861 Mail: PO Box 83720, Boise, ID 83720-0009

Children's Developmental Disabilities (DD) *Helps families care for their child who has a developmental disability through Medicaid funded DD services.*	Phone: 877-333-9681 Fax: 208-332-7331 Email: DDQI@dhw.idaho.gov Mail: PO Box 83720, Boise, ID 83720-0036 Online Complaint Submission Form: https://healthandwelfare.idaho.gov/childrens-developmental-disability-forms
Division of Behavioral Health (DBH)	
DBH Complaints Team *The DBH complaints team manages complaints for complaints about DBH contractors, DBH staff, DBH providers, DBH services outside of the IBHP and YES etc. can be submitted to the DBH Policy and Compliance Unit.*	Phone: 208-334-5628 Email: DBHPolicy@dhw.idaho.gov Mail: Division of Behavioral Health Policy & Compliance – Complaints Team PO Box 83720 Boise, ID 83720-0036
Division of Child, Youth, and Family Services	
Child Welfare *Child and Family Services helps Idaho families that are struggling to provide a safe place for their children.*	Phone: 208-334-5700 Fax: 208-332-7330 Email: CFSYESInq@dhw.idaho.gov Mail: PO Box 83720, Boise, ID 83720-0036
Other Idaho Department of Health and Welfare (IDHW) Contractors	
Medicaid Independent Assessor (IA) – *Liberty Healthcare*	Phone: 877-305-3469 Fax: 208-258-7985 Email: idahoyes@LibertyHealth.com Mail: 8850 W. Emerald St., Ste. 164 Boise, ID 83704
Medicaid Non-Emergency Medical Transportation (NEMT) – *Medical Transportation Management (MTM)*	Phone: 866-436-0457 Fax: 877-220-7330 Email: QM@mtm-inc.net Mail: PO Box #210, Meridian, ID 83680 Online Complaint Submission Form: https://www.mtm-inc.net/contact/ • Select who you are • Select 'Complaint' from the drop down
Families and Youth of Idaho (FYIdaho) *FYIdaho provides family and youth advocates and support. They can accept complaints for the YES system of care and help you navigate the system.*	Phone: 208-433-8845 Email: info@fyidaho.org Mail: 704 N 7th St, Boise, ID, 83702 Online Complaint Submission Form: https://www.fyidaho.org/about-us/contact/ • Click 'send us a message'

After a complaint is filed with the YES Centralized Complaint Team*

After a complaint is received by the department, it is handled as outlined below.

1. The complaint is documented so it can be tracked.
2. The team that received the complaint confirms the complaint was received by contacting the person who filed it with a phone call, email, or letter (if available and not anonymous) within five (5) business days.
3. The complaint is reviewed and investigated by the appropriate team. The person who filed the complaint may be contacted during this time for additional information or clarification, or if the department has an update to provide.
4. Within thirty (30) days, the person who filed the complaint will receive follow-up by phone, email, and/or letter with the outcome or resolution and any next steps.

*The same process above is followed by the IBHP Governance Bureau in the Division of Medicaid and DBH.

Tips for providers

Providers can encourage youth and families to file complaints. Some things you can do to help clients through the complaint process are listed below.

- Encourage clients to leave feedback.
- Look at complaints as opportunities to improve your care and the system in general.
- Answer questions about complaints and help direct families to the correct process.

Idaho Behavioral Health Plan – Magellan

When Magellan's Quality Department receives a complaint they:

1. Review the complaint and assign it a unique tracking number.
2. Route the complaint internally for a staff member to investigate.
3. Classify the complaint into one (1) of these categories:
    - A Quality of Service complaint, which is a concern about non-quality of care matters managed by Magellan.
    - A Quality of Care complaint, which is a concern about services a member received from a provider in the Magellan Idaho network.
4. Send an acknowledgment letter within five (5) business days of the receipt of the complaint. This letter includes the tracking number for follow up purposes.
5. Send a resolution letter for Quality of Service complaints within ten (10) business days of the receipt of the complaint.
6. Resolve Quality of Care complaints within thirty (30) days of the initial receipt of the complaint. Due to privacy issues and federal and state regulations, the actions taken by Magellan cannot be shared with Medicaid Members.

Medicaid Independent Assessor – Liberty Healthcare

When Liberty Healthcare receives a complaint, they:

1. Send an acknowledgment letter within five (5) business days of the receipt of the complaint.
2. Investigate the complaint. During this process they may reach out to the individual who filed the complaint to get additional information, and they may speak with the independent assessor.
3. Send a resolution letter within ten (10) days of the receipt of the complaint.

Medicaid Non-Emergency Medical Transportation – MTM

MTM receives complaints via the We Care phone Line, through the online complaint web page, or in writing by mailing your complaint to MTM. MTM's complaint process includes acknowledging receipt of the complaint. Research, education, and communication to reach an acceptable resolution is completed and communicated back to the complainant within 5 business days of receipt of the complaint for critical incidents, or within 30 business days of receipt for all others.

1. All complaints are logged, tracked, and assigned to a resolution specialist.
2. The assigned resolution specialist will contact all involved parties during their investigation.
3. The resolution specialist will work with all involved parties to appropriately resolve the complaint and provide education as part of the resolution process.

Child, Youth, and Family Services – Child Welfare

Child Welfare services are provided in the local offices. Complaints should be addressed to the case manager and their supervisor. If there is no resolution, the complaint should be referred to the Chief and Program Manager. If the Chief and Program Manager cannot resolve the issue with the person who has the complaint, then the individual is encouraged to reach out to CFSYESInq@dhw.idaho.gov to be connected with the Bureau Chief and Deputy Division Administrator of the Child and Family Services Program.

Tips for families

Complaints are important tools to help monitor and potentially change how the YES system of care is working. The following tips are meant to help youth and families when working through this process:

- You should file a complaint if you think something wasn't handled correctly. Don't be afraid to ask if something can be handled differently or better. These types of complaints help improve the system.
- You can call and ask someone if your issue is a complaint or an appeal. Whoever you talk to can tell you what steps to take.
- You should always ask for information to be provided to you in writing.
- Remember, you will not be penalized for filing a complaint.

Idaho Department of Juvenile Corrections complaint process

Complaints about mental health services within the Idaho Department of Juvenile Corrections should first be made with the youth's case manager. If the case manager and the person filing a complaint are unable to reach a resolution, the complaint moves up to the unit manager and then moves to the facility superintendent. This can be done through various methods, including but not limited to IDJC's formal grievance process for youth, and parents may contact any individual within IDJC to express any concerns. If a resolution still cannot be reached, or if the individual is still unsatisfied, they should contact the director of the Idaho Department of Juvenile Corrections.

State Department of Education Special Education's dispute resolution process

The Individuals with Disabilities Education Act (IDEA) requires states to have a formal process for parents and districts to resolve special education related disputes. The State Department of Education (SDE) oversees the state administrative complaints and due process hearings systems for special education-related disputes and offers free, voluntary facilitation and mediation of special education meetings in which impartial third parties help the Individualized Educational Program (IEP) team work together to problem-solve and determine services that will benefit students.

Special Education Dispute Resolution Contacts	
Phone:	208-332-6912, 208-332-6914, or 800-432-4601
Fax:	208-334-2228
Email:	disputeresolution@sde.idaho.gov
Mail:	State Department of Education Special Education, Dispute Resolution P.O. Box 83720 Boise, ID 83720-0027
Visit:	https://www.sde.idaho.gov/sped/dispute/index.html

Please contact the Special Education Dispute Resolution office to submit a request for facilitation or mediation, or to file a state administrative complaint or request for a due process hearing for special education. The table to the left includes contact information. Details about facilitation, mediation, state administrative complaints, and due process hearings are in the following sections of this Practice Manual.

Facilitation

Facilitation is a process offered to help special education teams reach agreements and decisions related to students' individual education programs. Any special education team meetings may benefit from skilled and capable facilitators who can assist the team in working together. The facilitator is neutral, is not a team member, and makes no decisions for the team. The facilitator is knowledgeable about special education, skilled at running effective meetings, and adept at managing challenging issues that may arise when teams disagree. There is no charge for facilitation to either the district or the parent.

Facilitation is mutually exclusive from the other dispute resolution processes of mediation, state complaint, or due process hearing. Facilitation can be requested at any time.

Mediation

Mediation is a voluntary process where an Idaho Special Education Department (Department) trained neutral and third-party provides a structure for parents/adult students and district personnel to identify points of agreement. They work to resolve points of disagreement concerning the identification, evaluation, educational placement, or provision of free appropriate public education (FAPE). Mediation aims to build positive working relationships, encourages mutual understanding, and helps the parties focus on their common interest – the student. There is no charge for mediation to either the district or the parent.

Mediation is mutually exclusive from the other dispute resolution processes of facilitation, state complaint, or due process hearing. Mediation can be requested at any time. Additionally, mediation is offered when a complaint or due process hearing is filed.

State Administrative Complaints

State administrative complaints can be filed by any individual or organization alleging any violation of Idaho Disabilities Education Act (IDEA), including an alleged failure to comply with a previous due process hearing decision. State complaint procedures are outlined in IDEA regulations requiring that, in part, a complaint must allege a violation that occurred no more than one year before the date the complaint was received.

The timeline for the resolution of a state complaint is 60 days. The Department will resolve the complaint by:

1. Carrying out an independent onsite investigation if it determines such an investigation is necessary;
2. Allowing the complainant to submit additional information, either orally or in writing, about the allegation(s) in the complaint;
3. Review all relevant information and make a determination as to whether the district is violating a requirement of Part B of the IDEA;

4. Issuing a written decision (with a copy sent to the complainant, the state director of special education, the district's superintendent, the special education director, and the board chair) that addresses each allegation in the complaint and contains findings of fact, conclusions, and reasons for the Department's final decision(s); and
5. Permit an extension of the time limit if exceptional circumstances exist or if the district and the complainant agree to extend the time to engage in mediation or another dispute resolution process available in the state.

The Department will issue a written corrective action plan addressing how the district shall remediate any denial of services and provide training or other technical support to ensure the district has solved any noncompliance.

Due Process Hearings

A due process hearing request involves an allegation or a series of allegations filed with the Department by either parent/adult student or the district on issues relating to the identification, evaluation, educational placement, and the provision of Free Appropriate Public Education (FAPE).

A due process hearing is a formal complaint regarding the identification, evaluation, educational placement, or provisions of a free appropriate public education for a student with a disability or suspected of having a disability. A due process hearing is a request to have an independent hearing officer determine a special education decision.

A due process hearing is conducted by a hearing officer appointed by the Department who will take evidence from both parties and make a decision about a dispute. The hearing officer will conduct the hearing under the Idaho Rules of Administrative Procedure of the Attorney General (IDAPA), IDEA requirements, and the Idaho Special Education Manual.

A due process complaint must be filed within two (2) years of the date you knew or should have known, about the alleged action/violation that is the reason for the complaint. There are limited exceptions to this timeline.

Expedited Due Process Hearings

An expedited due process hearing is an administrative hearing to resolve disputes concerning the discipline of a student with disabilities. An expedited due process hearing is a request to have an independent hearing officer review a disciplinary decision within twenty (20) school days, with a decision rendered within ten (10) days of the hearing.

In addition, the special education Dispute Resolution office provides ongoing support, technical assistance, and guidance to parents and school districts by taking calls, answering emails, collaborating with a variety of educational partners, and developing and distributing resources that address commonly asked questions or concerns specific to dispute resolution and compliance under the IDEA.

Submitting Appeals

Individuals who disagree or are not satisfied with a decision made by the Idaho Department of Health and Welfare or its contractors (Liberty, MTM, Magellan, MCNA) may want to submit an appeal. An appeal form is included with the Notice of Decision. An appeal is your request to dispute or challenge a decision that denies you benefits or services. Some decisions that you can appeal include:

- Denial or termination of Medicaid eligibility
- Denial or reduction of Medicaid funded services or supports
- Denial of Medicaid payment for services or supports
- A determination made by Idaho Department of Health and Welfare or the independent assessment contractor, Liberty Healthcare, that a youth does not meet the following criteria for serious emotional disturbance (SED):
    - A functional impairment identified by the Child and Adolescent Needs and Strengths (CANS) assessment
    - A mental Health diagnosis identified by a Comprehensive Diagnostic Assessment (CDA)
- When requests for Medicaid and YES eligibility or services are not acted upon with reasonable promptness
- Failure of the State or its contractor to provide a CANS assessment or make available any YES services or supports the youth is entitled to under the *Jeff D. Settlement Agreement*

If you want to submit an appeal, you must submit a timely appeal and meet all appeal timelines. If you believe your appeal isn't being addressed timely, you can submit a complaint, sometimes called a grievance, to the Department. A complaint is different than an appeal and can be submitted at any time. Information about submitting complaints is in the section immediately before this one. Youth and their families should never be penalized or retaliated against for submitting a complaint or an appeal. If you feel you are being penalized or retaliated against for any reason, you should submit a complaint directly to the Department as soon as possible.

Tips for families

Youth and families have the right to appeal. The following tips are meant to help youth and families when working through this process:

- You can call and ask someone if you're not sure if your issue is an appeal.
- It is important to pay attention to deadlines for requesting an appeal because missing a deadline may cause you to lose your right to appeal.
- If you're struggling to get the paperwork or documentation that you need to file the appeal, go ahead and make the request for the appeal without it. Include the information you currently have and make a note about the documentation you are waiting to receive.
- You should always ask for information to be provided to you in writing.
- Remember, you cannot be penalized for filing an appeal.

All the divisions within the Idaho Department of Health and Welfare – Medicaid, Behavioral Health, and Family and Community Services – follow the same appeal process while the Idaho Behavioral Health Plan (currently Magellan) has its own appeal process. Different divisions of Idaho Department of Health and Welfare may have their own contact information for appeals. The correct contact information will be written on the letter you receive about the determination, called a Notice of Decision or Adverse Benefit Determination. Contact information for each division is provided later in this chapter.

If you and the Department or Magellan cannot come to an agreement that satisfies your reasons for requesting an appeal during the appeal review process, a State Fair Hearing is available to you. During the fair hearing you will be given an opportunity to present evidence and have witnesses speak in support of your eligibility or need for services that were denied, reduced, or terminated by the Idaho Department of Health and Welfare. This process is known as Due Process rights and includes the procedural rights you are entitled to receive under state and federal law. The YES Due Process Protocol outlines the rights to due process procedures. This is available on the YES website at: https://yes.idaho.gov/wp-content/uploads/2022/04/YES-DP-Protocol-2022-for-YES-Website.pdf

The sections below describe the Idaho Behavioral Health Plan appeal process, The Idaho Department of Health and Welfare appeals process, the Independent Assessor Appeals process, and State Fair Hearings process. There is also information on how to submit an appeal with the Idaho Department of Juvenile Corrections, which does not have a formal administrative appeals process, and the dispute resolution process with the State Department of Education.

Tips for providers

Providers can encourage and help youth and families with appeals. Some things you can do to help clients through the appeals process are listed below.

- Answer questions about appeals help direct families to the correct process.
- Help facilitate the appeals process for families.
- Provide supporting documentation to families quickly so they can meet deadlines.
- Appeal on behalf of a family as their authorized representative. Ensure to get approval in writing from the family.
- Represent families in fair hearings by attending the hearing and/or providing written support.

Idaho Behavioral Health Plan appeals process

The Idaho Behavioral Health Plan (IBHP), Magellan, is the managed care contractor that manages outpatient behavioral health services for Medicaid. The IBHP manages all voluntary outpatient and inpatient behavioral health services covered by Medicaid and the Division of Behavioral Health. This section describes how the appeals process works for the decisions made by the IBHP.

An Adverse Benefit Determination letter is sent by the IBHP informing youth and their families that requested services or payments have been denied, reduced, or terminated. Magellan makes these decisions based on their criteria which can be reviewed at Magellan Care Guidelines. The youth, family, or an authorized representative can submit an appeal of the Adverse Benefit Determination. Medicaid members may continue to receive services while they are waiting for an appeal decision if all the following conditions are met:

- The appeal is requested within 10 days from the date the Adverse Benefit Determination is sent or before the date the decision made by the IBHP goes into effect, whichever is longer.
- The appeal review involves a service currently being provided prior to receiving the Adverse Benefit Determination.
- The services were requested by a provider who is qualified to recommend or deliver the services.
- The time frame in which services were originally authorized to be provided has not run out.
- A request for an extension of the services is made by the youth, family, or authorized representative. Providers appealing on behalf of the member cannot request this option.

An appeal to the IBHP may be either urgent or non-urgent. Each type of appeal and the process for appeal, is explained below.

Submitting an expedited or urgent appeal with the IBHP

An expedited or urgent appeal may be requested when the youth, family, authorized representative, provider, or the IBHP believes an expedited or urgent decision is needed based on a danger to the youth's health or safety. This includes situations where delays in the appeal process could seriously jeopardize the youth's life, health, or ability to attain, maintain, or regain maximum functioning.

To submit an expedited or urgent appeal, complete and return the Appeal Request form that is enclosed with the Adverse Benefit Determination, or call 855-202-0973 weekdays between 8:00 a.m. and 6:00 p.m. MT. The following actions occur:

1. The IBHP representative takes all the appeal information and may request supporting medical records or statements from you, your provider, or the Department.

2. The IBHP denies or approves the request for an expedited or urgent appeal.
    - If the expedited or urgent appeal is denied, the IBHP will notify you within 72 hours by phone and the appeal will be treated as a non-urgent appeal. The appeal will be resolved within thirty (30) days of the date the appeal was received. A written notice is also mailed.

    - If the expedited or urgent appeal request is approved, the IBHP reviews the appeal within seventy-two (72) hours of the date the appeal was received and notifies the youth, family, and the provider of the appeal outcome by phone. A written notification is also mailed.

        - The seventy-two (72) hour turnaround time can be extended up to fourteen (14) calendar days if the youth, family, and/or authorized representative request it. It can also be extended up to fourteen (14) calendar days if the IBHP needs additional information to make the decision. If additional time is requested by the IBHP, they would notify the youth, family, and/or authorized representative by phone within 72 hours and in writing. If the timeframe is extended, the decision must be made before the end of the fourteen (14) days.

If you don't hear from the IBHP within 72 hours of the date you submitted an urgent appeal, please call the IBHP to check the appeal status.

Submitting a non-urgent appeal with the IBHP

Non-urgent appeals must be submitted within sixty (60) days of the date on the Adverse Benefit Determination. To continue receiving services that were terminated, reduced, or suspended the appeal must be submitted within ten (10) days of the date the Adverse Benefit Determination letter is sent or by the date the decision made by the IBHP goes into effect, whichever is longer. Appeals may be submitted over the phone or in person, but the IBHP may request a written follow up. To submit an appeal in writing, the family or their representative should complete the Appeal Request Form that comes with the Adverse Benefit Determination, or you may send a letter requesting an appeal that contains the following information:

- The Medicaid member's name, Medicaid identification number, date of birth, and address.

- The service, dates, and/or units that are being appealed.

- Any additional information that you think should be considered during the appeal process, including records related to the current conditions of treatment, co-occurring conditions, or any other relevant information.

- An explanation of any reasons you have for why the decision is incorrect and should be changed.

- If a provider sends the appeal request, they must also include:

○ Their name, tax identification number, and contact information.

○ Written consent from the Medicaid member and/or their family. If the member is fourteen (14) years old or older and their appeal concerns mental health treatment, the member must give written consent. If the member is sixteen (16) years old or older and their appeal concerns substance use treatment, the member must five written consent.

Send IBHP appeals to:
Fax: 1-888-656-9795
Email: IDAC@magellanhealth.com
Mail: Magellan Healthcare, Inc.
Attn: Idaho Quality Department
PO Box 2188
Maryland Heights, MO 63043

When the IBHP receives the appeal request, the following actions take place:

1. Written confirmation of the appeal is sent to the person appealing within five (5) days of receiving it.

2. A staff member who was not involved in the first decision is assigned to the appeal. This person reviews all the records associated with the first decision and any new information that was received with the appeal.

3. A decision is made within thirty (30) days and a letter is sent with the outcome to the Medicaid member, their family, and the provider.

• If the original decision is overturned, the services or payments are approved, and the appeal process is complete.

• If the original decision is upheld, the IBHP appeal decision letter will identify the specific criteria that were not met in the service request and the facts that support the denial of the services.

If a family is not satisfied with outcome of the appeal to the IBHP, they can submit an appeal to the Idaho Department of Health and Welfare. A family member, a provider, or someone else who is acting for the youth and family as an authorized representative may help with the appeal request or submit the appeal request for them. The IBHP appeal decision letter will provide instructions on how to submit an appeal to the Idaho Department of Health and Welfare and include an appeal request form. The appeal request must be submitted within **one hundred twenty (120) days** of the date on the appeal determination letter from the IBHP. The following sections describe the Idaho Department of Health and Welfare appeal and State Fair Hearings processes.

Idaho Department of Health and Welfare appeals process

When families receive a Notice of Decision letter in the mail from the Idaho Department of Health and Welfare, or an appeal determination letter from the IBHP, and they disagree with the decision, they may submit an appeal to the Idaho Department of Health and Welfare. The following timelines apply for appeals:

• An appeal on the outcome of an IBHP appeal must be submitted within 120 days of the on the appeal determination letter.

• An appeal of the Idaho Department of Health and Welfare's decision to change, deny, or terminate Medicaid eligibility must be submitted within thirty (30) days of the date the Notice of Decision letter was mailed.

- An appeal of the Idaho Department of Health and Welfare's reduction, denial, or termination of Medicaid paid services or supports must be submitted within twenty-eight (28) day of the date the Notice of Decision letter was mailed.

- An appeal of Idaho Department of Health and Welfare's decision that a person is not or is no longer eligible for Children's Mental Health services from the Division of Behavioral Health must be submitted within twenty-eight (28) days of the date the Notice of Decision letter was mailed.

A family member, a provider, or someone acting for the youth and family may submit the appeal as an authorized representative. The person submitting the appeal should carefully read all the information in the Notice of Decision letter or the IBHP's appeal determination letter.

A notice of Decision from Idaho Department of Health and Welfare is required to have the information below.

- A statement of the action or decision made with a clear explanation that supports the specific reasons for the action or decision

- The date the action will be taken

- The rules, regulations, and/or statutes that support the action or decision

- A description of the documentation used to make the decision and how to access that information

- Instructions for submitting an appeal and an appeal request form or the contact information to request the appeal request form

- An explanation of the youth and their family's rights and instructions on how to exercise those rights, including their right to appeal the decision, their right to a fair hearing, an expedited fair hearing, and their right to represent themselves, use legal counsel, a relative, a friend, or other authorized representative during the appeal process

- The right to have an interpreter and who to contact if English is not the person's primary language

- If the person is disabled, the right to have a reasonable accommodation to process the appeal request

- Information on the continuation of benefits pending an appeal or state fair hearing

- Contact information if you have questions about your notice of Decision or how to submit an appeal or request a fair hearing

- The amount of time an agency has to take final action on the appeal

Youth and their families also have the right to request a copy of all documentation used in making decisions and/or the entire record the Idaho Department of Health and Welfare has for the youth. To do this, the family may submit a request to the Idaho Department of Health and Welfare by emailing MedicaidPRR@dhw.idaho.gov . Families should have the youth sign the request if the youth is fourteen (14) years or older. Please note, the Public Records Request unit tracks all requests for personal records, but they are not public records requests. More information about how to request records can be found at the Public Records Request webpage: https://healthandwelfare.idaho.gov/news-notices/public-records-requests.

Submitting an appeal

Appeals may be submitted by mail, email, fax, or phone using the contact information on the Notice of Decision. If an appeal is made over the phone, the individual may be asked to submit something in writing afterwards, but the appeal cannot be denied for this reason. If the family or their authorized representative wants or is asked to submit the appeal in writing, they may use a department appeal request form, but it is not required. A letter, email, or other written form can also be accepted. To request an appeal form, families should contact the number on the Notice of Decision.

Appeals may be standard appeals or expedited/urgent appeals.

- **Standard appeals** are processed within thirty (30) days. The process may take longer if the family asks for additional time or Idaho Department of Health and Welfare needs more information to process the appeal. The Department will contact the family before the thirty (30) days have expired.

- **Expedited/urgent appeals** take seventy-two (72) hours to process and may be requested by the youth's family, authorized representative, or provider if they believe that the youth's life, health, or their ability to gain, maintain, or regain maximum function is at risk or in danger.

    - When an expedited appeal is submitted, the request may be reviewed by a department Medical Director to verify that the youth's health and safety or ability to gain, maintain, or regain maximum function is at risk. The Medical Director will review all the medical records related to or submitted in the appeal to ensure the youth's life, health, or ability to function is at risk and would not be harmed. Department of Health and Welfare will contact the family or their authorized representative by phone as soon as possible, within the 72 hours, to let them know if the expedited appeal is granted or not. Notification of this determination will also be sent in writing and giving the reasons why an expedited appeal was not granted and will include the facts and documents relied upon to deny the expedited appeal.

For help submitting an appeal or to ask questions, families may contact the number listed on their Notice of Decision. They may also contact Families and Youth of Idaho (FYIdaho) for support during the process or help with submitting the appeal.

FYIdaho:
http://fyidaho.org
208-433-8845
support@fyidaho.org

Idaho Legal Aid Services:
208-746-7541
https://www.idaholegalaid.org/

Where to send appeals

Appeals should be sent to the contact information listed on the Notice of Decision. Below are the Idaho Department of Health and Welfare appeal contacts for different types of decisions.

Division of Medicaid (Independent Assessment from Liberty Healthcare, non-emergency medical transportation from MTM, and other Medicaid benefits)
Email: MedicaidAppeals@dhw.idaho.gov
Phone: 208-334-5747
Fax: 208-364-1811
Mail: Medicaid Appeals – IDHW, PO Box 83720, Boise, ID 83720-0009
In Person: Your local Health & Welfare Office

Idaho Behavioral Health Plan (IBHP) Governance Bureau (2nd level appeals for behavioral health services managed by Magellan)
Email: IBHPAppeals@dhw.idaho.gov
Phone: 866-681-7062
Fax: 208-364-1811
Mail: Idaho Behavioral Health Plan Governance Bureau, PO Box 83720, Boise, ID 83720-0009
In Person: Your local Health & Welfare Office

Division of Welfare/Self-Reliance (Eligibility for Medicaid and other benefits)
Email: MyBenefits@dhw.idaho.gov
Phone: 877-456-1233
Fax: 866-434-8278
Mail: Self-Reliance Programs, PO Box 83720, Boise, ID 83720-0026
In Person: Your local Health & Welfare Office

What happens after an appeal is submitted

When Idaho Department of Health and Welfare receives an appeal, the following actions occur:

1. The appeal is reviewed by someone with knowledge of the program or service that has been denied.

2. The reviewer may contact the family or authorized representative for additional information, which may include a request for additional documentation.

3. After researching and reviewing all the material, the reviewer may attempt to reach a mutually acceptable resolution with the family or authorized representative.

4. A decision should be reached and communicated with the family or authorized representative within seventy-two (72) hours for expedited (urgent) appeals and within thirty (30) days for standard appeals. An appeal can be resolved, withdrawn, or upheld.

- If the appeal is resolved, the decision is reversed and the service(s), payment, or eligibility that was reduced, denied, or terminated is approved.

- If the appeal is withdrawn by the family or authorized representative, a withdrawal letter will be sent to them by the Idaho Department of Health and Welfare and the appeal will be closed.

- If the decision being appealed is upheld, this means a mutually acceptable resolution was not reached and the department decision is affirmed. If the family or their authorized representative wish to request a State Fair Hearing, the Idaho Department of Health and Welfare will contact the Office of the Attorney General's Fair Hearings Unit to begin the State Fair Hearing process, which is described in the following section.

State Fair Hearings Process

A State Fair Hearing is the process for people to challenge decisions that affect the rights of children, youth, and families.

The fair hearing is conducted by an impartial state hearing officer who will guide the process and may ask questions of you and any witnesses who are present during the hearing. During the hearing, witnesses, including providers, can provide testimony and written documents, including treatment, medical, or school records. Families have the right to ask all witnesses questions and may have someone, including legal counsel, a relative, a friend, or other spokesperson represent them in the hearing. The hearing officer will issue a written decision based on the evidence presented during the hearing.

The State Fair Hearing process is governed by Medicaid Regulations on appeal rights and processes that can be found in 42 CFR § 431.200: https://www.ecfr.gov/current/title-42/part-431.

The Idaho Department of Health and Welfare has to prove that the decision to deny, reduce, or terminate Medicaid services was correct if the youth is eligible for Medicaid. The person appealing only has to prove eligibility for Medicaid if they had applied and were denied.

When an appeal goes to State Fair Hearing, the following actions take place:

1. The Office of Administrative Hearings schedules a telephonic State Fair Hearing and sends a scheduling notice to the family or their authorized representative and the Idaho Department of Health and Welfare.

- The scheduling notice will include the date, time, how to call into the hearing, timelines to submit supporting documents or records (called exhibits), and witness lists to the Fair Hearings Unit.
    - Witnesses are people you can have present at the hearing who can (testify) provide information and facts about the youth's situation and the appeal. Examples of witnesses could include a mental health or medical provider, a social worker, a family member or friend, or other person who can give information and facts about the youth's situation and the appeal.

- The scheduling notice will also include how to request a pre-hearing conference and how to reschedule the hearing if the date or time does not work.
    - The family or their authorized representative and Idaho Department of Health and Welfare representative must work together to fine three (3) new dates and give those to the Fair Hearings Unit if the scheduled hearing date does not work. The hearing officer will pick a new date and send out a new scheduling notice.

2. Either party may request a Pre-hearing Conference before the fair hearing occurs. A Pre-Hearing Conference provides an opportunity to exchange exhibits and have an important discussion between the parties and the Hearing Officer.

- It is used to identify the specific issue(s) for the hearing, allows for discussion of the important issue(s) or facts that each party thinks the Hearing Officer needs to know before the hearing, gives the Hearing Officer the chance to describe the hearing procedures, and allows for rescheduling of the hearing itself, if necessary.

- The issue(s) can also be resolved at the Pre-Hearing Conference through an agreement between the parties or by either party submitting a motion to dismiss or a motion for summary judgement.

- You can request a copy of all documentation used in making decisions and/or a copy of the youth's entire record, not just the documents the Department wants to use as exhibits at the fair hearing.

- The Department can only present evidence or reasons for the denial decision that were included in the Notice of Decision, including the rules or requirements listed in the Notice of Decision that were used to support the decision.

- If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer thinks it is necessary, they may request another assessment done by someone else who was not involved in making the original decision. That assessment must be paid for by the IDHW or their contractor and made part of the record.

3. The appellant (person appealing, family member, or their representative) and the Idaho Department of Health and Welfare begin preparing for the hearing.

- The person appealing may request the records from Idaho Department of Health and Welfare, and/or providers if they haven't already done so, talk to their witnesses, and gather any other supporting materials. They may also ask someone – a friend, relative, attorney, etc. – to assist them at the hearing and be a witness. If they have any documents or supporting materials (called exhibits), they should submit them to the Fair Hearings Unit and Idaho Department of Health and Welfare by the deadline in the Notice of Scheduling.
    - Supporting materials (exhibits) are documents or information that provide facts and information as to why you think the denial decision is wrong and should be changed and can include documents or information that may not have been available and considered before the denial decision was made.
- Idaho Department of Health and Welfare may talk to their witnesses, gather supporting material, and submit them to the Fair Hearings Unit and the person appealing by the deadline in the Notice of Scheduling.

4. During the State Fair Hearing, the following things will happen:

- The hearing officer will explain the processes for the hearing.
- Everyone who will be testifying will be sworn in.
- The appellant and/or their authorized representative and any witnesses tell the hearing officer why they believe the decision made by the Idaho Department of Health and Welfare is incorrect and present their supporting documents (exhibits).
- Idaho Department of Health and Welfare and/or their witnesses tell the hearing officer why they made the decision and present the documents they used to make the decision.
- The appellant, their authorized representative, the Idaho Department of Health and Welfare, and the hearing officer may all ask questions during the hearing.
- If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and the hearing officer thinks it is necessary, they may request another assessment done by someone else who was not involved in making the original decision. That assessment must be paid for by the IDHW or their contractor and made part of the record.

5. The hearing officer has thirty (30) days from the date of the State Fair Hearing to make a decision. The hearing officer's decision will be in writing and must be based only on evidence presented at the hearing. It must summarize the facts, identify the specific reasons, supporting evidence, and regulations they used to make the decision.

6. A Preliminary Order with the decision will be sent to both the family or their authorized representative and Idaho Department of Health and Welfare. Possible State Fair Hearing outcomes include affirmed, reversed, remanded, dismissed, or default.

- If the decision is affirmed, this means that the Idaho Department of Health and Welfare's denial decision is upheld (remains denied).
- If the decision is reversed, this means that Idaho Department of Health and Welfare's denial decision is overturned, and the services should be approved.

• If the decision is remanded, this means there was new information received during the hearing that was not previously given to Idaho Department of Health and Welfare which may change the original decision. Idaho Department of Health and Welfare will be asked to re-review and make a new decision that will also include appeal rights. New information must be information that was not available and/or was not provided before the date the denial decision was made.

• The Department has ninety (90) days from the time an appeal is submitted to make a final decision under federal Medicaid Regulations. This includes decisions that are remanded.

• If the decision is that the hearing is dismissed, this could mean that there is no longer an issue to appeal. This may be because the denied services, supports, or eligibility were approved, or because the family or authorized representative asks to withdraw their appeal before the hearing happened. A motion to dismiss can occur at a pre-hearing conference or at the scheduled hearing.

• If the decision is a default, this means that either the family or their authorized representative or Idaho Department of Health and Welfare did not appear at the scheduled hearing. Instructions will be provided with the written decision that explain how to reschedule the hearing. The party that did not appear at the hearing can explain why they missed the hearing to the Fair Hearings Unit. The Fair Hearings Unit determines if they had a good reason and the default decision may be rescinded (canceled), and the hearing will be rescheduled.

7. A Preliminary Order becomes a Final Order on the fifteenth (15^{th}) day after it is issued. If the family or their authorized representative, or Idaho department of Health and Welfare do not agree with the Preliminary Order, they can submit a Petition for Agency Review (also known as an Administrative Review) within fourteen (14) days of the date on the order before it becomes final. Instructions for how to submit an Administrative Review are included on the Preliminary Order. The decision (outcome) that results from the Petition for Agency Review (Administrative Review) will be the Final Order.

8. If the family or their authorized representative does not agree with the Final Order from the Petition for Agency Review, or if they do not want to submit a Petition for Agency Review and still wants to appeal the Preliminary Order, they can choose to submit a Petition for judicial Review in district court.

Idaho Department of Juvenile Corrections appeals process

IDJC collaborates with the families of the youth in IDJC custody on all treatment matters, including mental health decisions related to their care. Youth and families who wish to appeal a mental health decision made by the Idaho Department of Juvenile Corrections must do so through the District Court.

Terms to Know

Access Model

The Access Model describes how youth access and move through the YES system of care.

Administrative Hearing

See "Due Process"

Agency

The term "agency" usually refers to any local, county, or state government entity. Examples include the Idaho Department of Health and Welfare, the Idaho State Department of Education and the Idaho Department of Juvenile Corrections.

The term agency may also refer to a company that consists of numerous providers.

Appeals

See "Due Process"

CANS Screener

The CANS Screener is a tool based on the Child and Adolescent Needs and Strengths (CANS) that can help identify unmet mental health needs. Refer to Chapter 2 for additional information.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services 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.

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.

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a tool used in Idaho to identify functional impairment, support decision making in planning for treatment and monitor the outcomes of services. Refer to Chapter 3 for additional information.

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

Child and Family Team (CFT)

The Child and Family Team is a group of caring and invested individuals who are invited by the youth and family to work together to support the youth. Refer to Chapter 4 for additional information.

Child, Youth, and Family Services (CYFS)

Child, Youth, and Family Services (CYFS) is part of the Idaho Department of Health and Welfare and is responsible for many social service programs such as child protection, adoption, foster care, , and early intervention services for infants and toddlers.

Children's Mental Health (CMH)

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

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

A coordinated care plan is the result of the Child and Family Team coordinating care from all the providers involved in treatment and may take many forms. Refer to Chapter 4 for additional information.

Developmental Disabilities (DD)

Developmental disabilities are a group of conditions due to an impairment in physical learning, language or behavior areas. These conditions begin during a person's developmental period, may impact day-to-day functioning, and usually last throughout their lifetime.

Developmental Disabilities Program

The Developmental Disabilities 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 is a part of the Idaho Department of Health and Welfare. It operates community-based mental health services in each of the state's seven regions. The Division of Behavioral Health is responsible for multiple programs, including Children's Mental Health.

Division of 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.

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.

Due Process

Due Process refers to procedures an agency must take to ensure that a person is not treated in an unfair, unsupported, or unreasonable way. Due Process may include:

- A formal letter with specific information about a decision made by the agency regarding services that have been requested to the participant (also known as a "notice") and instructions on how to request an appeal.
- An informal resolution.
- A referral to a fair hearing to review decision the agency made that the participant disagrees with.

Refer to Chapter 7 for additional information.

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.

Fair Hearing

See "Due Process"

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.

Idaho Behavioral Health Plan (IBHP)

The Idaho Behavioral Health Plan is administered by Magellan of Idaho, provides outpatient mental health and substance use disorder services for adults and children enrolled in Idaho Medicaid and individuals who don't have Medicaid but qualify as eligible for services. Inpatient services are covered through the Idaho Medicaid State Plan and EPSDT.

Idaho Department of Health and Welfare (DHW)

The Idaho Department of Health and Welfare promotes and protects the health and safety of Idaho residents. They have multiple divisions, many of which work with youth and families. The Idaho Department of Health and Welfare is designated as the State Behavioral Health Authority under Idaho Statute Section 39-3123.

Idaho Department of Juvenile Corrections (IDJC)

The Idaho Department of Juvenile Corrections is responsible for the youth ages 10 to 21 who are committed to their custody by the Idaho court system. The department operates juvenile corrections centers in Lewiston, Nampa and St. Anthony, which allows 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.

Idaho 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 State Department of Education 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 a department within the State Department of Education and is responsible for ensuring that school districts are compliant with special education and federal program regulations.

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 to identify a mental health diagnosis, unless the family can provide the results of a comprehensive diagnostic assessment 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. An individualized treatment plan identifies:

1. Specific services or supports being offered by that provider.
2. The strength being applied or built, or the need being addressed.
3. Measurable goals as identified in the coordinated care plan created by the Child and Family Team.

Informal Supports

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

Intensive Care Coordination (ICC)

Intensive Care Coordination is case management for youth whose CANS score indicates that 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). Intensive Care Coordination may also be appropriate when intervention is needed to keep a child from being moved to an out-of-home placement.

Intensive Care Coordination 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 Intensive Care Coordination, 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 provides Intensive Care Coordination to youth in their care under a model unique to their mission.

Jeff D. Class Action Lawsuit

The Jeff D. et al. v. C.L. "Butch" Otter et al. class action lawsuit was filed in 1980 and sought to address two primary issues:

1. Mixing adults and juveniles at State Hospital South.
2. The provision of community-based mental health and education services to children with serious emotional disturbance.

To resolve the suit the state focused on the provision of community-based mental health services. In 2007, the federal district court dismissed the case. The Ninth Circuit Court of Appeals overturned the decision in 2011, reinstating the case. The federal district court advised the parties to engage in a mediation process to arrive at a solution to the suit.

The parties, including parent, provider and advocacy representatives, collaborated from October 2013 to December 2014 to create a Settlement Agreement leading to an improved children's mental health system of care. This new system is community-based, easily accessed, family-driven and follows the system of care, Practice Model and Principles of Care outlined in the agreement.

Jeff D. Settlement Agreement

The Settlement Agreement is a contractual agreement between the parties to the Jeff D. class action lawsuit to resolve the underlying dispute. It is a high-level description of what the State has agreed to do to have the lawsuit dismissed.

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 provided through Magellan of Idaho, be found on their website. For Providers - Magellan of Idaho - Liferay DXP

Natural Supports

See "Informal Supports"

Needs

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

Magellan of Idaho

Magellan is contracted by the Division of Medicaid to administer the Idaho Behavioral Health Plan.

Home - Magellan of Idaho - Liferay DXP

Person-Centered Service Plan

The person-centered service plan, frequently referred to as simply a person-centered plan, includes information about the youth, including preferences, strengths and needs as identified in the CANS, and goals. The plan also includes a list of all the formal and informal services and supports needed to achieve the identified goals and whether they are reimbursable by Medicaid. Care is taken to make sure there is no duplication of services delivered through other agencies or programs.

Youth with traditional Medicaid who want respite services, and youth who receive Medicaid after receiving an SED diagnosis under the higher income limit are required to have a person-centered service plan.

Refer to Chapter 4 for additional information.

Practice Model

The Practice Model describes the six key components required to provide care in the Youth Empowerment Services (YES) system of care. Refer to Chapter 1 for additional information.

Primary Care Physician

A primary care physician is a doctor who provides regular and continuing care for youth and families, and is
trained to be the first point of contact for an undiagnosed condition.

Principles of Care

The Principles of Care are 11 values that are applied in all areas of Youth Empowerment Services (YES). Refer to Chapter 1 for additional information.

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.

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 a youth 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 Child and Family Team.

Screening

A screening is a method of determining if a child may need to access mental health services. Refer to Chapter 2 for additional information.

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

A Medicaid term that identifies the difference between services provided by a licensed and/or experienced provider and functional supports needed to help a youth and family live their lives.

Stakeholders

The term "stakeholders" refers to people who have an investment, share or interest in a specific subject. In relation to YES, a stakeholder is a person or group that has an interest in mental healthcare for youth. Youth, families, service providers, governmental agencies, 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.

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

The YES system of care is a continuum of services and supports for youth 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 families. It is an approach that 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 youth 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 youth 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 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. Refer to Chapter 6 for additional information.

Wraparound

Wraparound 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 youth and families and is successful by creating relationships with a team of involved people to support treatment needs.

Youth Partners

Youth Partners may be part of the Wraparound team. Their role is to act as an advocate and support for the 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.

Appendix A — Resources

Resource	Description
Idaho Department of Juvenile Corrections Behavioral Health | Juvenile Corrections (idaho.gov)	Describes the clinical services the Department of Juvenile Corrections provides to youth in their care. These services are unique to the mission of the department. For additional information, email contactus@idjc.idaho.gov or call 208-334-5100.
Idaho State Department of Education http://www.sde.idaho.gov/sped/sped-manual/	This manual provides information on special education in Idaho. It includes information on 503 Education Plans, Individualized Education Plans and complaints with the State Department of Education. For additional information, call 208-332-6800.
Idaho Training Clearinghouse https://idahotc.com/	Links school professionals and parents with special education training opportunities and resources across the state. For additional information, email itc@uidaho.edu

Resource	Description
Medicaid Application http://idalink.idaho.gov	Links to the online application for Medicaid. To apply over the phone, call 1-877-456-1233.
Magellan Member Handbook Magellan + the new IBHP | Magellan Healthcare	Provides information for members on services and supports, complaints and appeals, and member rights. To request a printed copy, contact Magellan at 1-855-202-0973.
Magellan Provider Manual Provider Handbooks & Forms - Magellan of Idaho - Liferay DXP	Provides information for providers on various topics, including benefits, authorization requirements, and access to care, privacy practices, compensation and claims, appeals and disputes, and member rights and responsibilities. To request a printed copy, contact Magellan at 1-855-202-0973.

Wraparound “What is Wraparound “ Video”	This link opens a video that provides information on Wraparound for families.
YES Website http://www.yes.idaho.gov	The information center for all things related to the YES system of care and the YES project, including additional resources, training information and documentation.

Appendix B — Contact Information

Department of Health and Welfare Appeals

Phone: 1-208-334-5564

Division of Behavioral Health / Children's Mental Health

Regional Office Location		Phone number
Region 1	Coeur d'Alene	208-769-1406
	Kellogg	208-769-1406
	St. Maries	208-769-1406
	Ponderay	208-769-1406
Region 2	Grangeville	208-983-2300
	Lewiston	208-799-4440
	Moscow	208-882-0562
Region 3	Caldwell	208-459-0092
	Nampa	208-459-0092
	Payette	208-459-0092
Region 4	Boise	208-334-0800
	Mountain Home	208-334-0808
Region 5	Twin Falls	208-732-1630
	Burley	208-732-1630
Region 6	Pocatello	208-234-7900
	Preston	208-234-7900
	Blackfoot	208-785-5871
Region 7	Idaho Falls	208-528-5700
	Rexburg	208-528-5700
	Salmon	208-528-5700

Idaho Department of Juvenile Corrections

Phone: 208-334-5100

Email contactus@idjc.idaho.gov

Idaho CareLine

Phone: 2-1-1

Idaho State Department of Education

Phone: 208-332-6800

Email info@sde.idaho.gov

Liberty Healthcare

Phone: 877-305-3469
208-258-7980

Magellan of Idaho

Phone: 855-202-0973

Medicaid Eligibility

Phone: 877-456-1233

Medicaid Early and Periodic Screening, Diagnosis and Treatment

Email: EPSDT@dhw.idaho.gov

Medicaid Medical Care Unit

Phone: 866-205-7403
208-364-1833
Email: MedicalCareUnit@dhw.idaho.gov

Medicaid Pharmacy

Phone: 866-827-9967
208-364-1829

Medical Transportation Management (MTM)

Phone: 866-436-0457
Form: http://www.mtm-inc.net/contact/

Medicaid YES Program Team (Medicaid eligiblilty)

Phone: 208-364-1910
Email: YESProgram@dhw.idaho.gov

YES Complaints

Phone: 855-643-7233
Fax: 208-334-5998
Email: yes@dhw.idaho.gov

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