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# CHILDREN'S MENTAL HEALTH WORKFORCE DEVELOPMENT PLAN: PROVIDER SURVEY RESULTS

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REPORT TO  
BOISE STATE UNIVERSITY  
SCHOOL OF SOCIAL WORK  
STATE OF IDAHO  
DEPARTMENT OF HEALTH AND WELFARE  
DIVISION OF BEHAVIORAL HEALTH

June 5, 2018

## Table of Contents

<b>Introduction .....</b>	<b>5</b>
<b>Methodology .....</b>	<b>6</b>
<b>Research.....</b>	<b>6</b>
Kick-off meetings .....	6
Survey .....	6
Selecting respondents .....	6
Survey response .....	7
<b>Analysis .....</b>	<b>8</b>
The data is a first-time picture of providers' services and workforce needs.....	8
Confirm analysis with stakeholders.....	9
<b>The Respondents .....</b>	<b>10</b>
<b>Organizations: a snapshot of the field.....</b>	<b>10</b>
Type of organization.....	10
Respondents' position in their organizations .....	11
<b>Solo practitioners: a snapshot of the field.....</b>	<b>13</b>
<b>Findings and observations .....</b>	<b>14</b>
<b>Age ranges served.....</b>	<b>14</b>
Organizations.....	14
Solo practitioners.....	15
<b>Optum .....</b>	<b>17</b>
Organizations.....	17
Solo practitioners.....	17
<b>Services.....</b>	<b>18</b>
Organizations.....	18
Solo practitioners.....	19
<b>Communities served .....</b>	<b>20</b>
Days and times of service availability .....	26
Evidence-based practices .....	32
Telehealth.....	38
Prescribing Professionals .....	42
<b>Services by community and region .....</b>	<b>46</b>
Individual Counseling.....	47
Child and Family Counseling.....	49
Group Counseling.....	51
Crisis services .....	53
Case management services .....	56
Community-based rehabilitation services.....	60
Social Skills Training.....	62
Wraparound services .....	65
Respite Care.....	68
Medication Management.....	69
<b>Planning for future services .....</b>	<b>71</b>

Organizations.....	71
Solo practitioners.....	75
<b>The Behavioral Health Workforce.....</b>	<b>77</b>
Job titles .....	77
Staffing: full-time and part-time .....	79
<b>Demographics .....</b>	<b>80</b>
Caseloads.....	84
Licensure .....	87
Languages.....	92
Metrics for future use: NAICS codes.....	94
Recruitment and hiring: Workforce gaps and Strategies .....	99
Gaps between education and readiness to practice .....	108
<b>Implications for Idaho's Youth Empowerment Services .....</b>	<b>111</b>
<b>Services.....</b>	<b>111</b>
Crisis services .....	111
Medication management .....	111
Case management.....	111
Critical community-based services.....	112
Evidence-based practices .....	112
Telehealth.....	112
Small business development training and funding: infrastructure and start-up.....	113
Confirm reimbursement rate-setting regularly.....	114
<b>Workforce.....</b>	<b>114</b>
<b>Recruitment &amp; Retention .....</b>	<b>115</b>
Barriers to recruiting.....	115
<b>Works Cited .....</b>	<b>117</b>
<b>Appendix A.....</b>	<b>118</b>
<b>Organizational provider survey instrument .....</b>	<b>118</b>
<b>Solo provider survey instrument.....</b>	<b>118</b>
<b>DHW introduction letter .....</b>	<b>119</b>
<b>Follow-up email #1 .....</b>	<b>120</b>
Organizations.....	120
Solo providers .....	121
<b>Follow-up email #2 .....</b>	<b>122</b>
Organizations.....	122
Solo providers .....	123
<b>Telephonic follow-up protocol and script .....</b>	<b>124</b>
<b>Instructions for calls.....</b>	<b>124</b>
Location for the call .....	124
<b>Instructions for the interviewer .....</b>	<b>124</b>
Preparation.....	124
Principles for interviews.....	124
Use effective call techniques.....	124

<b>Instructions for conducting the call.....</b>	<b>124</b>
<b>Intro Script .....</b>	<b>124</b>
<b>During the call.....</b>	<b>125</b>
<b>Concluding the call .....</b>	<b>125</b>
<b>Final follow-up reminder .....</b>	<b>126</b>
Organizations.....	126
Solo providers .....	126
<b>Appendix B: NAICS codes and occupational titles.....</b>	<b>127</b>
<b>Appendix C: Idaho cities with populations of 100 or more, by population .....</b>	<b>128</b>
<b>Appendix D Maps .....</b>	<b>131</b>
<b>Appendix E .....</b>	<b>133</b>
<b>Comparison with IDOLWD employment demand projections .....</b>	<b>133</b>
<b>Post-secondary Education system .....</b>	<b>135</b>



## Introduction

The purpose of this report is to inform the State of Idaho's Children's Mental Health Workforce Development Plan by providing information regarding Idaho mental health providers' capacity to serve children and youth who have serious emotional disturbance.

The State is developing a new system of care in children's mental health as the result of the Jeff D. class action lawsuit and the resulting Settlement Agreement. The Jeff D. lawsuit began in 1980 when children were co-mingled with adults at State Hospital South. There was a lack of appropriate treatment services at State Hospital South, as well as a lack of community-based mental health services across Idaho.

In 2015, the lawsuit was settled after a mediation process. The Settlement Agreement requires the State to create a new system of care for children's mental health. The new system of care is called Youth Empowerment Services (YES), and the framework for YES is the Idaho Implementation Plan.

One of the seven objectives of the Idaho Implementation Plan is Workforce Development and Training. The Idaho Department of Health and Welfare, Division of Behavioral Health (IDHW-DBH) is implementing the 2017 Workforce Development Plan in accordance with the requirements of the Jeff D. Settlement Agreement. (State of Idaho, Department of Health and Welfare, Division of Behavioral Health, 2017)

IDHW-DBH has contracted with Boise State University's School of Social Work to complete a workforce capacity and gaps analysis as one input to the State's Children's Mental Health Workforce Development Plan. In this report, we present the results of two point-in-time surveys of Idaho mental health providers conducted in early 2018. The survey asked providers about their services, the communities they serve, their workforce, and issues in recruitment and retention.

This report is one of four deliverables provided by Boise State University to the Division of Behavioral Health as part of the overall workforce capacity and gaps analysis. The purpose of this report is to present mental health provider profiles and workforce capacity based on the results of the survey. The work for this deliverable was conducted by Mary Elizabeth Rider, MSW of Rider Consulting under the direction of Dr. Nathaniel Williams. A subsequent report provides additional analyses of these survey data including population totals of Idaho's children's mental health workforce and an estimate of the gap between Idaho's current children's mental health workforce capacity and the capacity needed to deliver YES services and supports statewide.

## Methodology

The work plan involved research, analysis, data confirmation, and reporting. The product is a report delivered electronically to Boise State University School of Social Work. The project required regular communications with the Boise State University School of Social Work and the Idaho Department of Health and Welfare, and coordination with the appropriate stakeholder groups.

## Research

### Kick-off meetings

The researchers conducted a series of face-to-face and video-conference meetings with IDHW and BSU-SSW leadership, including Workforce Development Committee meetings.

### Survey

The target population of the survey was mental health providers who deliver Medicaid-funded services to youth and their families in Idaho. The sampling frame was secured from Optum, which manages Idaho's Medicaid-funded mental health services. Using web-based survey methodology [www.surveymonkey.com](http://www.surveymonkey.com), the researchers surveyed Optum network mental health providers who deliver Medicaid-funded services to youth and their families. Implementation of the survey included a six-step process based on empirical research regarding methods to optimize response rates. The six steps are described below.

### Introduction

A letter of introduction to the project was faxed from Idaho DHW to Medicaid network providers via Optum's network fax system in January 2018.

### Survey instruments

The initial invitation to complete the survey was emailed to executive staff from organizations (i.e., group practices) and operators of solo practices identified by Optum Idaho in January 2018.

Two survey instruments were generated, one for organizations and one for solo practitioners, with the assumption that solo practitioners make up a substantial number of the providers in Idaho and that they do not have employees, so some questions would need to be reframed and some of the questions would not apply.

The survey instruments were web-based, designed in partnership by Rider Consulting and BSU-SSW, and vetted by stakeholders, approved through the BSU Institutional Review Board.

### Follow-up

- The researchers sent three follow-up emails to potential survey respondents. The timing of these follow-up emails occurred one week after the initial invitation, two weeks after the initial invitation, and one week after the direct telephone follow-up calls.
- Graduate Assistants from Boise State University followed up with survey respondents via telephone to ensure high-quality data. Graduate assistants contacted all providers who had not responded to the survey after the second email follow-up. This included a total of 341 telephone calls direct to providers.

### Selecting respondents

Optum provided Boise State University with a list of Optum providers including provider organizations and solo practitioners with the following information about each practice:

- Taxpayer Identification Number
- National Provider Identification number
- Street address
- Email address
- Secondary email address
- Telephone number

The original list contained 686 duplicate taxpayer identification numbers, indicating duplicate information for a single organization. The researchers unduplicated the tax identification numbers, and combined contact information for those organizations. This reduced the field of potential invitations to 457.

The researchers confirmed contact names and email addresses for each entity with a taxpayer identification number by checking the state business license database, telephone calls, and by web search. Some organizations had gone out of business; others had no email address availability. This reduced the number of entities to be invited to 407.

In this process, we identified entities that appeared to be sole proprietors and others that appeared to be organizations with employees. The researchers separated these entities to direct the sole proprietors to the solo practitioners survey, which was substantially similar to the larger survey but which did not include questions about employees.

There was more than one email address for many of the entities in the Optum database and in our confirmation process. In the interest of securing responses, we used all available email addresses for organizations and solo proprietors. In addition, many professionals who work for organizations also are Optum providers in private practice; of those, many used their organization's email address for Optum purposes.

### Survey response

The total number of organizations and solo providers invited to participate in the survey was 392. Two hundred forty-four responded to the survey: 152 responded to the organization survey, and 92 responded to the solo provider survey. Ten invitees opted out of the survey. The total response rate was 65 percent. The average response time was 20 minutes for the organizational survey and nine minutes for the solo provider survey.

### Organizations

The researchers started with 414 email addresses for the leadership of 250 organizations. Of these:

- 19 email addresses were duplicates.
- Eight additional emails had no names associated with the email addresses. We sent these emails without named respondents.
- SurveyMonkey will not send duplicate invitations to the same email address; as a result, of the 414 email addresses, 392 emails were sent.
- The researchers secured nine additional email addresses, and invited them on 2/21/18.
- Of the 401 emails sent, 25 were returned as undeliverable.
- In total, 376 emails were sent to the 250 organizational leaders.
- Eight potential respondents opted not to participate.
- 152 organizational leaders responded to the survey (61% of 250 leaders).

### ***Solo practitioners***

The researchers started with 162 email addresses for 156 solo providers with their own Taxpayer Identification Numbers. Of these:

- Six providers had two different email addresses
- Optum has a single, shared email address for 18 solo providers. In addition to private practice, each of these providers also works for Sage Counseling and an email address from that company is what was made available.
- Optum has a single, shared email address for two solo providers and another single, shared email address for another two solo providers.
- SurveyMonkey will not send duplicate invitations to the same email address. Of the 162 individuals with email addresses; as a result, 142 invitations were extended to 142 solo practitioners.
- The researchers secured one additional email address for an additional solo provider, and invited them on 2/21/18.
- Overall, two emails were returned as undeliverable.
- 2 potential respondents opted to not participate.
- Ninety-two responded to the survey (64.7% of 142 solo providers).

### ***Analysis***

The results were analyzed through tables derived from SurveyMonkey and BatchGeo, a web-based data mapping service. BatchGeo maps were exported to Google Maps so that layers of services and populations could be viewed by city on the same map.

### ***The data is a first-time picture of providers' services and workforce needs***

While it is tempting to generalize, this data may not be generalizable to all providers in the whole state. For example, the organizational respondents report that 14 communities with populations of 100 and over receive no services. In fact, these communities may be served by organizations that did not respond to the survey.

### ***Can we track who responded to the survey?***

In order to encourage respondents to be candid in the data they provided, and in order to facilitate approval of the research by the BSU IRB, survey responses surveys were completely anonymous: we cannot track back who responded to the survey or what responses any provider gave.

### ***Could respondents have answered more than one time for their organization?***

Because we had more than one email address for some organizations (414 email addresses for 250 organizations), there was potential for duplicate responses.

One tribe had three individuals responding for their organization. This was determined based on the respondents' self-identification as working for tribes, and by following back on the communities they serve—which are all in the service area of the same tribe. Based on this, we combined the responses from these individuals.

Some organizational representatives and solo providers responded to the survey instrument not intended for them. Specifically, one solo provider responded to the organizational survey and one organization with more than six employees responded to the solo provider survey: a residential ranch program.

The researchers corrected for this by unduplicating where duplication was clear, and by moving responses from one survey to the other for purposes of analysis.

#### **Confirm analysis with stakeholders**

The researchers confirmed analysis with IDHW stakeholders in April and May 2018. In these meetings, the researchers confirmed the results of the survey; the geographic analysis of location of services and providers; recruitment and retention issues of employers and impacting workforce, training in evidence-based practices, linguistic and cultural competency access and gaps with the providers.

## The Respondents

### Organizations: a snapshot of the field

As discussed earlier, the organizations survey was distributed to individuals who appear to represent an organization. Most had websites or Facebook pages, and most evidenced a number of practitioners in their public presence. One hundred fifty-two responded out of 250 (60.8%), and 125 serve children and youth. Most also serve adults.

The majority are private for-profit businesses, which limits their access to public funds outside of contracts. They cannot generate tax-deductible charitable gifts from public and private foundations. This limits their ability to subsidize services when the cost of service is more than the reimbursement rate allowed by insurers, including Medicaid.

- Their locations of service are statewide but concentrated in Regions 3, 4, 6 and 7.
- Clinical caseloads are primarily between 21 and 40 clients per week.
- Organization representatives who responded report that staff is made up of mostly white (92.94%) women (75.38%). The employees are of all age groups, from late teens to mid-70s. The most frequent age group is 25 to 34.
- The primary languages used to deliver services are English (51.9%) with some services delivered in Spanish (48%). Respondents rely on a variety of translation methods to provide services where language would otherwise be a barrier.

### Type of organization

One hundred fifty-two (152) respondents stated that they represent an organization.

Overwhelmingly, the respondents stated that they represent for-profit organizations. One represented a school; three were faith-based, and three represented a tribal government. One private practitioner responded to this survey.

**Figure Types of organizations**

Type of organization	# Responses
For profit	99
Not-for-profit	23
Faith-based	3
School	1
Tribal governments	3

### Not-for-profit organizations

In the review process, there were questions about whether the organizations described as not-for-profit were actually profit organizations that are not making a profit. The researchers reviewed the non-profit providers in the state to confirm the context of the non-profit field. The reviewers' concern may be valid.

A review of non-profit organizations in the State of Idaho reveals that there are 74 organizations that have a mental health mission. Twelve provide mental health services; four more are community mental health centers. Of these 16 organizations, only six generate enough income to file a full tax return with the IRS. (Guidestar)

While some not-for-profit organizations providing behavioral health services to youth and their families may have larger health-related missions (such as hospitals and community health centers),

Twelve hospitals and primary medical care facilities generated enough revenue to file a full tax return with the IRS. Eight community health systems file a full tax return. (Guidestar)

The researchers compared Tax ID numbers between Optum and Guidestar mental health and healthcare providers. In total, of 44 health and mental health non-profits found in the Guidestar registry and that file a full tax return with the IRS, only nine are Optum behavioral health providers. This is a cursory review of proxy data, but appears to validate the reviewers' concern about the number of non-profit mental health providers for children and youth in Idaho.

### **Tribal Governments**

The federal government, and each state, has a special relationship with tribal governments and a continuing obligation to fund health services to eligible members of tribes. The Indian Health Service owns and operates health systems across the country, and some tribes have elected to deliver health services through their own Tribal Health Organizations. While billed through the state Medicaid system (in Idaho, Optum), Medicaid services delivered to American Indian and Alaska Native people by Tribal Health Organizations are 100 percent reimbursable by the Indian Health Services. State governments benefit from Medicaid services delivered to Native people by Tribal Health Organizations because there is no state cost to those services.

Within the state of Idaho, there are four federally recognized tribes and tribal governments. All provide health services and could bill Medicaid.

Three respondents reported that they work for tribal governments. All three serve the same communities within the Shoshone-Bannock Tribes. The Shoshone-Bannock Tribes is a federally recognized sovereign nation located in southeast Idaho, with over 5,900 tribal members.

### **Respondents' position in their organizations**

125 respondents answered this question. The individuals completing the survey were most likely to be the CEO of the organization (41, or 32.8%). The next most likely respondent was the clinical director (33, or 26.4%), followed by the owner of the company (15, 12%).

**Figure 1 Position of respondent in organization**





### Solo practitioners: a snapshot of the field

As discussed earlier, the solo practitioners' survey was distributed to individuals who have NPI numbers and Taxpayer Identification Numbers and who appear to have a private practice. Ninety-two practitioners out of 142 responded (64.7%), and 69 serve children and youth. In their responses to open-ended questions, it appears that many of these solo practitioners are growing their small businesses to include other practitioners.

- Most solo practitioners serve communities in regions 1, 3 and 4.
- Caseloads are generally 15 to 25 clients (26% of those who answered this question).
- Solo practitioners who responded are mostly white (98.2%) women (86%) in the age ranges of 45 to 49 (19.64%), 35 to 39 (17.86%), and 69 to 64 years old (17.86%).

Most (63%) speak English only, and a few offer services in Spanish (11.76%).

## Findings and observations

### Age ranges served

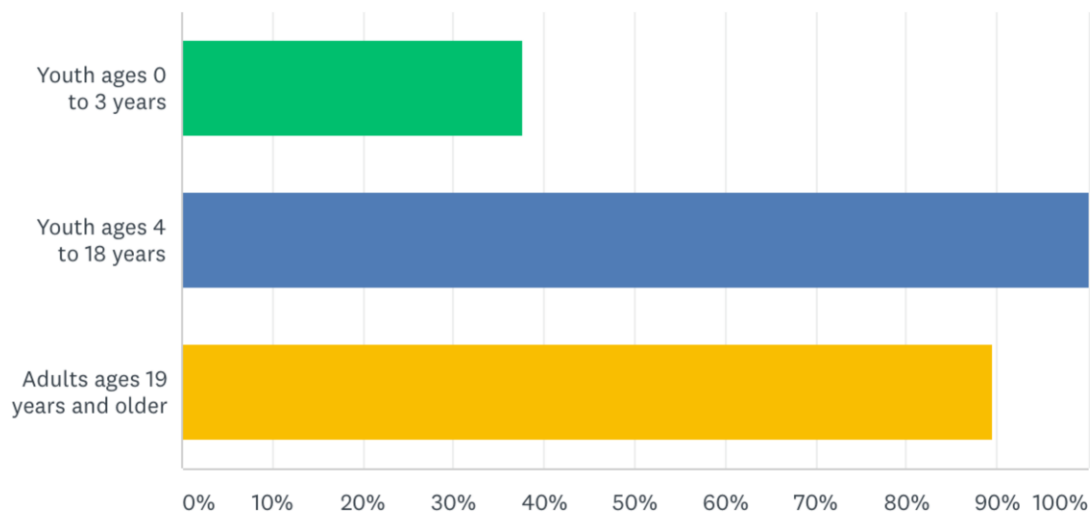
#### Organizations

Of the 152 respondents, 125 (82%) stated that they provide services to children and youth ages birth through 3 and 4 to 18. The rest (n = 27, 18%) stated that they provide services to adults only, and were therefore ineligible for the survey.

Of the 125 organizations who serve youth, 112 (89.6%) also provide services to adults. Only 13 organizations (10.4%) provide services to children and youth only.

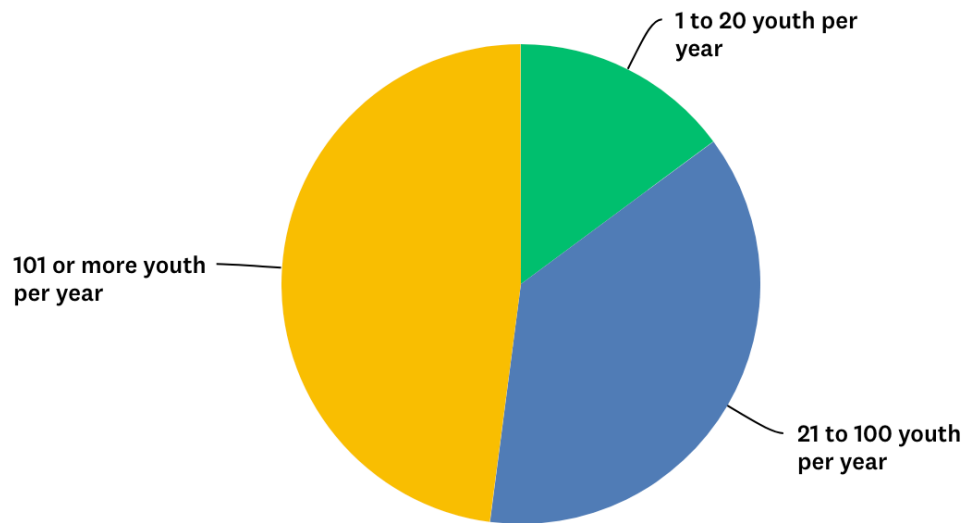
Of the 125 respondents, 47(37.6%) provide services to children ages birth through 3. All 125 organizations provide services to youth ages 4 to 18.

**Figure 2 Age ranges served by organizations**



18 respondents (14.9%) provide services to 20 or fewer children and youth in a year. 45 (37%) provide services to 21-100 children and youth in a year. Fifty-eight, or 48%, provide services to more than 100 children and youth in a year.

**Figure 3 Number of youth served by organizations**



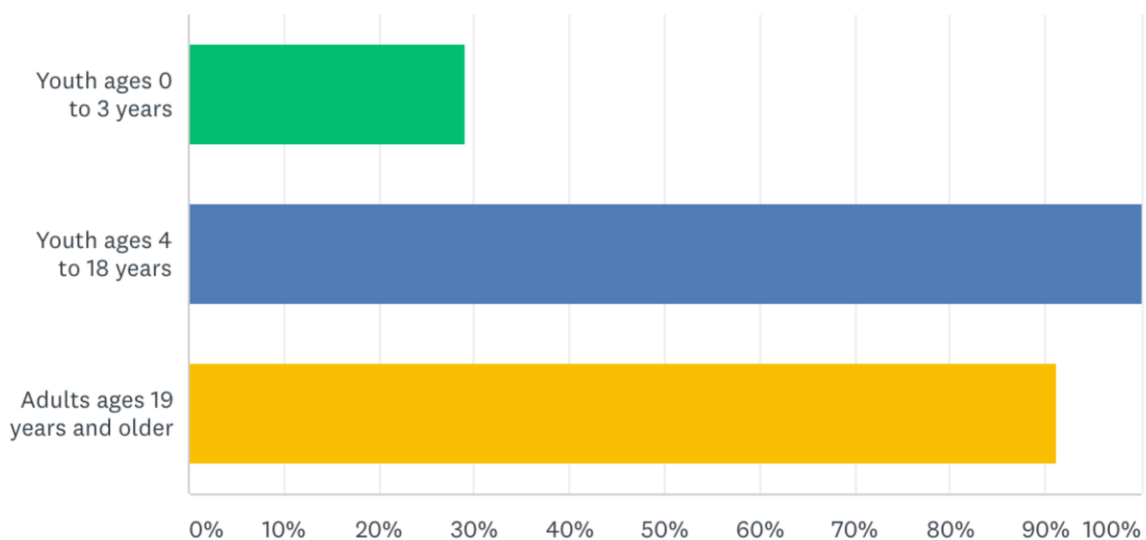
#### **Solo practitioners**

Of the 92 respondents to the Solo Providers survey, 69 (75%) stated that they provide services to children and youth ages birth through 3 and 4 to 18. The rest (n = 23, 25%) stated that they provide services to adults only, and were therefore ineligible for the survey.

63 of the 69 respondents (91.3%) also provide services to adults. Six provide services to children and youth only.

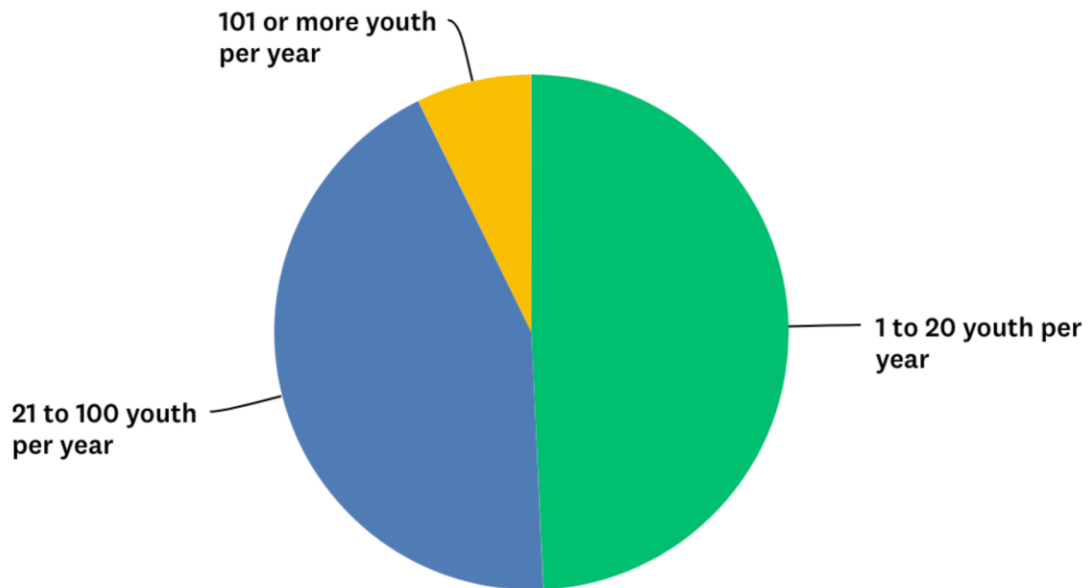
All 69 respondents provide services to youth ages 4 to 18. Of the 69 respondents, 20 (28.9%) provide services to children ages birth through 3.

**Figure 4 Age ranges served by solo practitioners**



34 respondents (49.28%) provide services to 20 or fewer children and youth in a year. 30 provide services to 21-100 children and youth in a year. Five, or 7.25%, provide services to more than 100 children and youth in a year. Of note, one of these solo providers serving more than 100 youth in a year delivers substance abuse screenings and drives from community to community to deliver services.

**Figure 5 Number of youth served by solo providers**



## Optum

### Organizations

Two of the 125 respondents were not sure whether their organizations were in the Optum network. It is unlikely that these organizations are not Optum members.

What would increase your organization's interest in becoming a member of the Optum Network?

- *Probably reimbursement and decrease in pre-auth and requirements to see patients*

### Solo practitioners

Only one of the 69 providers is not in the Optum network.

- *"The credentialing process took almost an entire YEAR. That is completely unethical and therefore I do no contract work with Optum as a result."*

What would increase your interest in becoming a member of the Optum Network?

- *"Ethical credentialing process (timely, use of a universal provider database such as CAQH to expedite process, reduce paperwork required—if a provider is licensed in Idaho by IBOL, they are already vetted to have met requirements to be able to provide mental health services within their scope of practice/licensure level)"*
- *"Massive reduction in patient paperwork required by clinicians"*
- *"Competitive reimbursement rates for commonly used codes"*
- *"Massive reduction of clinical reviews: mental health providers—NOT managed care—determine appropriate length and type of treatment for our patients."*

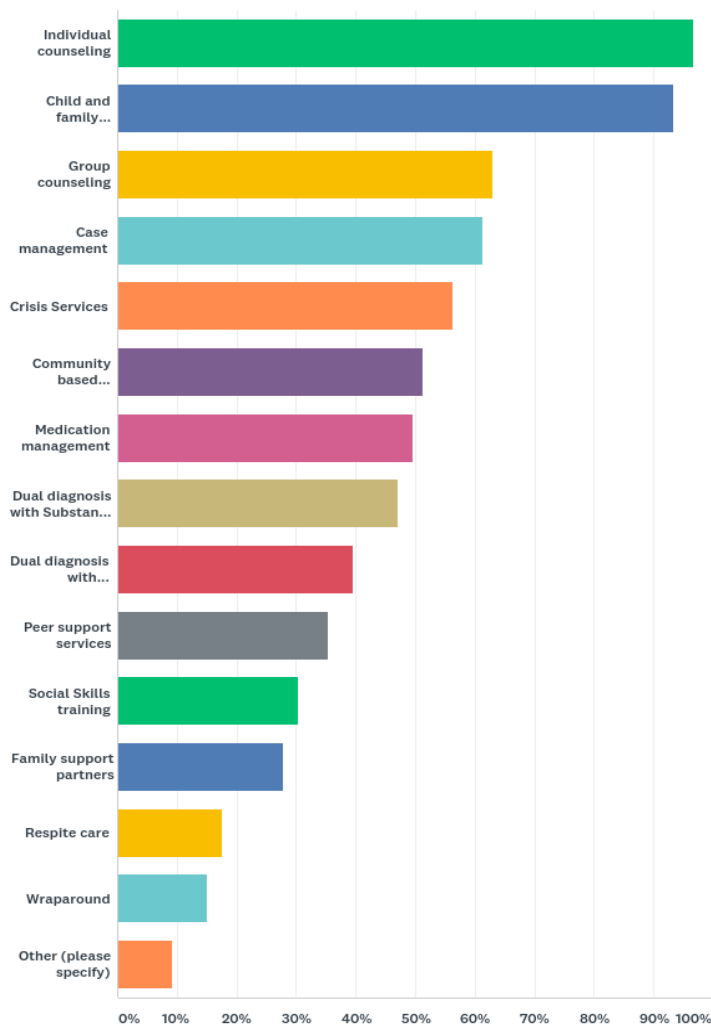
## Services

### Organizations

119 respondents answered this question. Almost all (115, 96.6%) provide individual counseling and child and family counseling (111, 93.3%), Cognitive Behavioral Therapy was a response option. Although they responded later about using Cognitive Behavioral Therapy, no respondent reported that modality when answering this question.

Figure 6 Services provided by organizations

Q10 What services does your organization offer to youth and their families? Include any services your organization provides to youth in any site in Idaho.



Other responses:

- Primary care
- Primary Care
- Community Health Workers

- Cultural Support
- Psychological Services
- Psychological and Neuropsychological Testing
- Neuropsychological and Psychological Testing
- As an accredited Child Advocacy Center, we work almost exclusively with victims (or suspected victims) of sexual abuse and their families.
- Restorative After School Services and Equine Therapy
- GED and credit recovery through on-line schooling
- We used to provide more till it was discontinued.

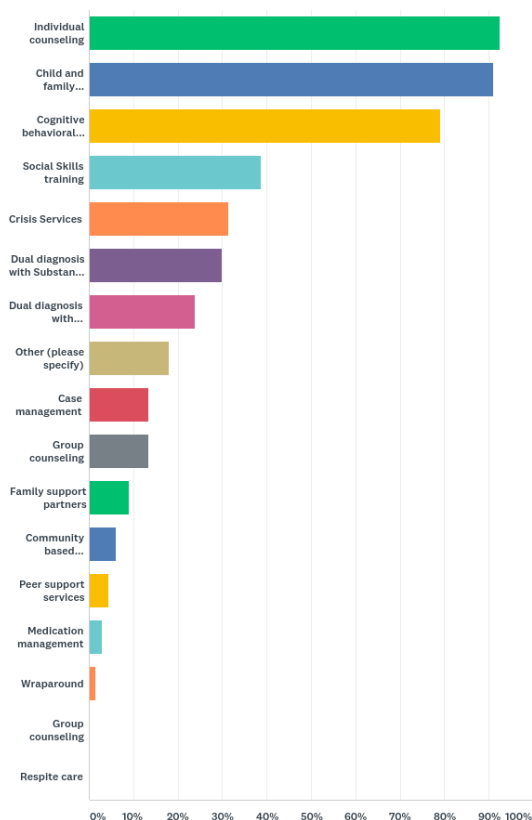
### Solo practitioners

Sixty-seven out of 92 respondents answered this question. Like the organizational respondents, the solo practitioners provide mainly individual (62, or 92.5%) and child and family counseling (61, or 91%). Unlike the organizational respondents, none of whom identified Cognitive Behavioral Therapy as a service as an answer, 53 (79%) identified CBT as a service they provide. No solo practitioners reported offering respite care.

In answering this question, no respondent reported offering group counseling. When asked later where they provide group counseling, respondents identified 53 communities where they provide this service.

**Figure 7 Services provided by solo practitioners**

Q8 What services do you offer to youth and their families? Include any services you provide to youth and their families in any site in Idaho.



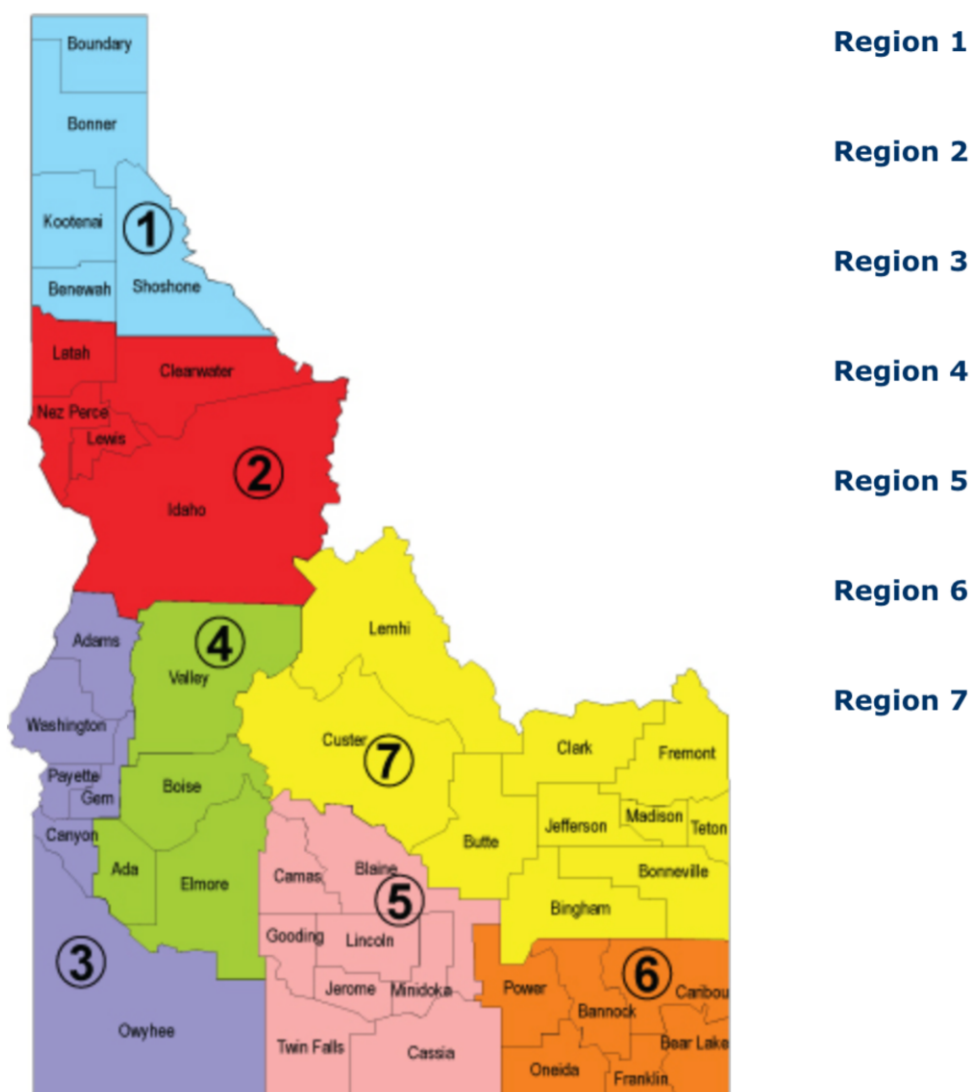
## Communities served

In two separate questions in each survey, we asked respondents to tell us which cities they serve and what services they provide in each. The city list was comprised of 187 cities in Idaho that have populations greater than 100 persons, according to the 2014 U.S. Census Bureau's American Community Survey. This section reports on the communities served by respondents, and the days and times of day they offer services in each community.

The full list of cities included is included as an appendix in Appendix C: Idaho cities with populations of 100 or more, by population.

The State of Idaho Department of Health and Welfare uses a regional system to organize services across programs. There are seven regions, each of which includes several counties. Idaho's ten largest cities are in Regions 4 (Boise, Meridian) and 3 (Nampa, Caldwell), Region 7 (Idaho Falls), Region 6 (Pocatello), Region 1 (Coeur D'Alene and Post Falls), Region 5 (Twin Falls) and Region 2 (Lewiston).

Figure 8 State of Idaho DHW Regions

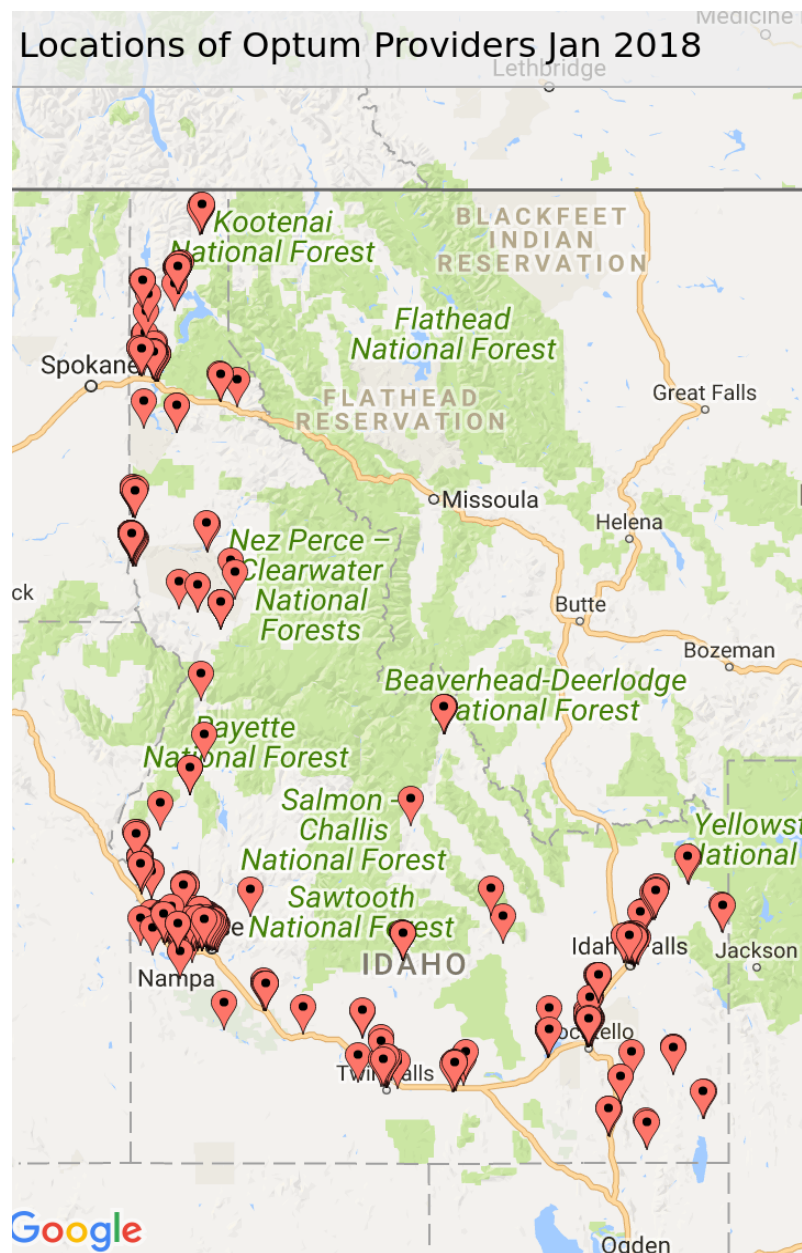




### *Locations of all Optum behavioral health providers*

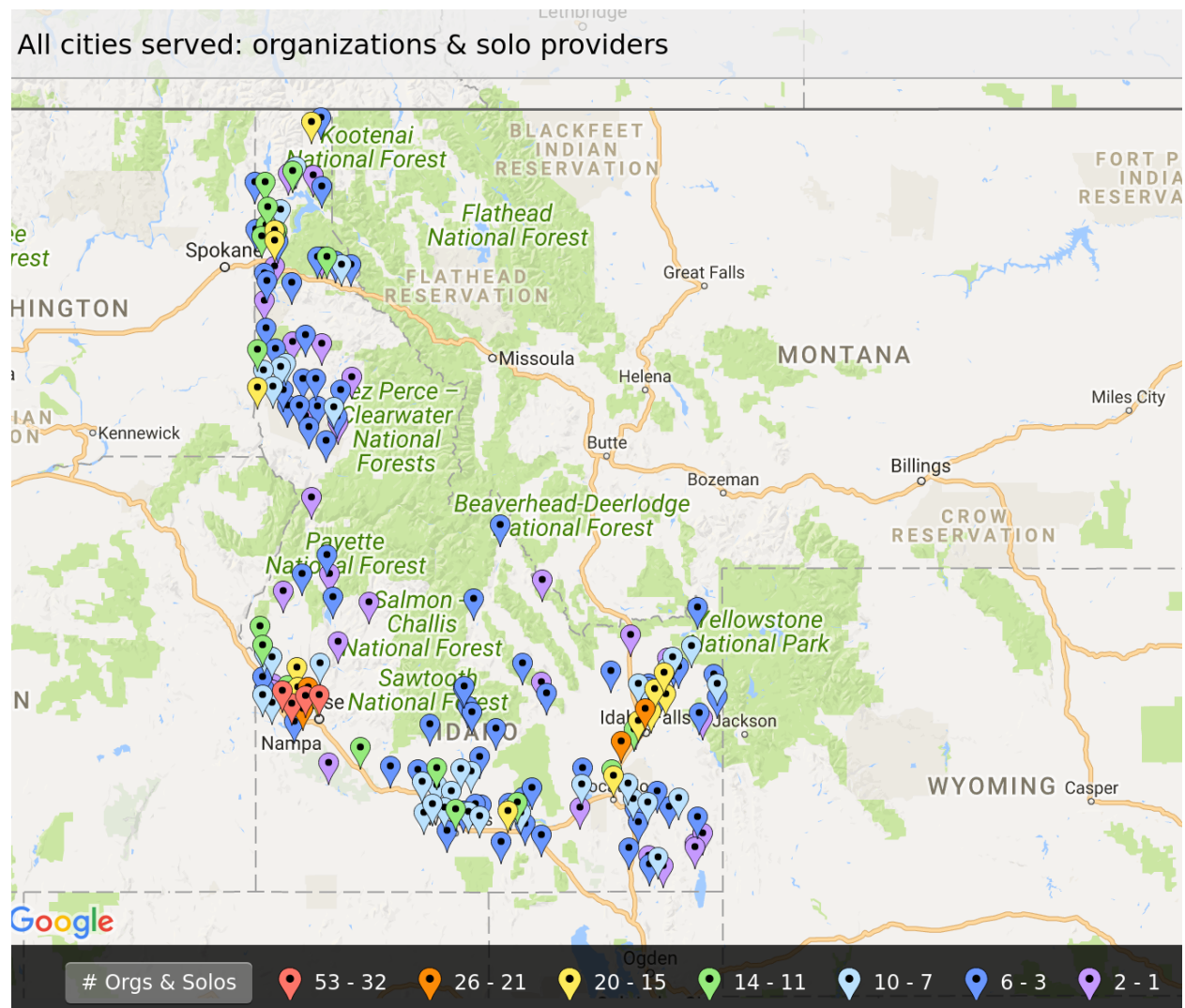
The researchers mapped the addresses of each location from the Optum provider list, including those providers that did not respond to the survey and for which there were no email addresses. The Optum provider list contains one to several physical addresses of services for each provider, with a total of 687 locations. This includes all providers, whether they serve children and youth or adults only. Most of the state's behavioral health resources are concentrated in two regions, with Pocatello/Idaho Falls as a distant second. This map is provided to give context to the results that follow.

**Figure 9** Locations of Optum behavioral health providers



The full map offers considerable detail and is located here:  
<https://batchgeo.com/map/0be160082cf641b6d10b9841068797d5>

**Figure 10 All cities served by organizations and solo providers**

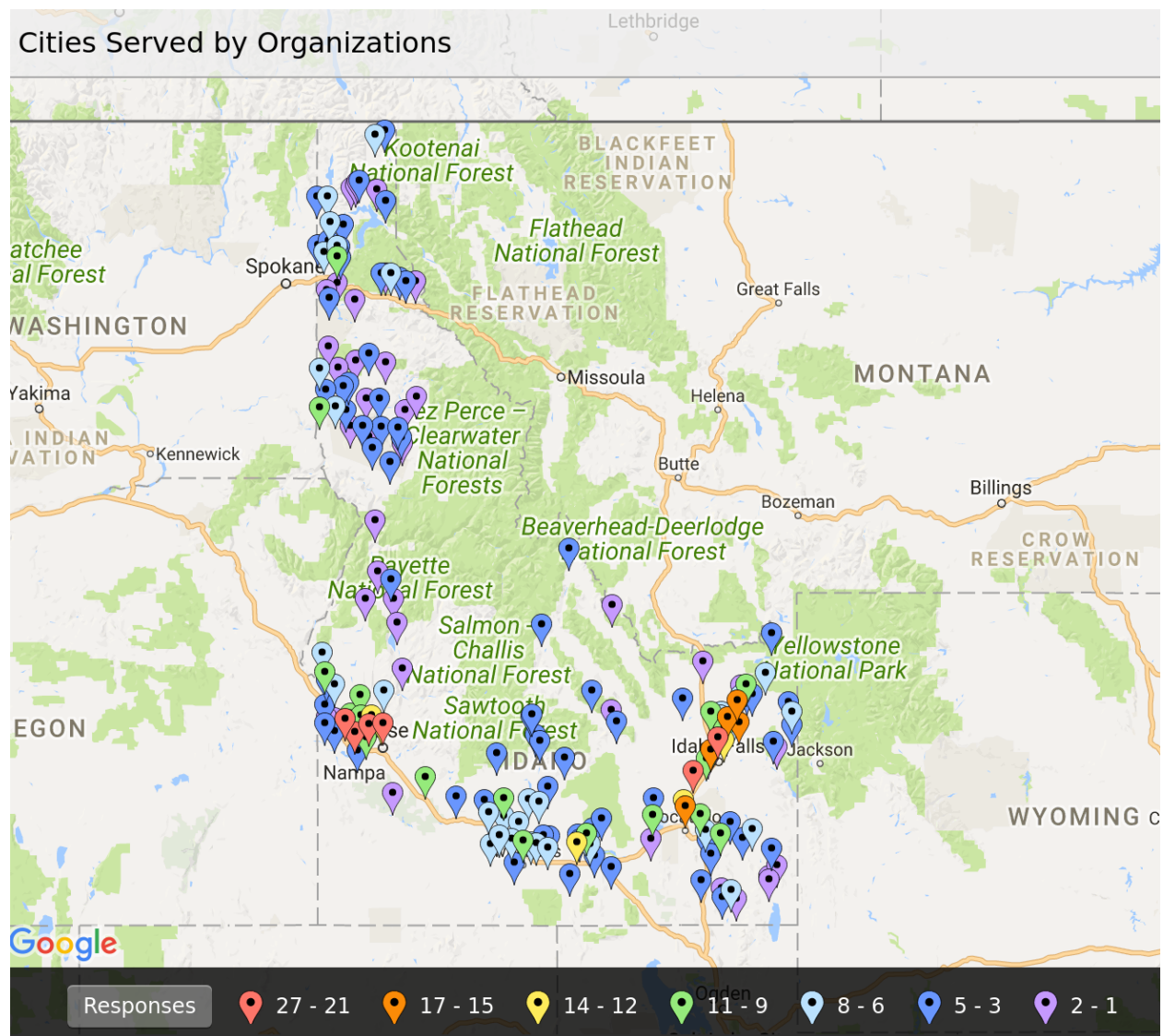


The map above shows the communities served by all responding providers. The key notes the number of providers in each city with a population over 100. The map offers considerable detail and may be found here <https://batchgeo.com/map/b2e0131e15aae0622d20e145f9d15f31>

### Organizations

120 respondents reported the cities their organizations serve. Most respondents serve communities in Regions 3, 4, 6 and 7.

Figure 11 Cities served by organizations



The map of the organizations serving each city is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/f52f39a6577153cae9620f452eb17982>

There are 187 communities in Idaho with populations of 100 or more. The respondents for organizations report that they provide no services to these nine communities with populations of 100 or more. It could be valuable to follow up with providers that have office locations in these communities to confirm services and availability:

**Table 1 Cities that are not served by organizations**

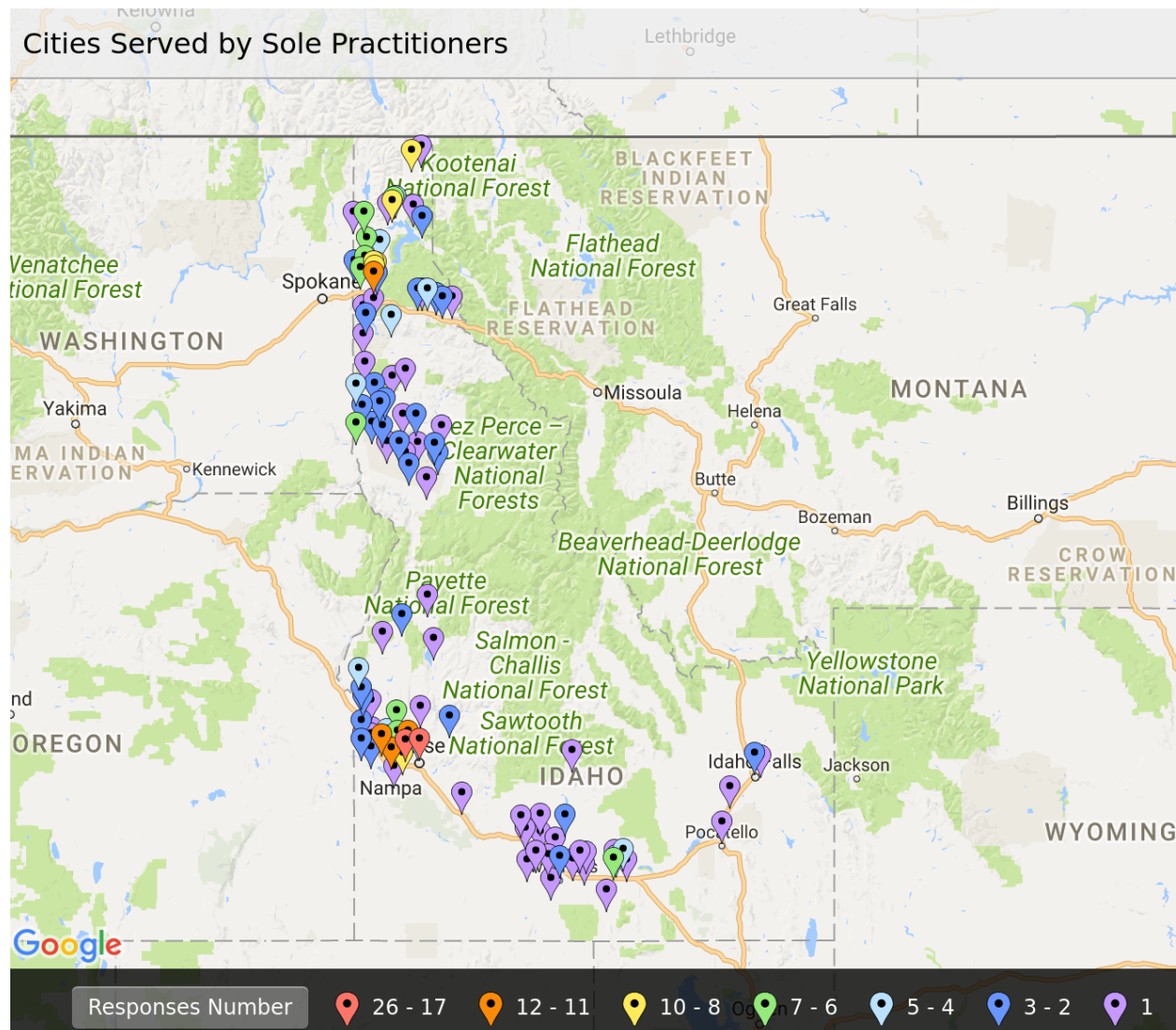
<b>City</b>	<b>2016 Est. population under 18</b>
Cambridge	41
Clifton	193
Dayton	219
Huetter	21
Midvale	36
Notus	188
Onaway	23
St. Charles	42
Tensed	21
Wardner	30



### Solo practitioners

Solo practitioners serve 108 of the 187 communities with populations over 100 around the state. Most solo practitioners serve communities in regions 1, 3 and 4.

Figure 12 Cities served by solo practitioners



The map of cities served by solo practitioners is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/4f2d045101ff9e8042ae5d8c07009703>

Some solo practitioner respondents serve communities that organizational respondents do not. Most notably, solo practitioners reported that they serve Cambridge, Notus, and Tensed.

### **All respondents: communities served**

Combining all organization and solo practitioner responses, all but six cities with populations of over 100 have some service (181 of 187 cities in Idaho). Cities with no services reported are:

**Figure 13 Cities not served by solo practitioners responding**

<b>City</b>	<b>2016 Est. population under 18</b>
Clifton	193
Huetter	21
Midvale	36
Onaway	23
St. Charles	42
Wardner	30

It could be valuable to follow up with providers that have office locations in these communities to confirm services and availability.

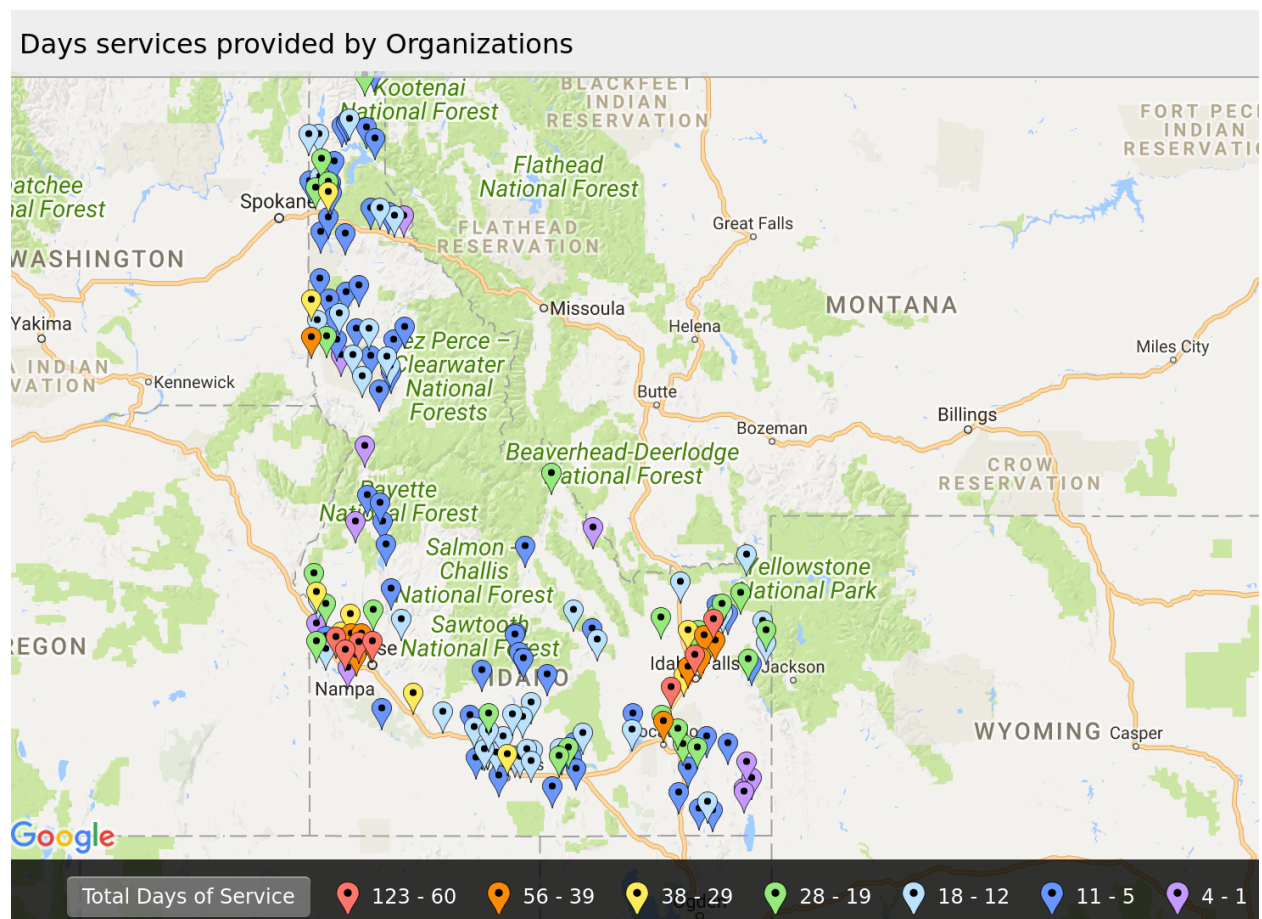
### **Days and times of service availability**

The researchers asked about the days and times of day that providers offered services in each community. Between organizations and solo practitioners, there are evening, overnight, and weekend gaps statewide.

### **Organizations**

One hundred respondents (80%) answered this question. Based on their responses, almost all communities with populations of over 100 have access to services from organizations Monday through Friday. Seventy-two of 187 communities (38.5%) have access to services from organizations on Saturdays. Sixty-five of 187 communities (34.7%) have access to services on Sundays.

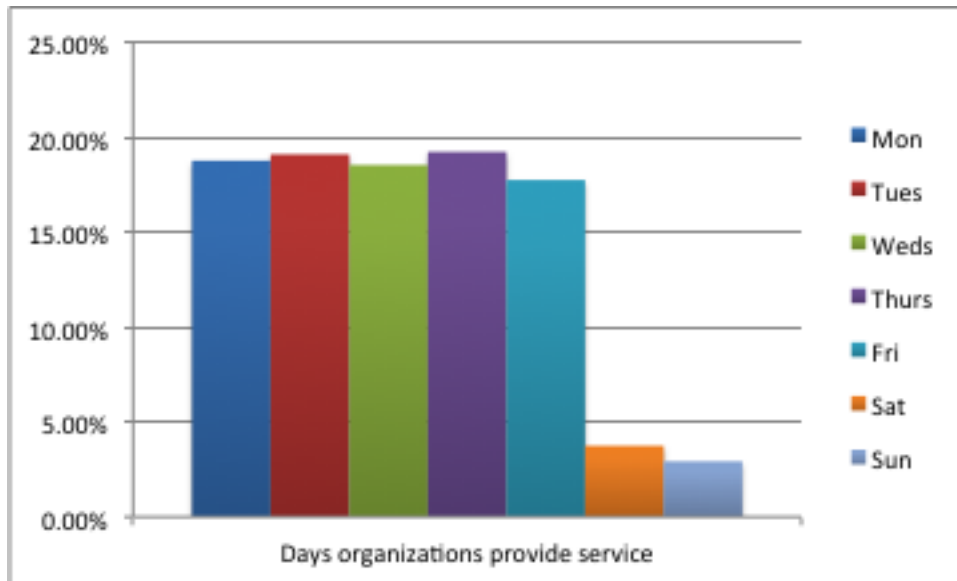
Figure 14 Number of days per week organizations provide services



The map above shows the total days of service available in each community, each week, reported by respondents. The map offers considerable detail and may be found here: <https://batchgeo.com/map/70438fedba0707943a9eb5d69f104abc>. Several population centers have the most days of service.

Overwhelmingly, organizations provide services Monday through Friday and service availability drops off on the weekends.

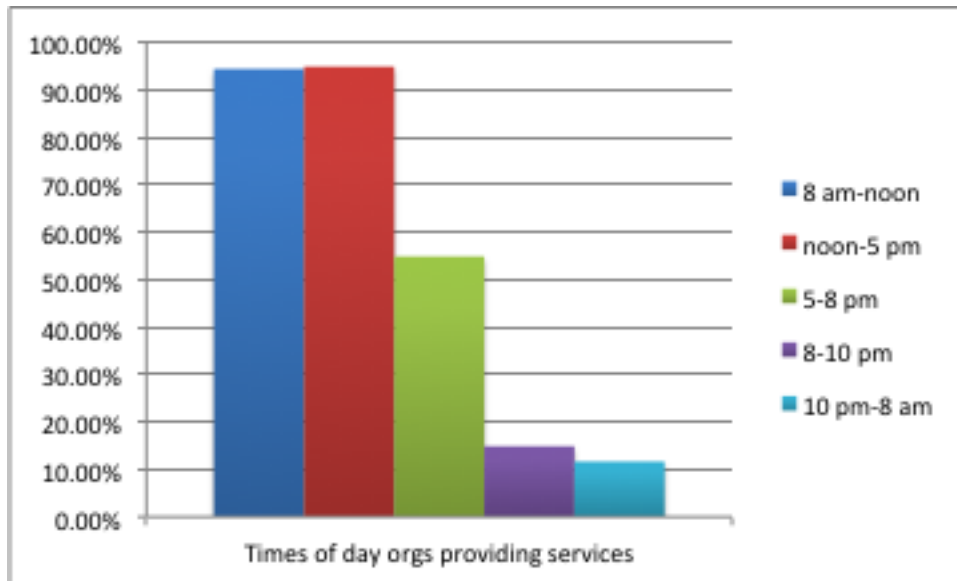
Figure 15 Days services are offered across communities by organizations





Overwhelmingly, respondents report that their organizations provide services on weekdays between 8 a.m. and 5 p.m.

Figure 16 Times of day that organizations offer services



Most respondents state that they offer services from 8 a.m. to 5 p.m., Monday-Friday, in all but 21 communities.

Respondents report that they provide services after 5 p.m. to 127 communities, and to 69 communities from 8 to 10 p.m.

Sixty communities have access to services from 10 p.m. to 8 a.m. One of the not-for-profit providers offers services from 10 p.m. to 8 a.m. in one community.

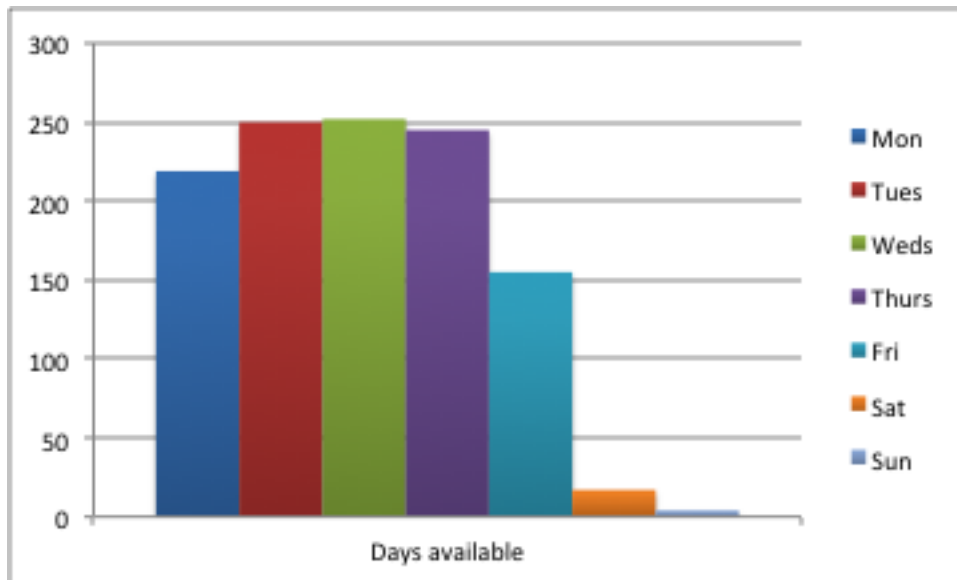
There was no response about services in 21 communities, although respondents had previously stated that they served seven of those communities.

### Solo practitioners

Sixty-four responded to this question, and five skipped the question. Providers are offering services to residents of more than one community in a day.

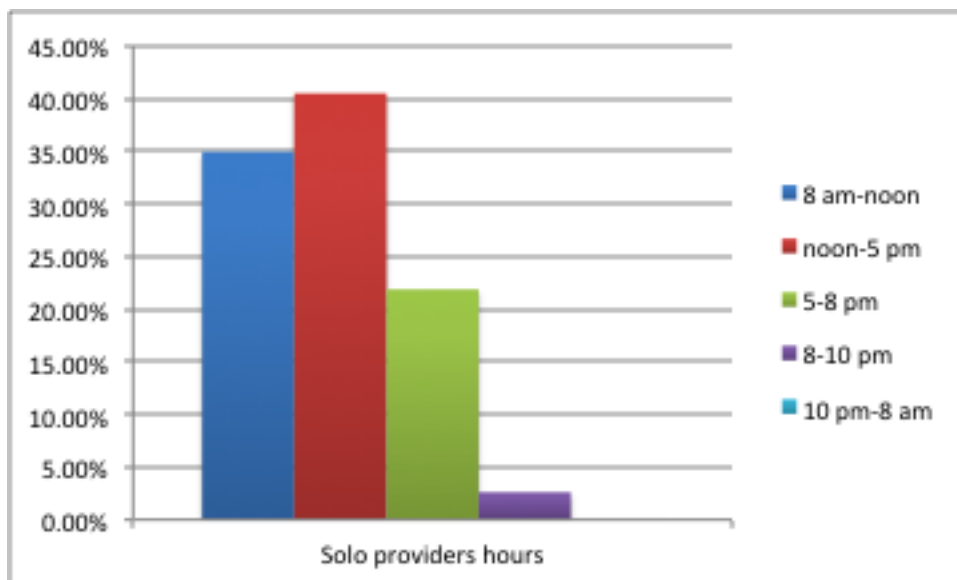
Respondents offer most days of service Monday through Thursday with a distinct drop on Fridays.

Figure 17 Days of service by solo practitioners



Respondents report that they serve most communities between noon and 5 p.m. (248 days of service by community). They serve fewer hours 8 and noon (214), and very few between 5 and 8 p.m. (134). Seventeen offer services between 8 p.m. and 10 p.m.

Figure 18 Hours that solo providers offer services



17 provide services on Saturdays in these communities:

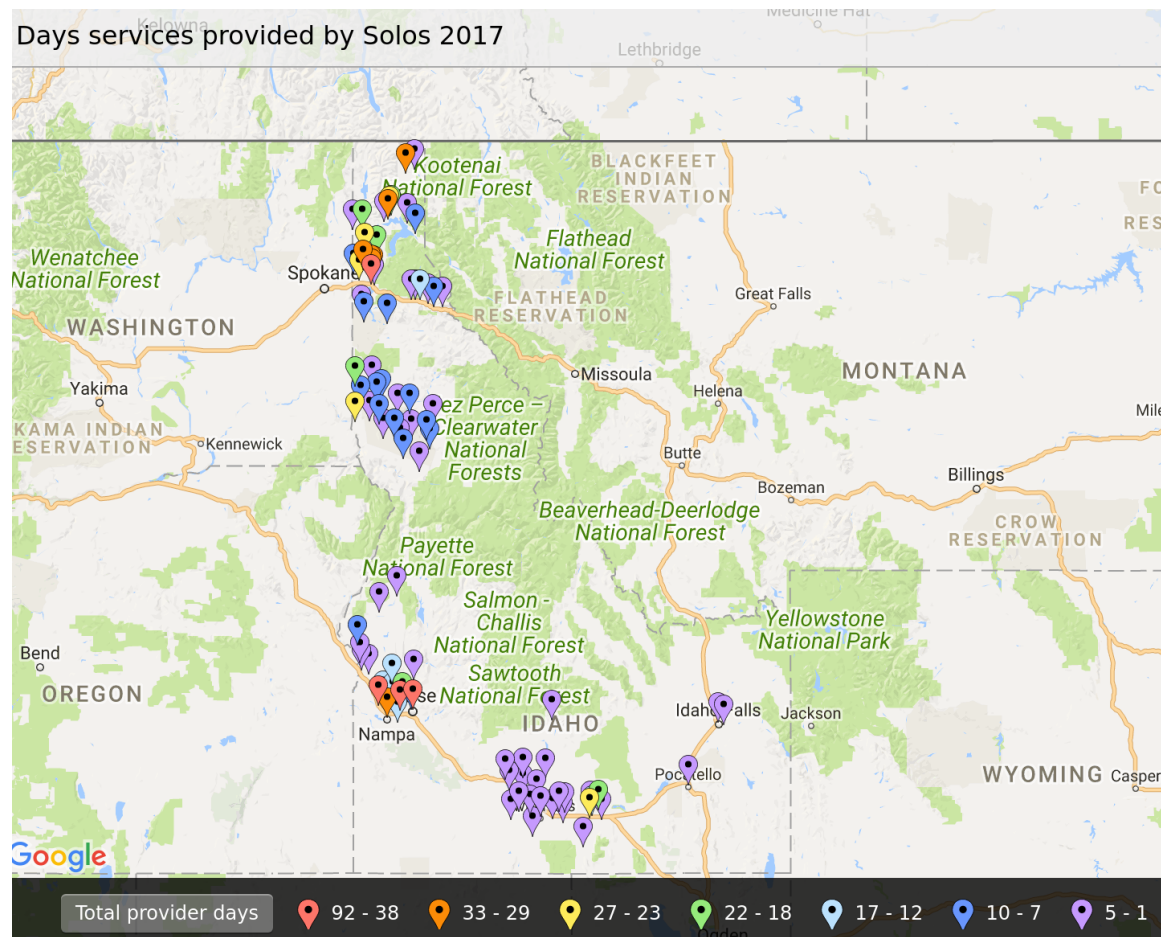
**Table 2 Cities served on Saturdays by solo practitioners**

City	Number of solo practitioners
Boise	4
Coeur d'Alene	2
Meridian	2
Caldwell	2
Emmett	2
Sandpoint	1
Eagle	1
Moscow	1

Three providers offer services on Sundays in Bonners Ferry, Coeur D'Alene.

When mapping the communities served and days of service, it is of particular note that the solo practitioners are disproportionately providing services in communities with small populations. See the map below for more detail.

**Figure 19 Number of days per week solo practitioners provide services**



The number of providers is indicated by the key below the map showing the colors of each peg and the number of responses. <https://batchgeo.com/map/878a4b6bd4e28a682427f8eb039b9077>

### Evidence-based practices

The survey asked respondents about the evidence-based services they provide to youth and their families, and provided links in the titles of the evidence-based practices to assist providers in responding.

Organizations and solo practitioners reported using more than one evidence-based practice in their services to youth and their families, and appear to use six or more evidence-based practices in their work.

### Organizations

Eighty-one of 125 (64.8%) respondents answered this question, and the follow-up of the number of children they serve with each evidence-based practice. Graphs below show the number of staff trained in each model and the approximate number of youth served using each model in 2017.

**Cognitive Behavioral Therapy (CBT)** is widely used. Seventy-nine of eighty-one respondents (97.5%) reported using the model, and reported that over 345 staff are trained in the model. Thirty-four respondents (34.97%) said that six or more staff are trained in CBT. It follows that this is the modality that was most widely delivered to the largest numbers of children and youth served in 2017.

**Trauma Focused Cognitive Behavioral Therapy** is the modality in which the second largest group of staff is trained and the model that is most likely to be used following CBT. Fifty-seven respondents (70.4%) stated that their staffs are trained in this model: over 198.

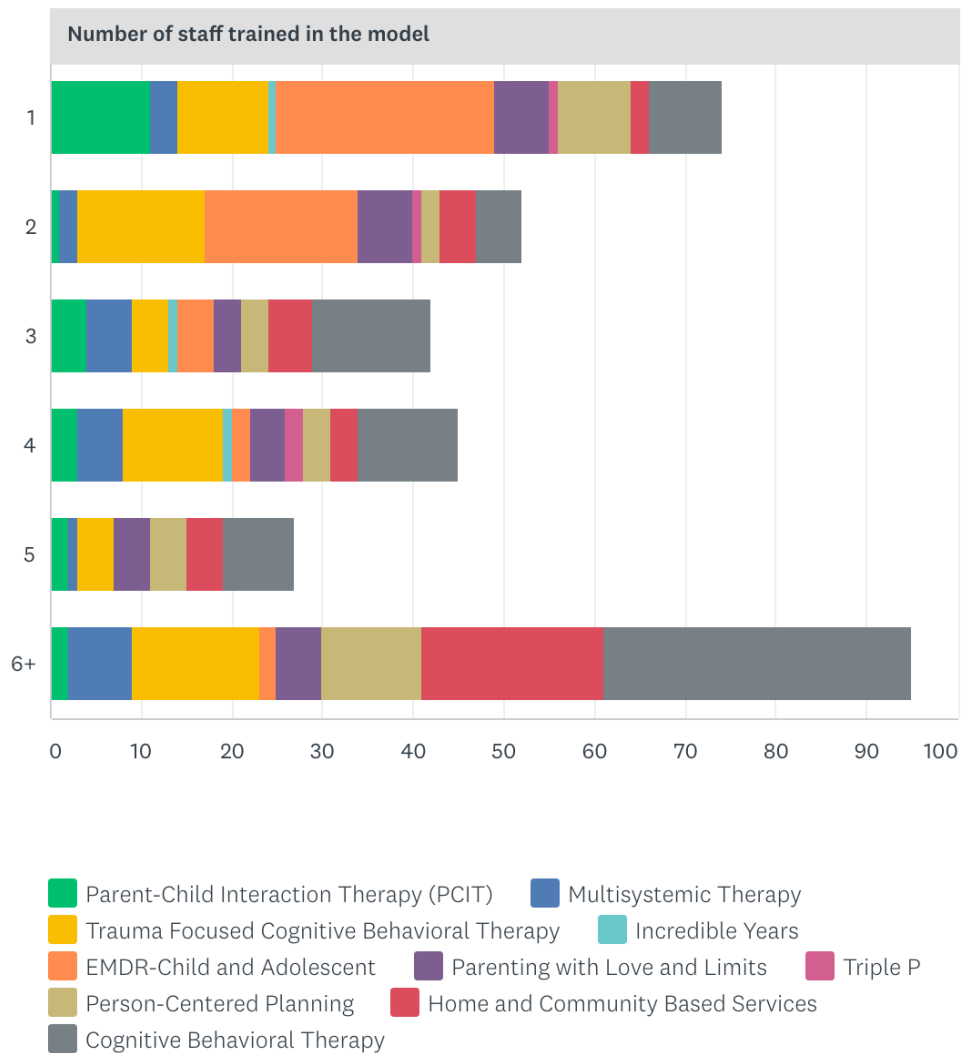
The modalities in which fewest staff are trained and least in use are Triple P and Incredible Years. The highest possible response for number of staff trained was 6+. Using 6 as the lowest possible answer by each respondent choosing the response, the minimum number of staff trained in each model among the 81 organizations is:

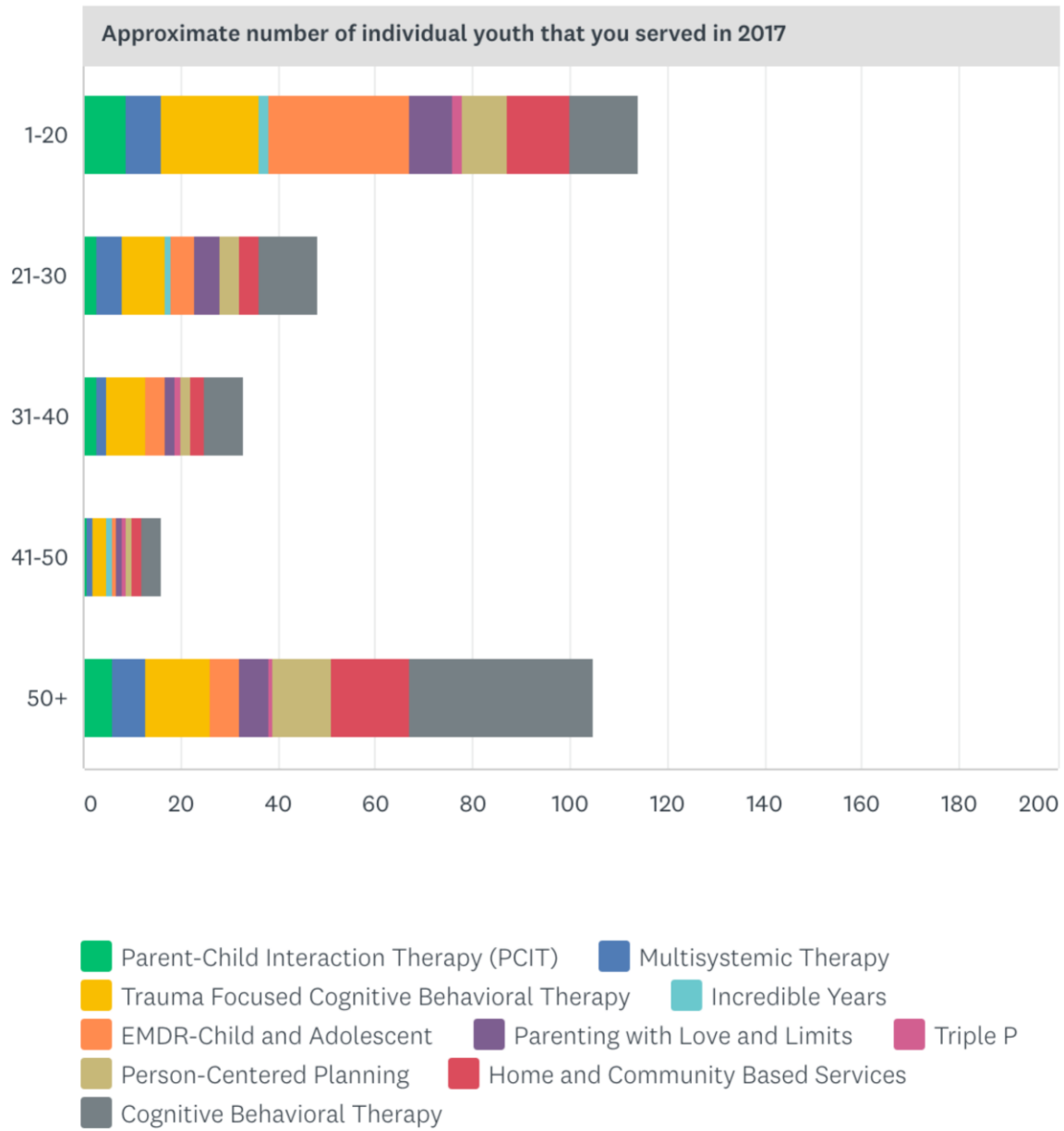
**Table 3 Evidence-based practices in which staffs are trained**

Model	# Of Staff trained
Cognitive Behavioral Therapy	345
Trauma-focused Cognitive Behavioral Therapy	198
Home and Community-Based Services	177
Person-Centered Planning	119
Eye Movement Desensitization and Reprocessing-Child and Adolescent	90
Parenting with Love and Limits	89
Multisystemic Therapy	84
Parent-Child Interaction Therapy	59
Positive Parenting Program	11
Incredible Years	8

The number of youth served using each model varies considerably. CBT is the most widely used modality. However, although trauma-focused CBT is the system in which the next highest number of staff is trained, the modality used for second-largest number of youth is home and community-based services followed by trauma-focused CBT and closely followed by person-centered planning.

Figure 20 Evidence-based practices delivered by organizations, and youth served by each



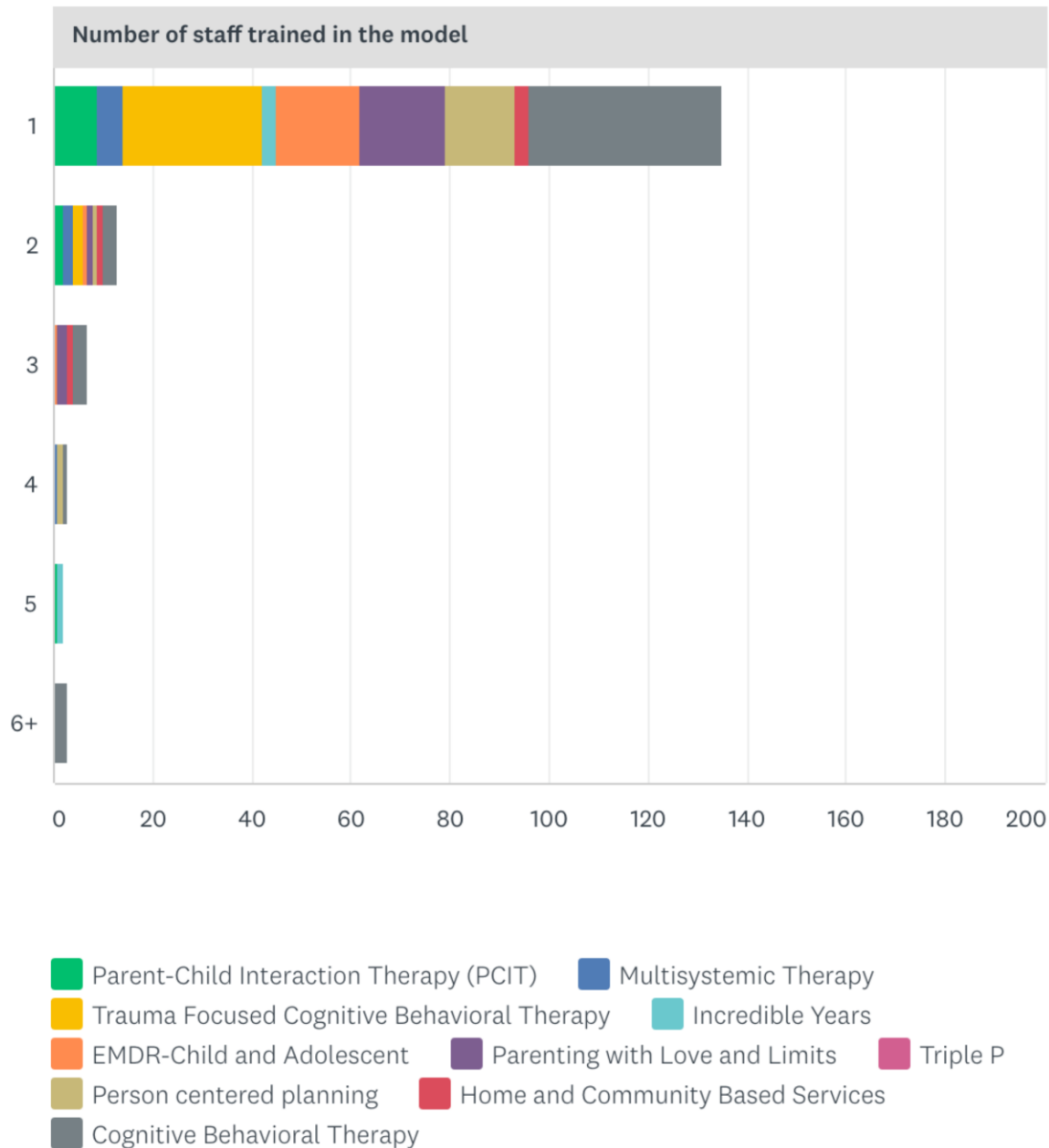


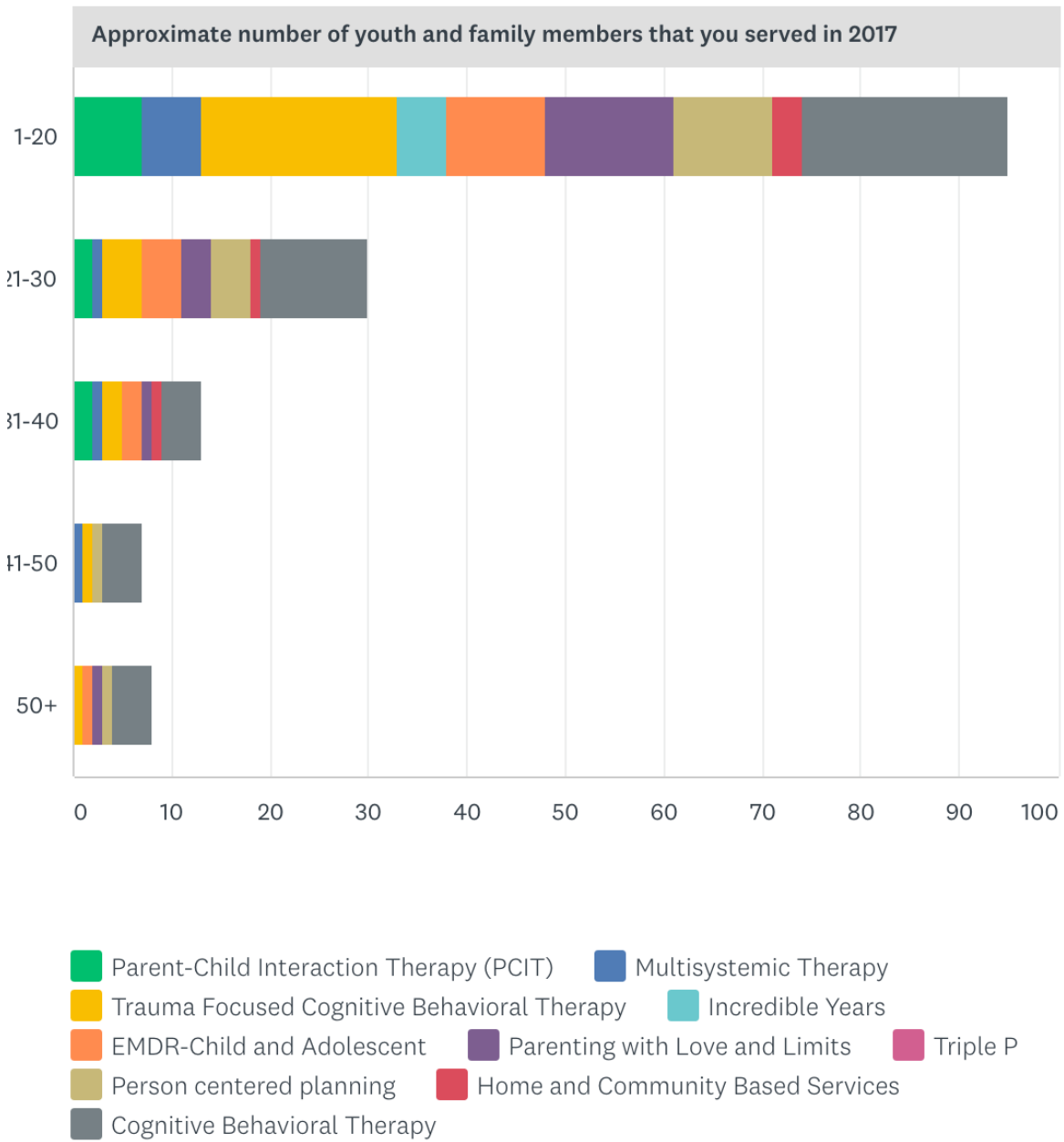
### *Solo practitioners*

Fifty-four respondents (78.26%) answered this question. The answers about the numbers of staff trained in each modality reveal that the solo practitioners are practicing in tandem with others: either in small groups or in growing small businesses. Ten respondents (18.5%) reported more than one person trained in Cognitive Behavioral Therapy, and three of those (5.5%) reported six or more trained in that model.

Overall, providers report that they serve 1 to 20 youth per year in each model. No solo practitioner reported using Triple P.

**Figure 21 Evidence-based practices used by solo practitioners, and youth served by each**







### *Matching evidence-based practices to client needs*

The researchers asked about the methods that providers use to identify the best match of evidence-based practice to clients' needs. One model, PracticeWise, was of particular interest to the state and was mentioned specifically.

#### *Organizations*

Seven use PracticeWise (8.6%), and 74 (91.36%) do not. Comments about other methods for matching practice to client needs follow:

- APA best practice guidelines
- Adherence to Optum practice standards
- PHQ-9 for children
- GAD
- ACE (short form)
- DSM 5
- Pediatric Symptom checklist
- Wender
- In process of integrating CANS
- Client centered, match the client to the therapist modalities.
- Clinical judgment
- Clinical supervision
- Professional assessment and utilization
- The counselors use the training they received to pick.

#### *Solo practitioners*

Five of 61 respondents (8.1%) use PracticeWise.

Others state:

- Diagnostic Assessment
- I tailor my approach to each individual as trained
- I have just joined Practice wise, I use websites and Nat Mental Health websites, SAMHSA, NIMH
- Our EHR assessment tool
- I am not aware of PracticeWise-I use Optum's Best Practices/Evidence-Based Practices
- I use APT Best Practices and Evidence-Based Practices.

## Telehealth

### Organizations

104 respondents (832%) answered this question on behalf of their agencies. Of these, 79 (76%) state that they do not provide services via telehealth. This may be an opportunity for organizations to provide future services to underserved populations and in underserved areas.

The organizations that report using telehealth methods offer individual counseling (15, or 14.4%) and medication management (13, or 12.5%).

Seven (6.7%) use telehealth methods to provide crisis services or crisis management.

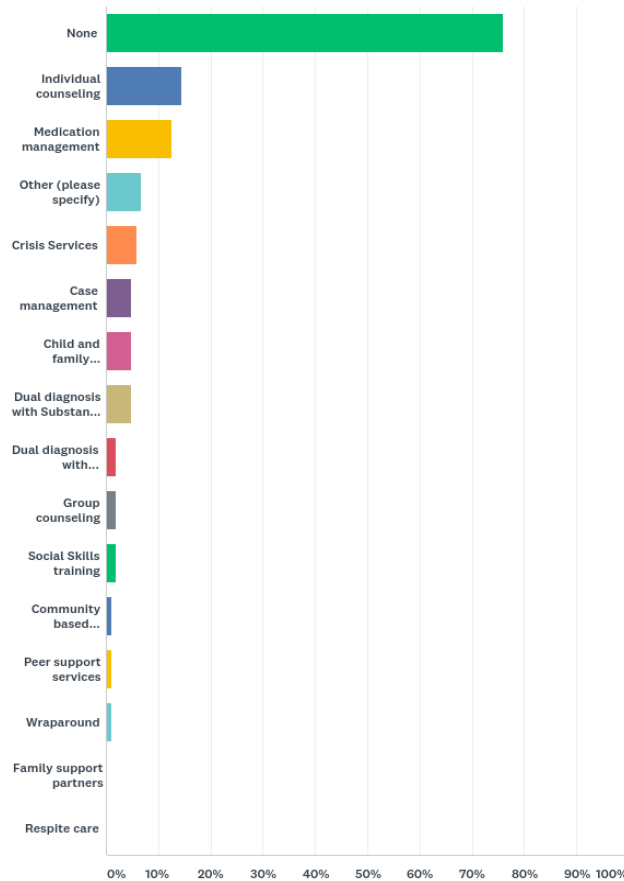
Five (4.8%) use telehealth for case management, child and family counseling, or dual diagnosis with substance abuse services. One each uses telehealth for dual diagnosis with intellectual disabilities, group counseling, social skills training, community based \* services, peer support services or wraparound services.

Three (2.88%) organizations report that they are interested or moving towards providing services via telehealth.

One reports that while it is needed, Medicaid does not cover this service. In fact, Idaho Medicaid does cover a series of services provided via telehealth, including behavioral health; case management and crisis intervention <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/TelehealthCodes%20.pdf>. This is discussed further in Telehealth.

Figure 22 Services that organizations offer by telehealth

Q11 What services does your organization offer to youth and their families via telehealth?

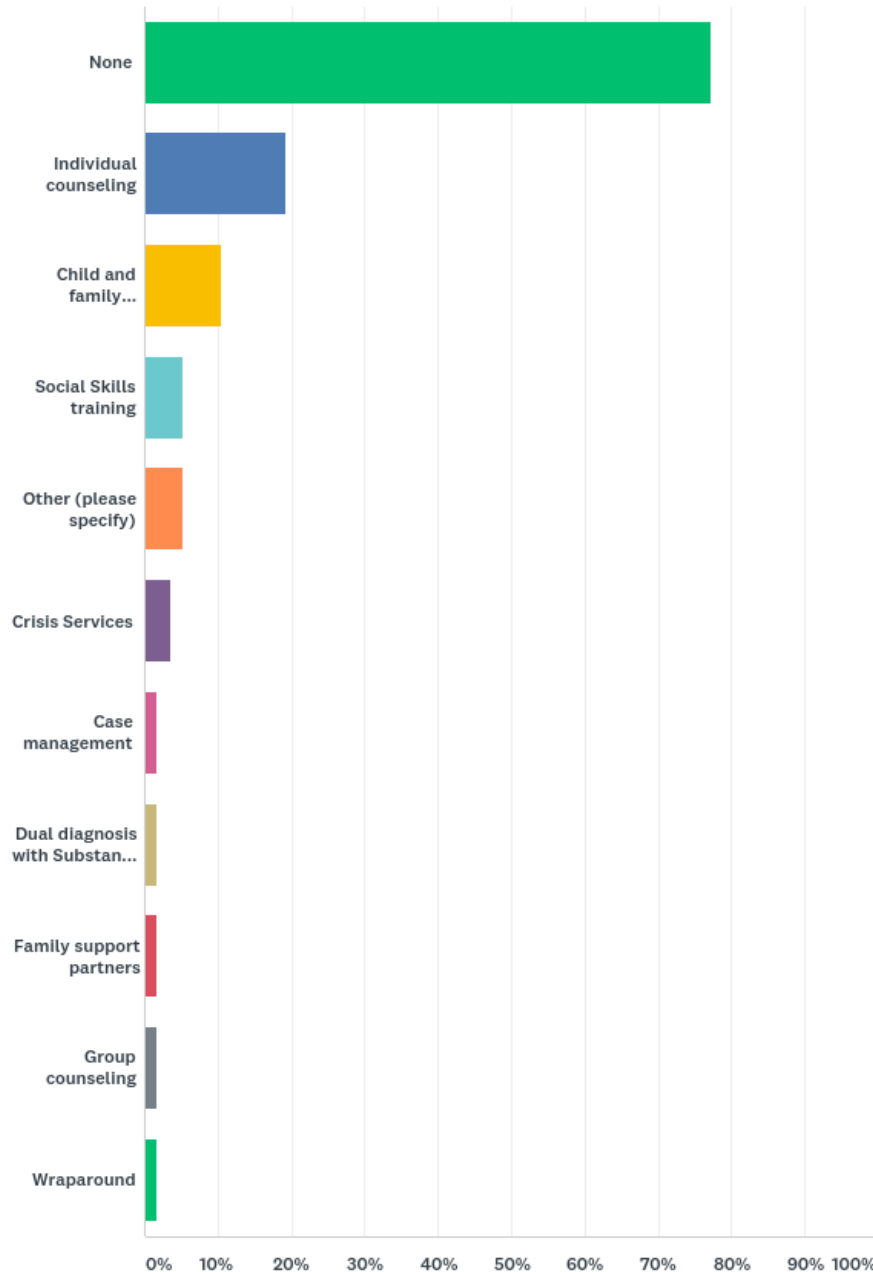


### Solo practitioners

Fifty-seven providers (82.6%) responded to this question. Forty-four (77%) do not use telehealth.

Figure 23 Services that solo practitioners offer by telehealth

## Q9 What services do you offer to youth and their families via telehealth?



Eleven (19.3%) provide individual counseling and six (10.5%) provide family counseling. Although no provider claimed to provide crisis services in another question, two answered that they provide crisis services by telehealth to this question. Of note are these comments, for respondents who checked “other”:

- Consult with parents
- Cannot provide any of these mid-level practitioners cannot engage and get paid for Telehealth, especially with Medicaid
- Optum told me I cannot do this

## Prescribing Professionals

### Organizations

The researchers asked if a prescribing professional worked with the organizations, under contract or as employees. The prescribing professionals were identified as physician, nurse practitioner, and physician assistant. Seventy-two organizations responded of 125 (57.6%). The majority (35%) does not work with a prescriber either under contract or as an employee.

Thirty-eight prescribers work under contract as the only prescriber to an organization, and 21 work as employees as the only prescribers in an organization.

Seven organizations report having six or more prescribers work as employees, and five work with six or more under contract.

The respondents that answered 0 stated that they work with no prescribers of that type. The responses that answered 1 or more stated which type of prescribers with whom they work, and the number of each.

Figure 24 Organizations working with prescribing healthcare professionals under contract

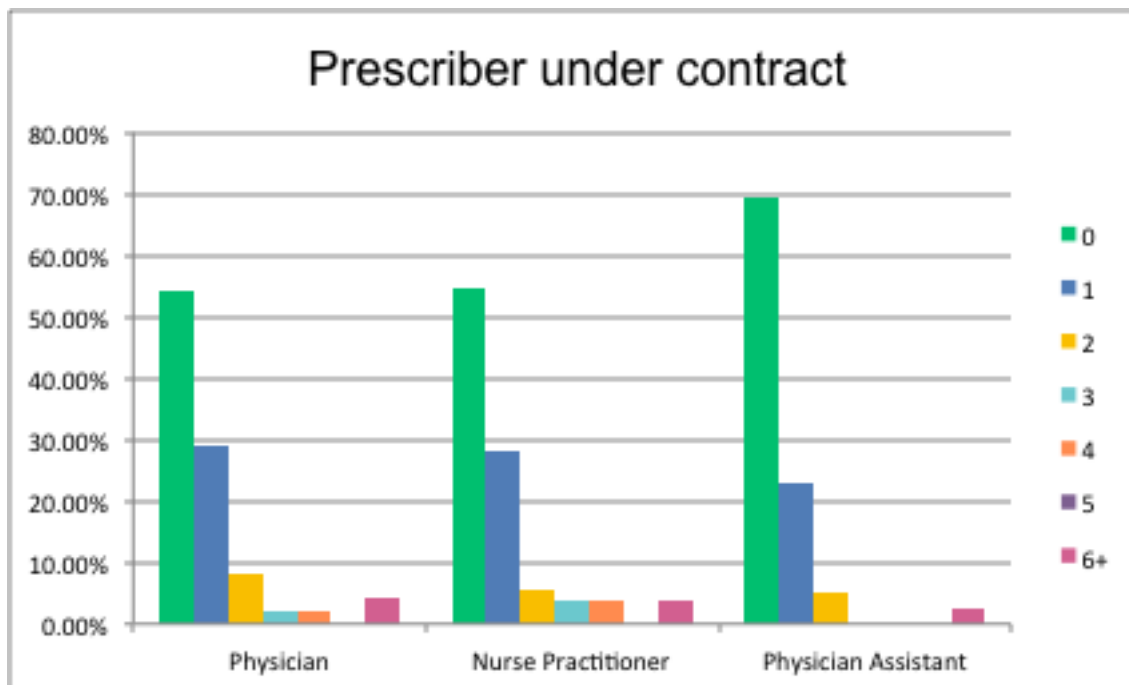
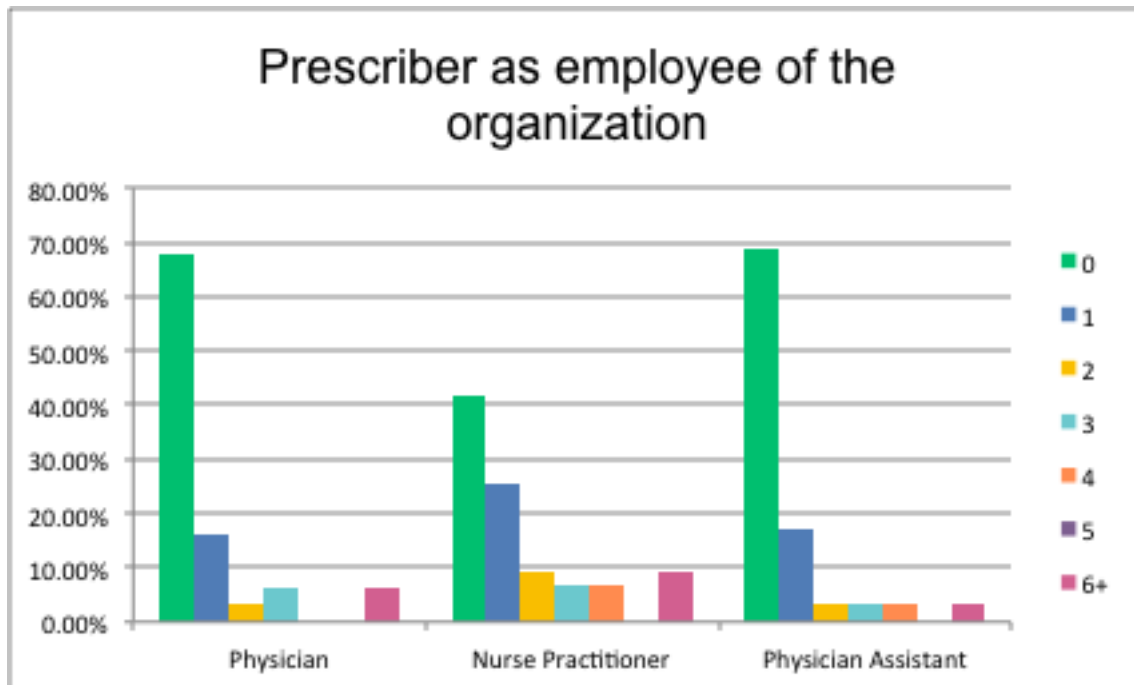
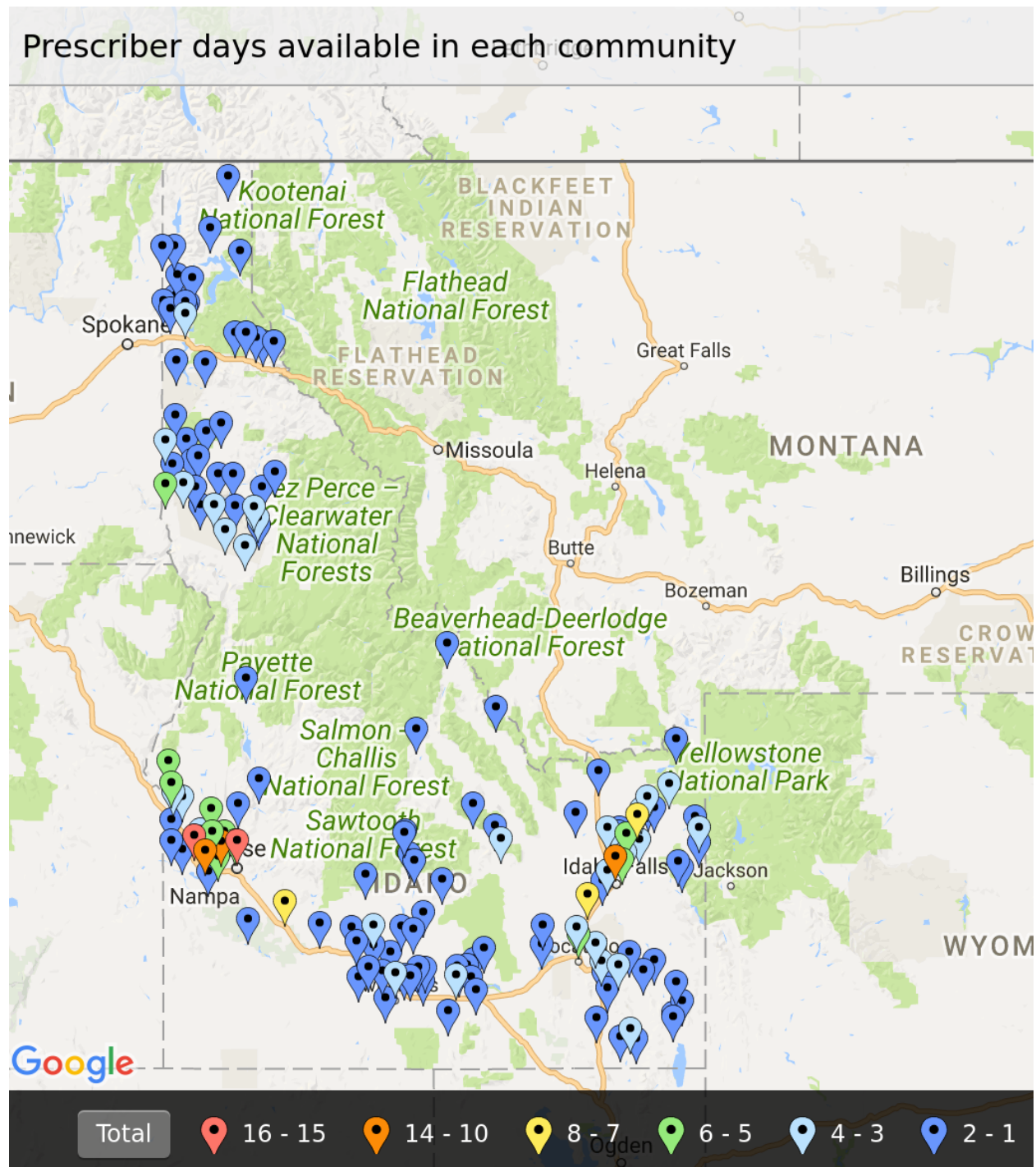


Figure 25 Organizations working with prescribing healthcare professionals as employees



Prescriber availability is limited for most communities. That said, 85 communities (45%) have 16 or more days of prescriber services available each month. The map below shows the availability of prescribers by community.

Figure 26 Days available by organization prescribing professionals



Each pin represents the number of days that prescribers are available in each community per month. Note that most have 1-2 days available each month. The map offers considerable detail and may be found here: <https://batchgeo.com/map/4cd7c475c81ad07cf14c798880877cf4>. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses.



All prescribers work Monday through Friday, and some work one day each week in different communities. One respondent indicates that the organization's prescriber works on Sundays, and two indicated that a prescriber works on Saturdays.

Where prescribers are available, they all work between 8 a.m. and 5 p.m. Prescribers are available between 5 and 8 p.m. in 36 communities, and between 8 and 10 p.m. in 13 communities. No prescribers are available between 10 p.m. and 8 a.m. in any community.

### *Solo practitioners*

Almost no solo practitioners report work with a prescribing professional. Those that do so work with larger practices. Three work with one Advance Practice Registered Nurse (APRN); another works with two; and another works with six. One works with two physicians.

## Services by community and region

The researchers asked about specific services available to children and youth and their families in the communities that respondents said they served. The services identified in the survey were:

- Individual counseling
- Child and family counseling
- Group counseling
- Crisis services
- Case management services
- Community-based rehabilitation services
- Wraparound services
- Medication management
- Respite care
- Social skills training
- Cognitive Behavioral Therapy

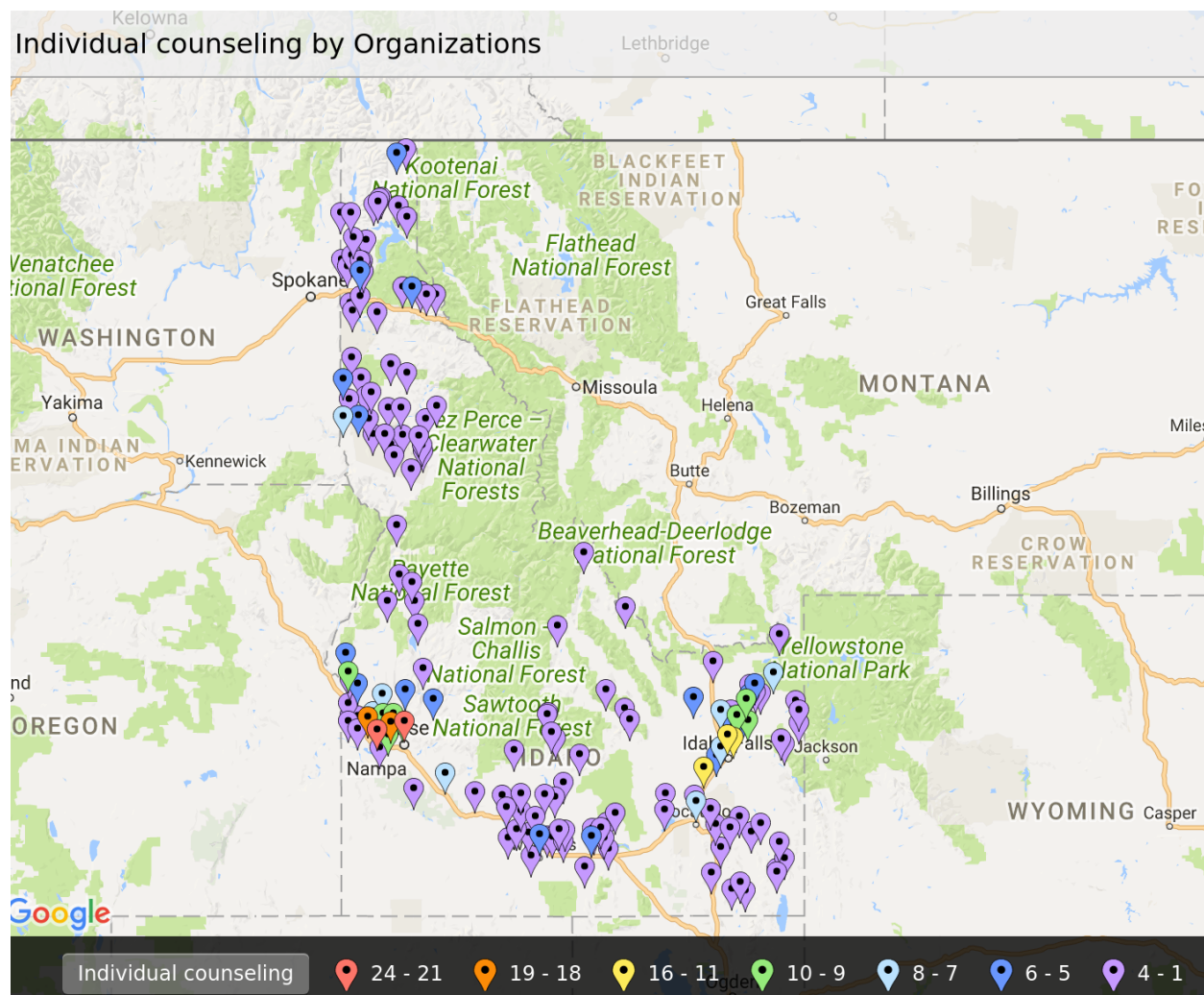
102 organizations (81.6%) and 64 solo providers (92.7%) responded about the location of services they provide. Each service is described below by the number of respondents representing organizations and solo practitioners delivering the service in each community identified by the respondents. Responses are mapped by community, coded by the number of providers in each community delivering each service. The responses on Cognitive Behavioral Therapy are discussed under Evidence-Based Practices.

## Individual Counseling

### Organizations

Individual counseling is the service most frequently offered by organizations. It is widely available in most communities of populations over 100. The communities with the highest density of services are Boise (24, 23.5%), Nampa (21, 20.58%), Caldwell (19, 18.6%), and Meridian (18, 17.6%), followed by Idaho Falls (16, 15.68%) and Blackfoot (11, 10.8%).

**Figure 27 Individual counseling provided by organizations**



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/ae63c7f1e70ed0b545a20c482a79351b>

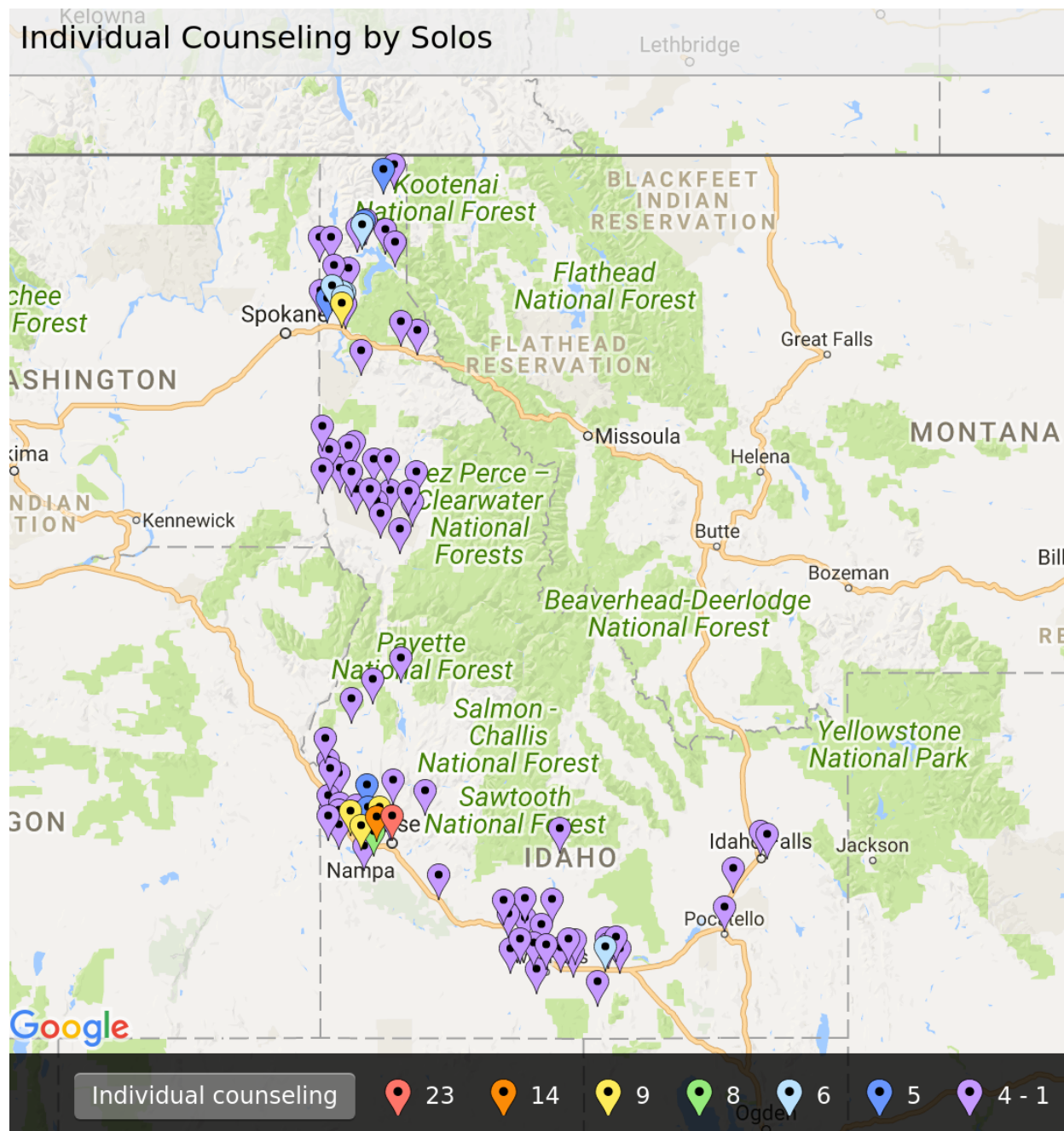
### Solo providers

Respondents provide services in 94 communities (50%). One respondent each provides services in 45 communities; two each provide services in 19. Most provide services in Boise (23, 35.9%) and Meridian (14, 21.87%).

The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/6f080b1ebd9de5b48bf965bd5335e7db>

Figure 28 Individual counseling provided by solo practitioners



## Child and Family Counseling

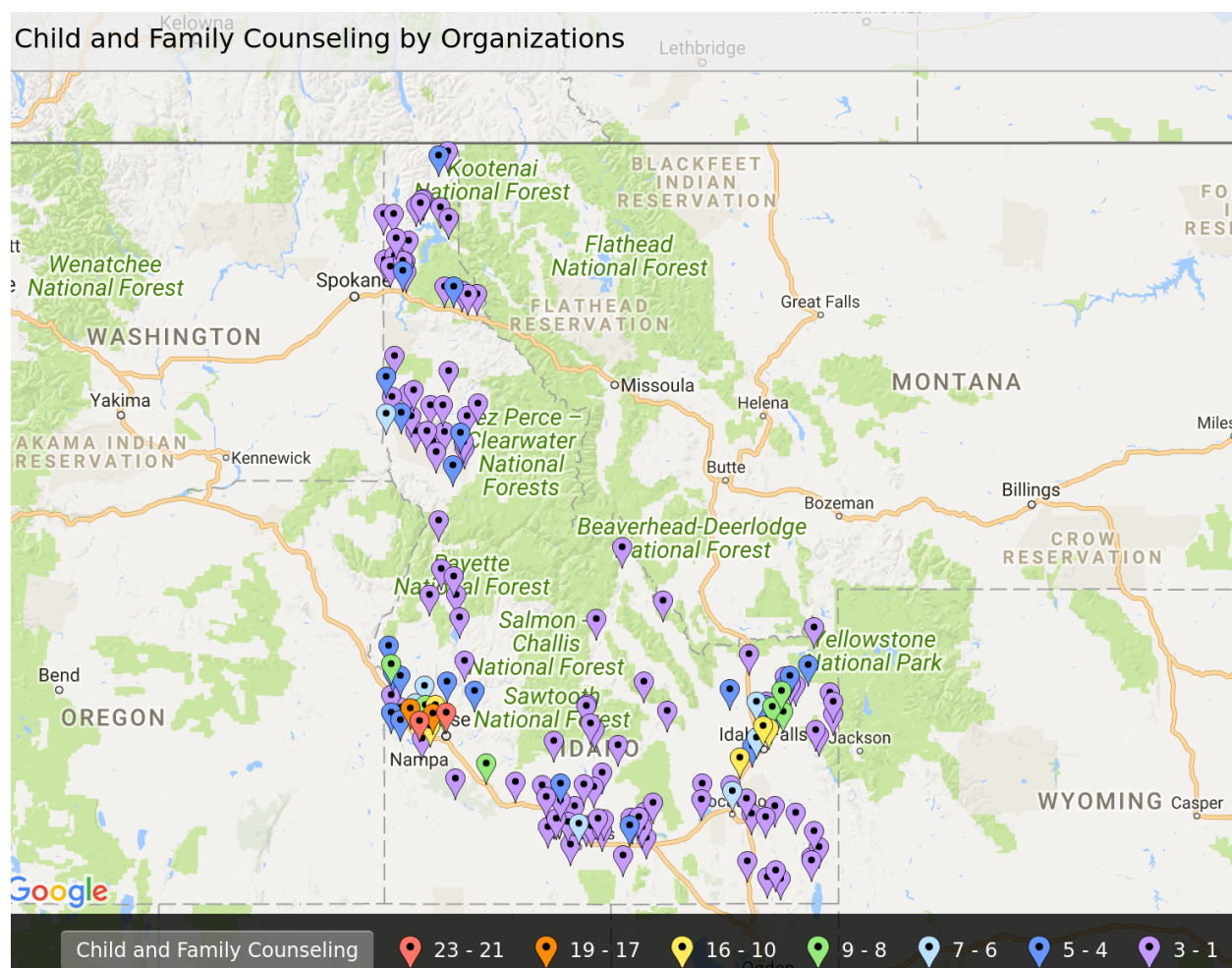
### Organizations

Most providers provide child and family counseling in Boise, (23, 22.5%) Nampa (21, 20.58%), Caldwell (19, 18.6%), Meridian (17, 16.67%) and Idaho Falls (16, 15.68%).

The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/7804275e2538d823911428beb38c0433>

Figure 29 Child and family counseling provided by organizations

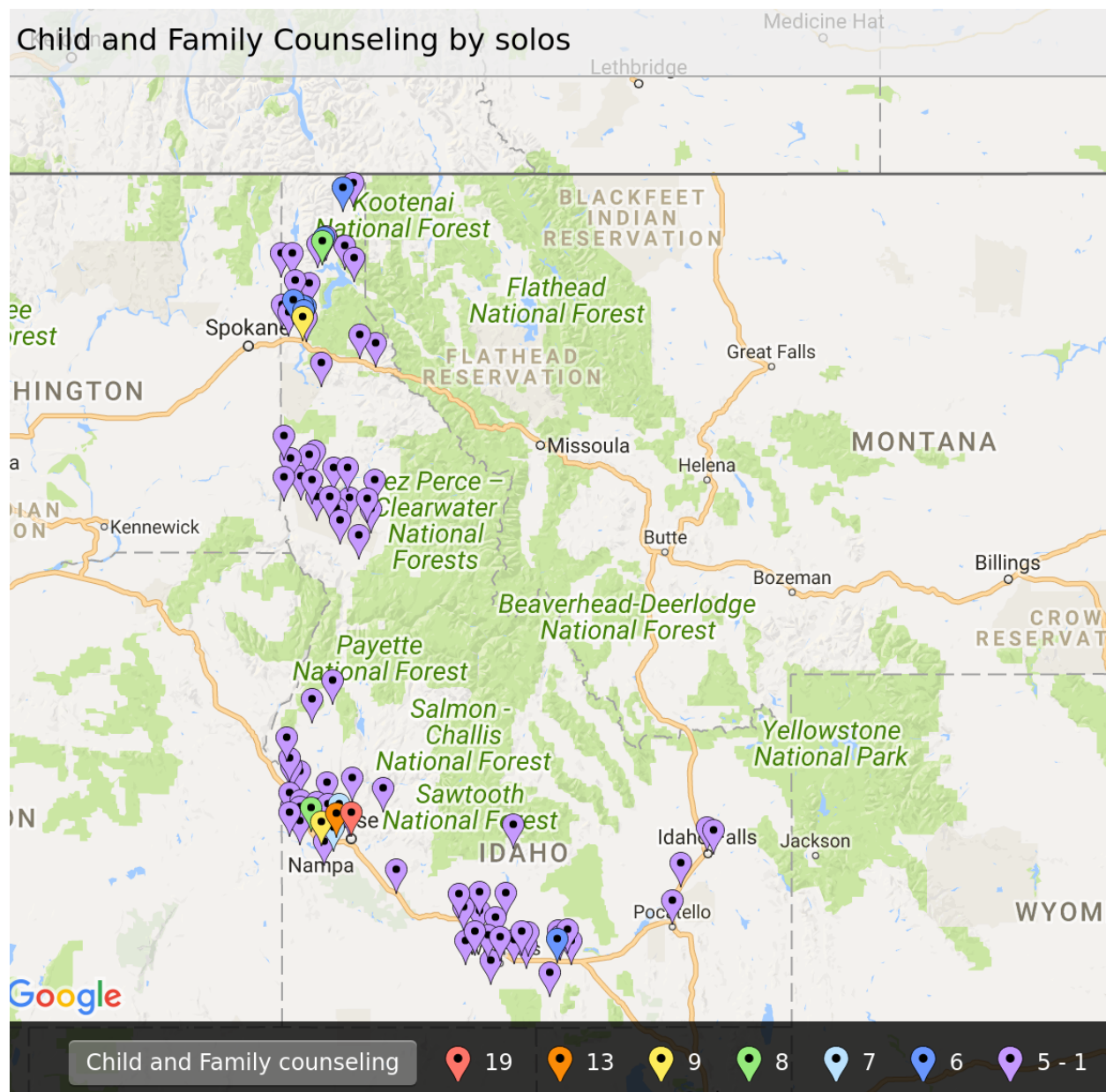




### Solo practitioners

Respondents report that solo practitioners provide child and family counseling to 93 of 187 communities (49.7%). These are clustered in Boise (19, 29.6%) and Meridian (13, 25%), Nampa (9, 14%), Coeur D'Alene (9, 14%), Caldwell (9, 14%), Sandpoint (8, 12.5%), Eagle (7, 10.9%), and Kuna (7, 10.9%).

Figure 30 Child and family counseling provided by solo practitioners



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/d732265b05f392094e7787aab0a102f1>.

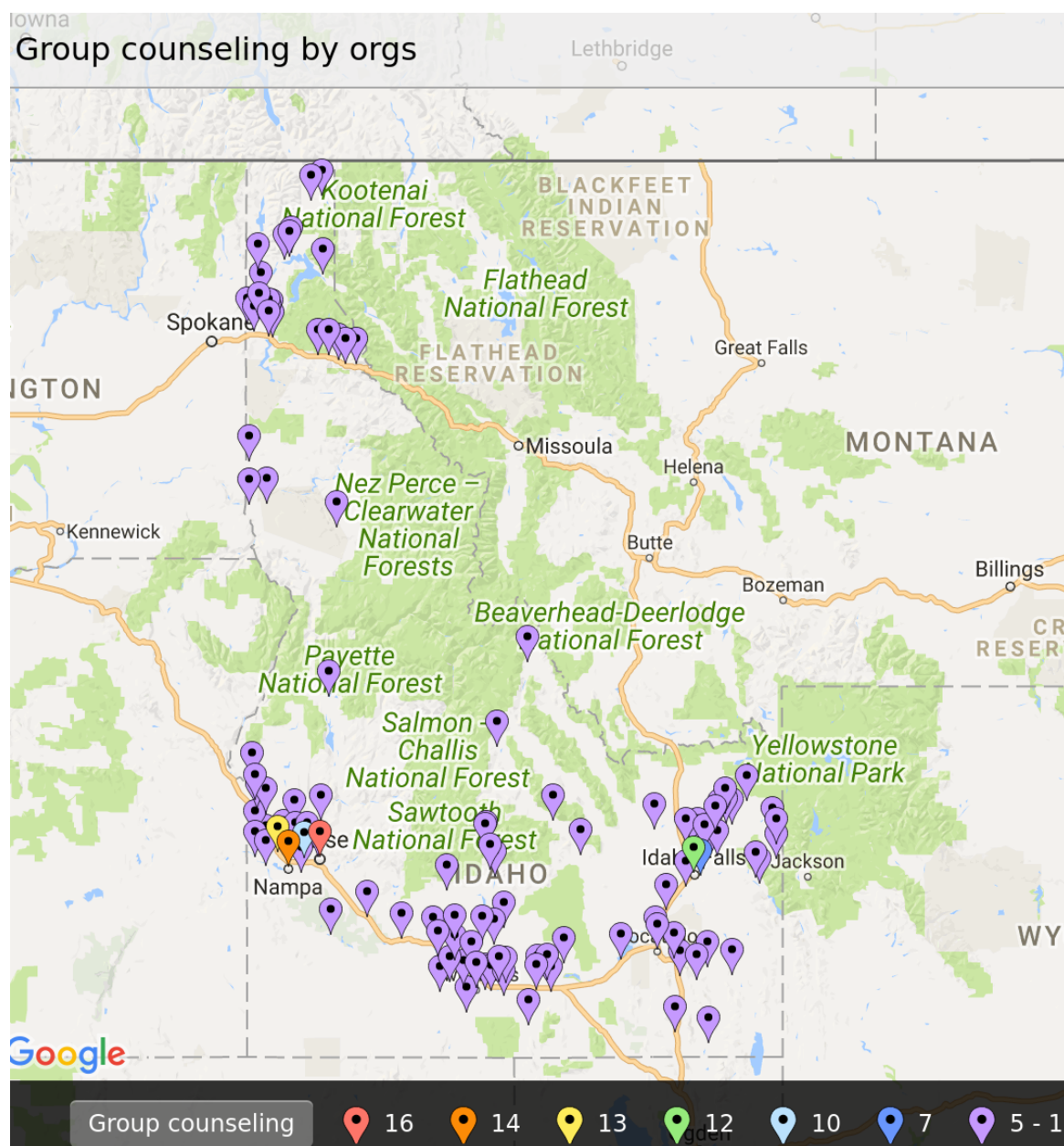
## Group Counseling

### Organizations

Seventy-five, or 63.3%, of organizations offer group counseling. Group Counseling is offered by the largest number of organizations in Boise and Nampa, followed by Caldwell and Idaho Falls areas. The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/53abb353c879740677fbb574485227f0>

Figure 31 Group counseling provided by organizations

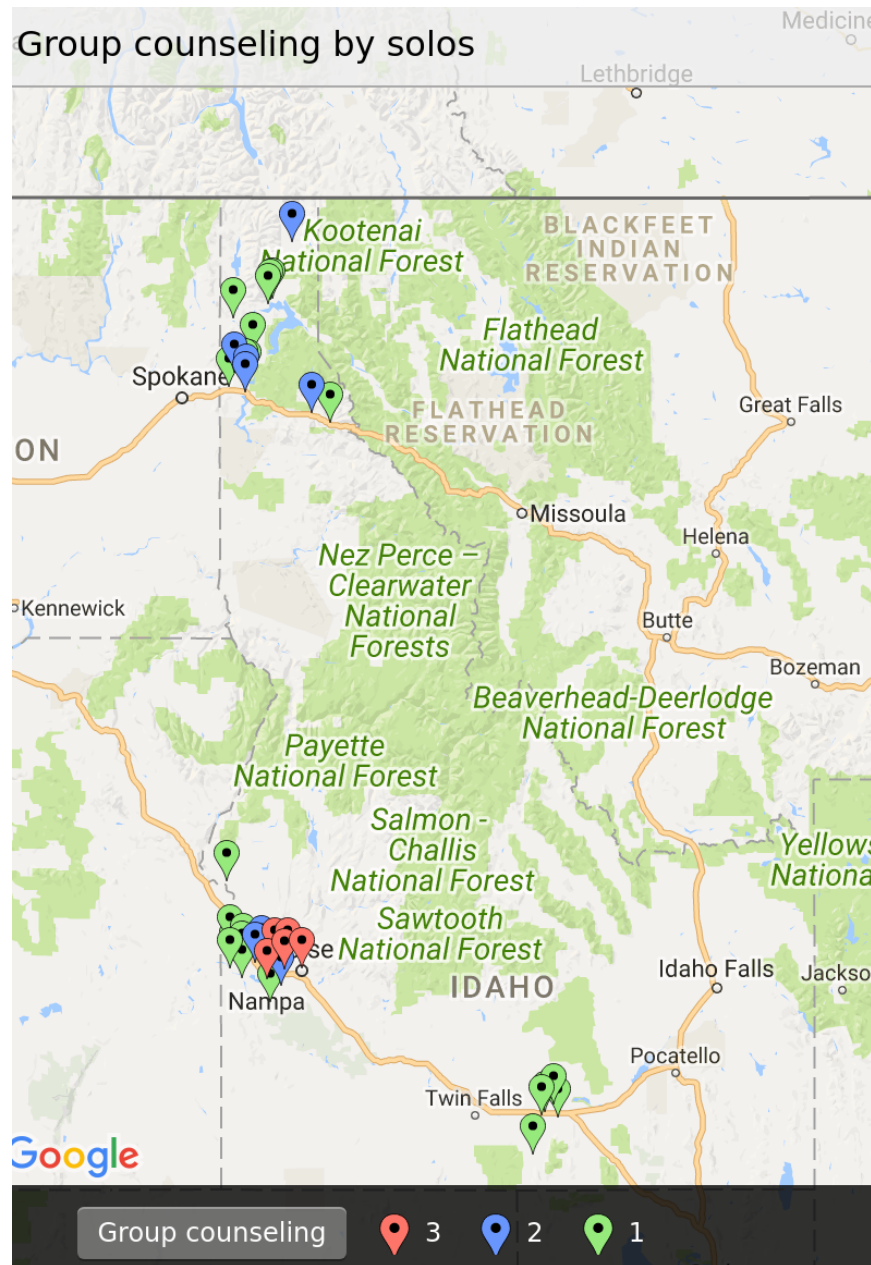


### Solo practitioners

Few solo practitioners (9, 13.43%) reported offering group counseling. Those services are clustered in Regions 3 and 4: Boise, Meridian, Eagle, Star, Nampa, Caldwell (3 each) followed by the Coeur D'Alene area. The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/a8f80de5199efe6fb141e03aa714a56c>

Figure 32 Group counseling provided by solo practitioners





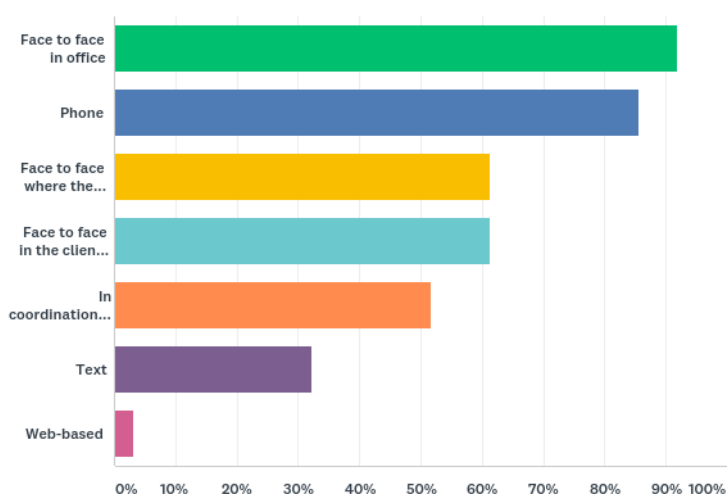
## Crisis services

### Organizations

Sixty-two organization respondents (49.6%) stated that they provide crisis services to 152 communities (81.28% of 187 communities). These services are largely offered face-to-face, either in the office, where the client is, or in the client's home. Phone-delivered crisis services are second to office-based services. Twenty respondents (32.25%) state that they provide services via text, and two (3.2%) provide services that are web-based.

**Figure 33 Crisis services and modalities provided by organizations**

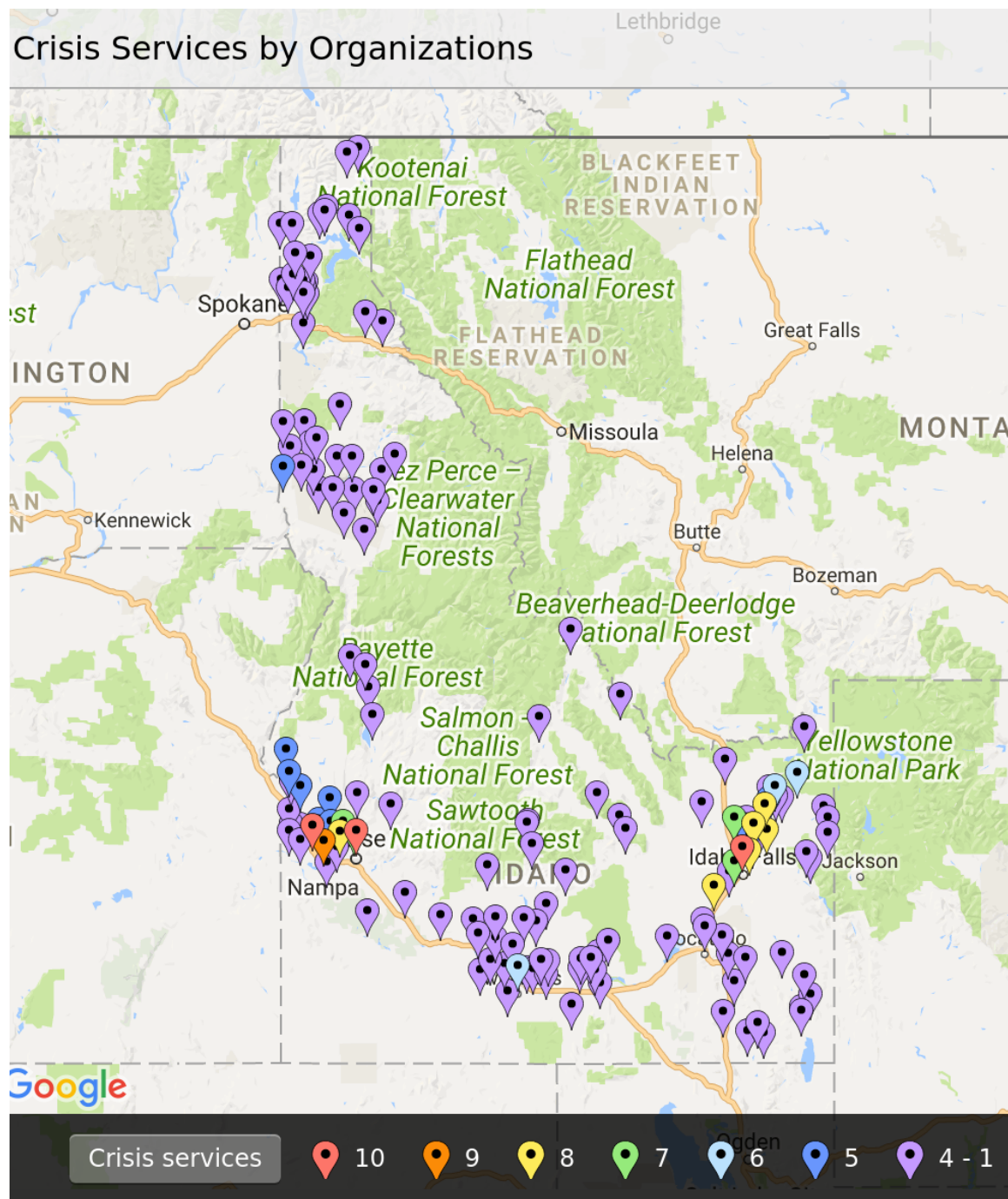
**Q16 You noted that your organization provides crisis services. How and where does your organization provide crisis services to youth and their families?**



Ten respondents (16%) report that their organizations provide crisis services in Boise, Idaho Falls, and Caldwell. These are followed closely by Nampa (9), Meridian (8), Ammon (8), Rigby (8), Rexburg (8), Ririe (8), and Blackfoot (8).

Thirty-six communities of 187 communities (19.25%) with populations of 100 or more have no access to crisis services from respondents. Fifty-two communities (27.8%) have access to crisis services provided by one provider.

Figure 34 Crisis services provided by organizations



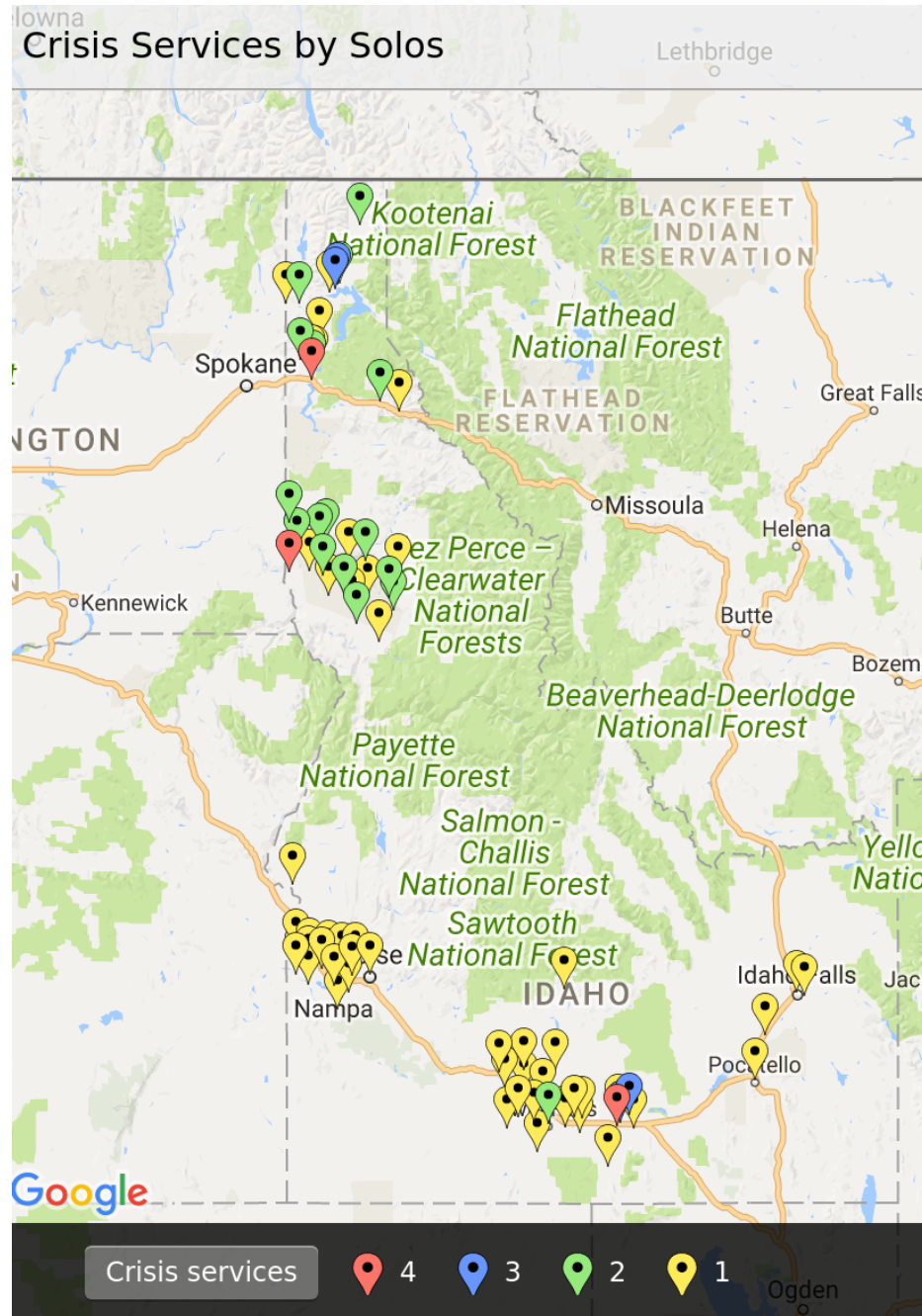
The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/2147ff16e2fbfa660d0e7cc8bca51818>

### Solo practitioners

Solo practitioners state that they offer crisis services in a 75 communities (40.1%, but none responded about the ways they provide services: face-to-face, on the phone, web-based, or text.

Figure 35 Crisis services provided by solo practitioners



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/75b86cf5f2d096cd8240b8a0b11e3b06>

## Case management services

### Organizations

Most organizations reported that they provide case management services in Boise (18, 17.6%), Meridian (14, 13.7%), Nampa, (13, 12.7%), Caldwell, (13, 12.7%), Idaho Falls, (13, 12.7%), Blackfoot (11, 10.7%) and Eagle (10, 9.8%).

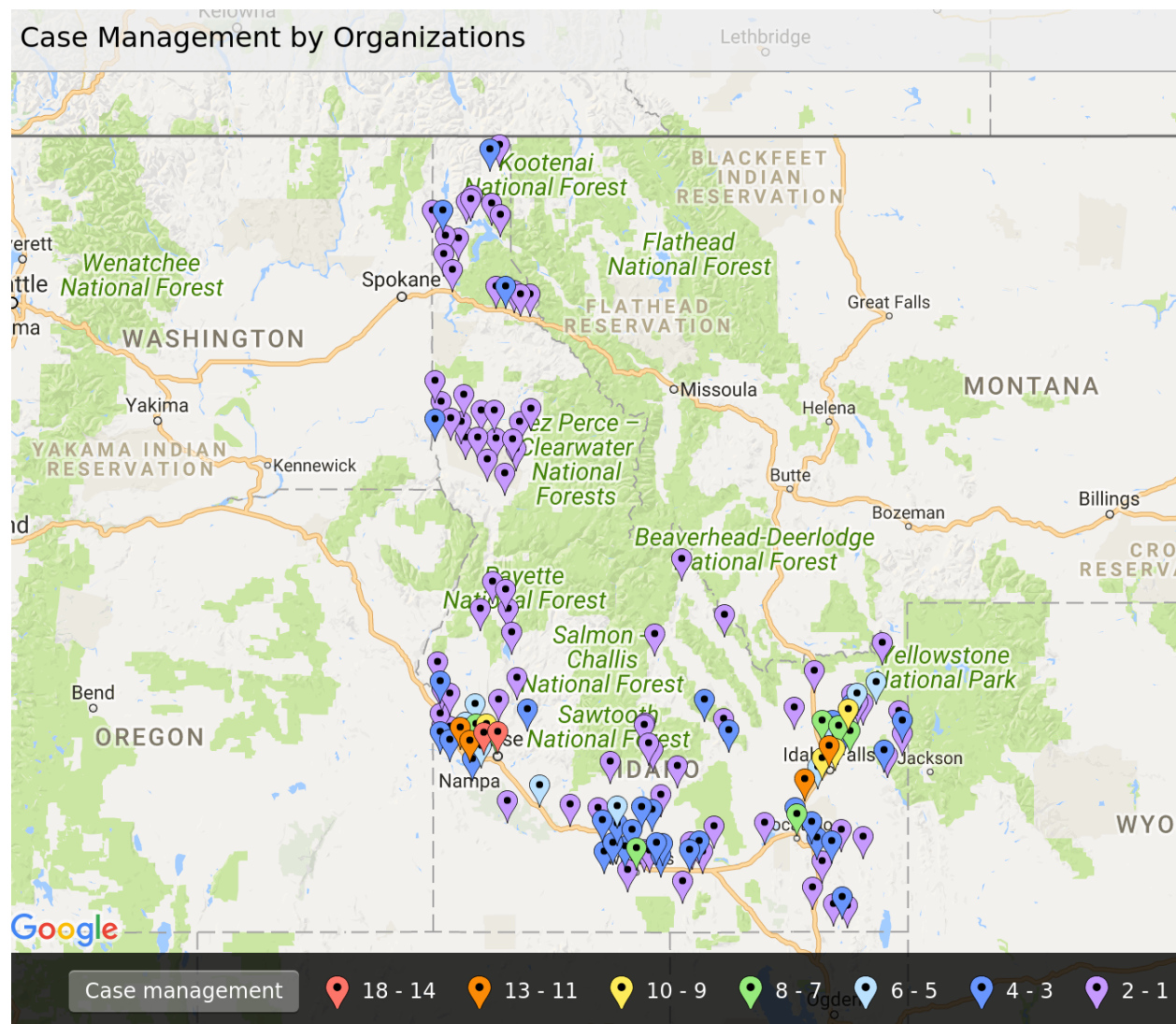
Seventy-one respondents reported that 588 staff are providing case management services, and 418 (71%) are certified.

The map shows that in communities where services are available, most can access services from 1 to 2 organizations. 43 communities receive no case management services. 51 communities receive case management services by one organization each.

Case management offerings by a single behavioral health agency could be an issue to watch for in the future. The federal government has required senior and disability services to move into conflict-free case management, in which the case management agency is separate from the service delivery agencies used by the individual. If the federal government were to expand this requirement for conflict-free case management into behavioral health, these organizations would not be able to provide case management as well as direct services.



Figure 36 Case management provided by organizations



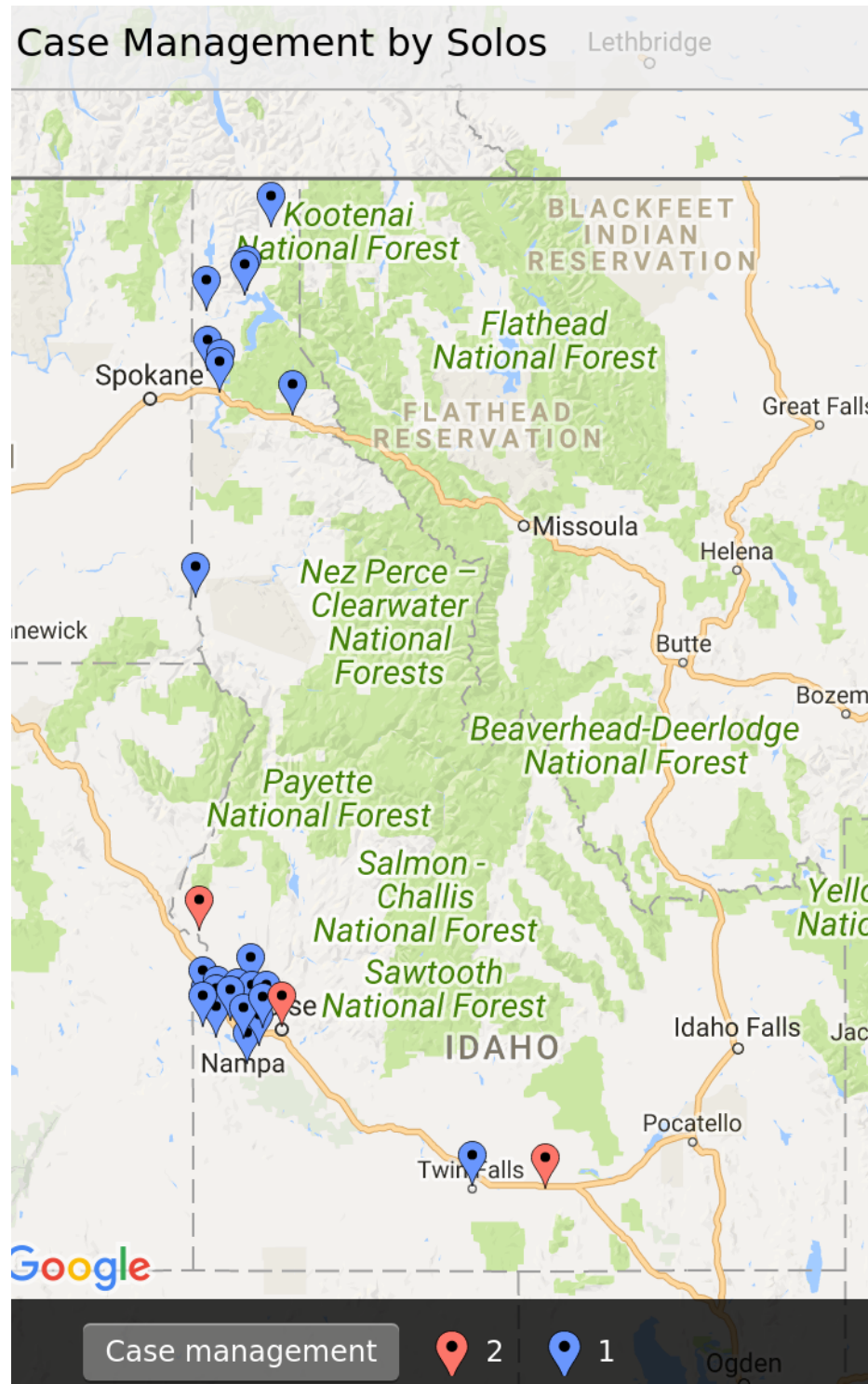
The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/25ff7204509eaa53dd12790c17b6a67a>

### *Solo practitioners*

Nine respondents (13.4%) report providing services in the earlier question. When asked where they provide services, they report delivering case management in 27 communities (14.4%), mainly in regions 1, 3, and 4.

**Figure 37 Case management provided by solo practitioners**



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/bcd4ebb04976f5331b3e05d12bd58091>

## Community-based rehabilitation services

### Organizations

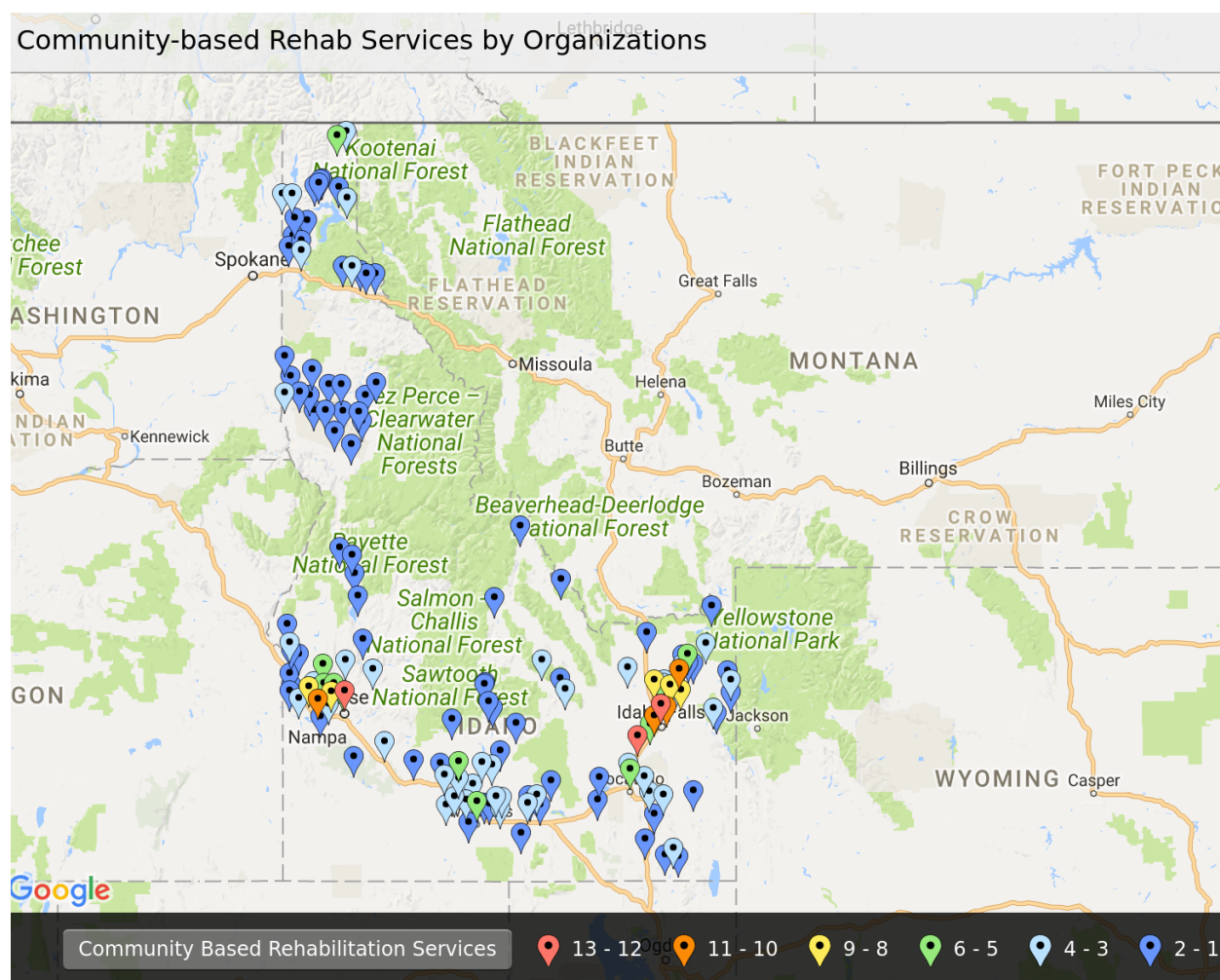
The depth of providers for community-based rehabilitation services differs from some of the counseling services. For this service, Idaho Falls (13, 12.7%), Blackfoot (12, 11.7%), and Boise (12, 11.7%) lead the way, followed by Nampa (11, 10.7%), Ammon (10, 9.8%), Rexburg (10, 9.8%) and Shelley (10, 9.8%).

Fifty-six organizations reported a total of 748 staff providing community-based rehabilitation services. 259 are certified (34.6%), and another 156 (20.85%) are working towards certification. This is 55 percent of staff delivering services.

The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses.

<https://batchgeo.com/map/f5c93da23582f547c8918d32e88dda26>

Figure 38 Community-based rehabilitation services provided by organizations

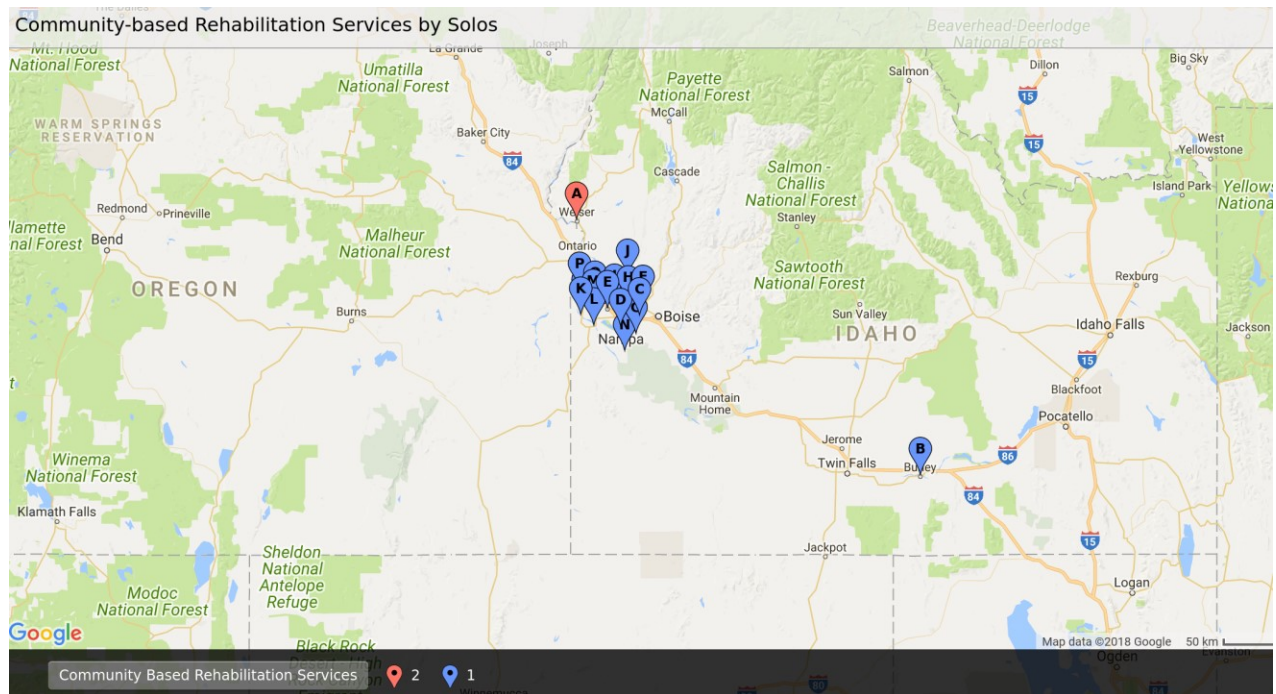




### Solo practitioners

Few solo practitioner respondents indicated providing community-based rehabilitation services. Only seventeen communities (9%) are in service by responding solo practitioners. The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here: <https://batchgeo.com/map/0f6cb5d5cad1b3925551a71ad4c78dc5>

**Figure 39 Community-based rehabilitation services provided by solo practitioners**





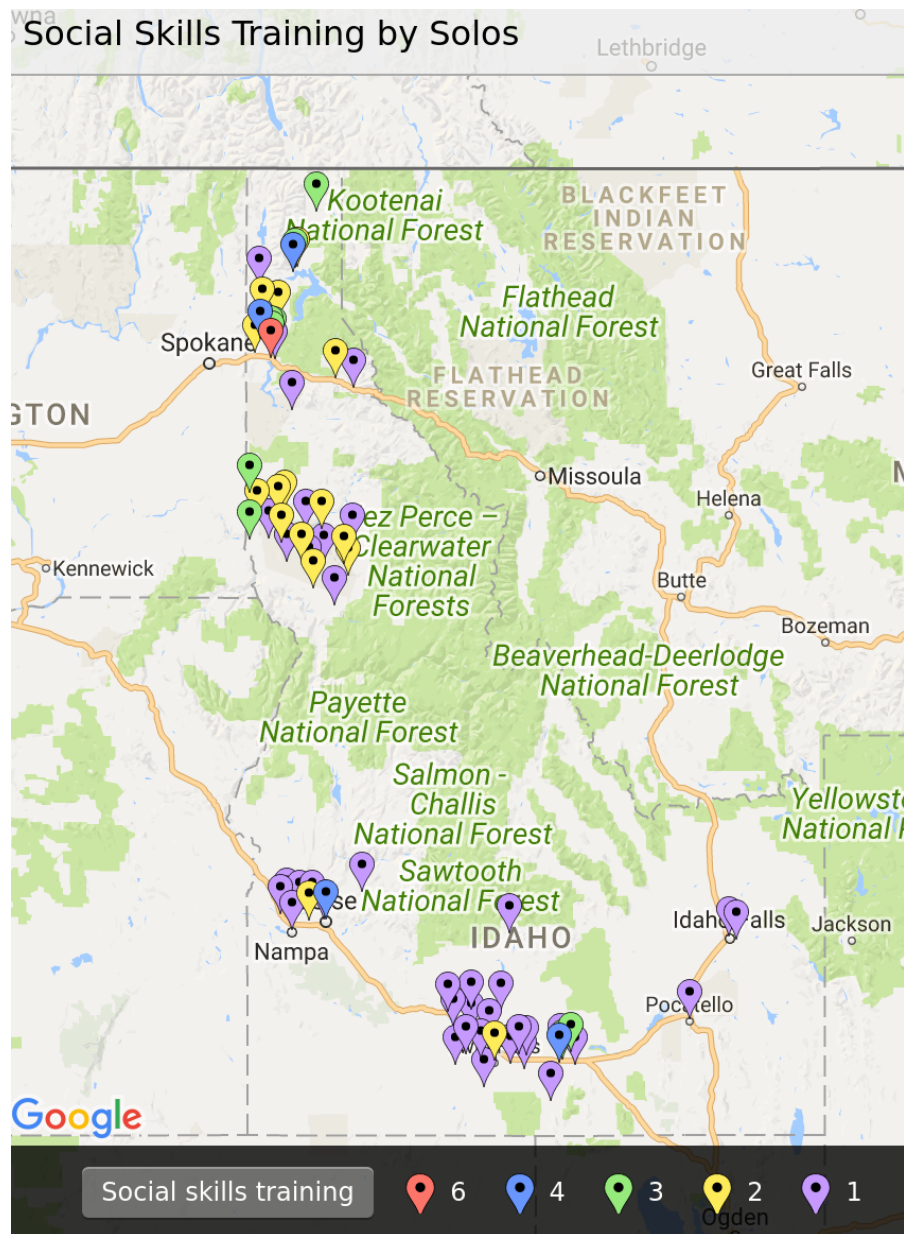
The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/e8c3714980ef17911aff418848947f7f>

### Solo practitioners

Solo practitioners report delivering social skills training in a number of communities, most notably Coeur D'Alene (6, 9.37%); Boise (4, 6.25%); Burley (4, 6.25%); Sandpoint (4, 6.25%); Rathdrum (4, 6.25%); Dalton Gardens (3, 4.68%); Bonners Ferry (3, 4.68%); Ponderay (3, 4.68%); Lewiston (3, 4.68%); Hayden, (3, 4.68%); Hayden Lake (3, 4.68%); Rupert (3, 4.68%); Heyburn (3, 4.68%); and Moscow (3, 4.68%).

Figure 41 Social skills training provided by solo practitioners



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/98659b089308084e3660327fa7e748f2>

## Wraparound services

### Organizations

Forty organizations (39.2%) responded to the question about wraparound services. They noted 198 staff are trained and providing wraparound services. They ensure fidelity to the model through:

- Routine supervision, mentoring, and documentation review.
- Regular review of guidelines, weekly staff meeting
- We do person centered planning
- In-service training
- Periodic WRAP trainings by advanced practitioner
- Follow Optum LOCs
- Quality assurance review
- Following the National wrap model through peer
- Informally
- Consistent communication and coordination
- Ongoing services to ensure compliance,
- Collaboration with other providers

Other comments:

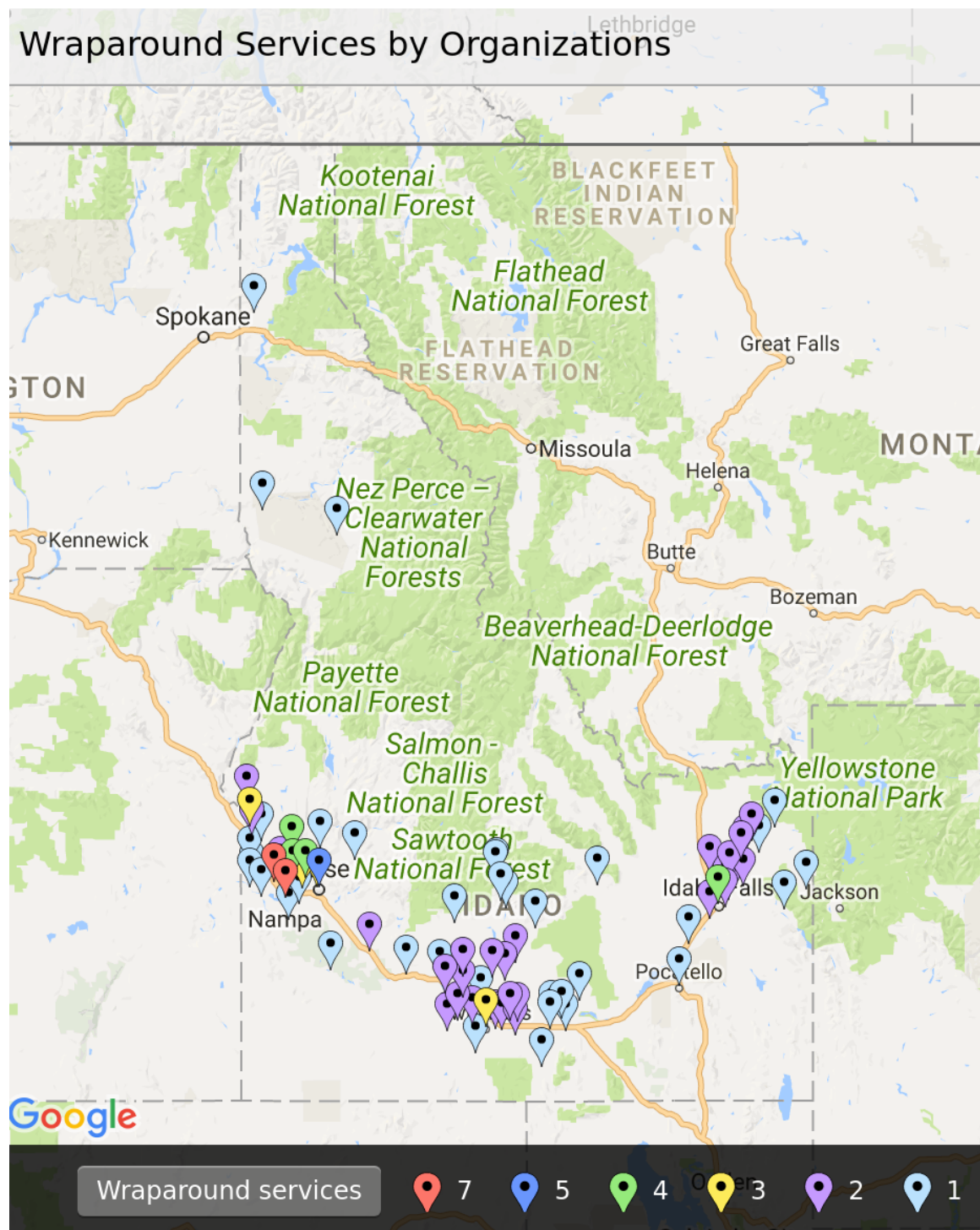
- Provide wrap around in the sense that some clients have multiple services and providers coordinate together.
- The Crosspointe team composed of clinicians and other staff who are relevant to the well-being of the child or youth (e.g., family members and other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time.

Caldwell and Nampa each have seven providers (6.8%), followed by Boise (5,4.9%).

There appears to be a noticeable deficit in service providers for wraparound services in the northern part of the state.



Figure 42 Wraparound services provided by organizations



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/2ac0a50dc95578fc41c364aa89afbeb5>

### *Solo practitioners*

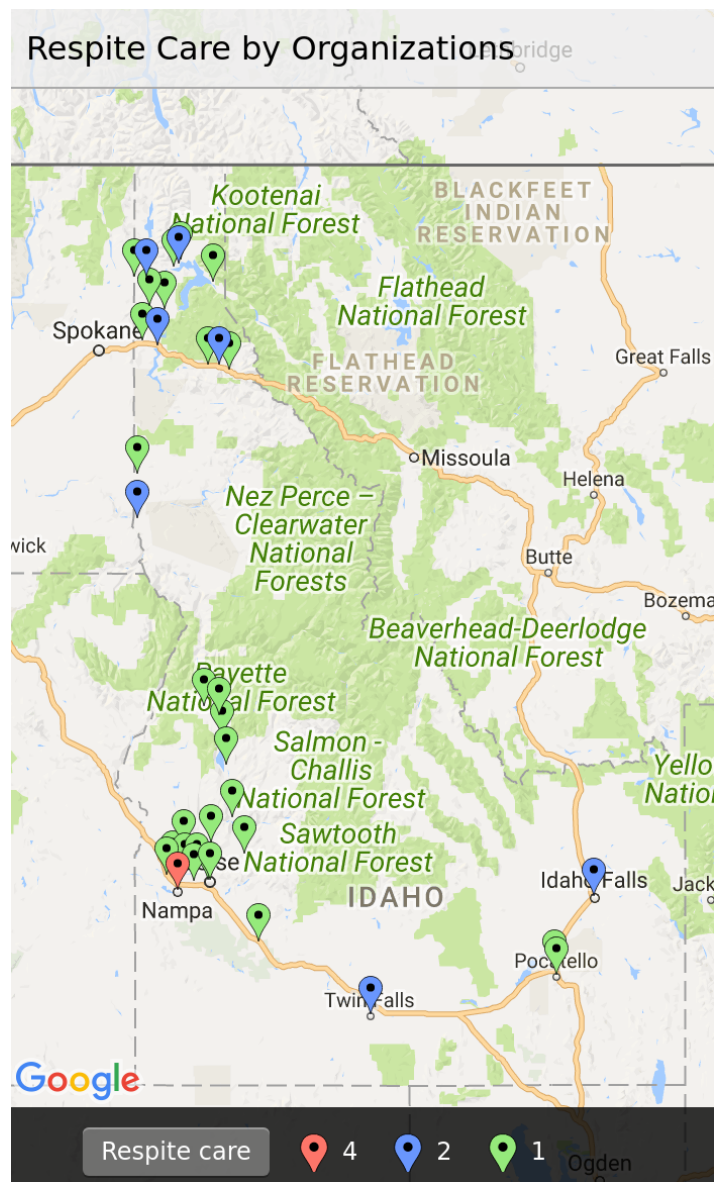
Few solo practitioners state that they offer wraparound services. Where they do, services are offered only in Kuna (2), Boise (1), Nampa (1), Eagle (1), Caldwell (1), and Garden City (1).

## Respite Care

### Organizations

Few respondents stated that their organizations provide respite care in Idaho, and only in 36 communities. Nampa has four providers identified through this survey.

Figure 43 Respite care provided by organizations



The map of this service is detailed community by community. The number of providers serving each community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/ff542ec8812dbc8167bf6c453283e2bf>

### Solo practitioners

No solo practitioners reported delivering respite care.



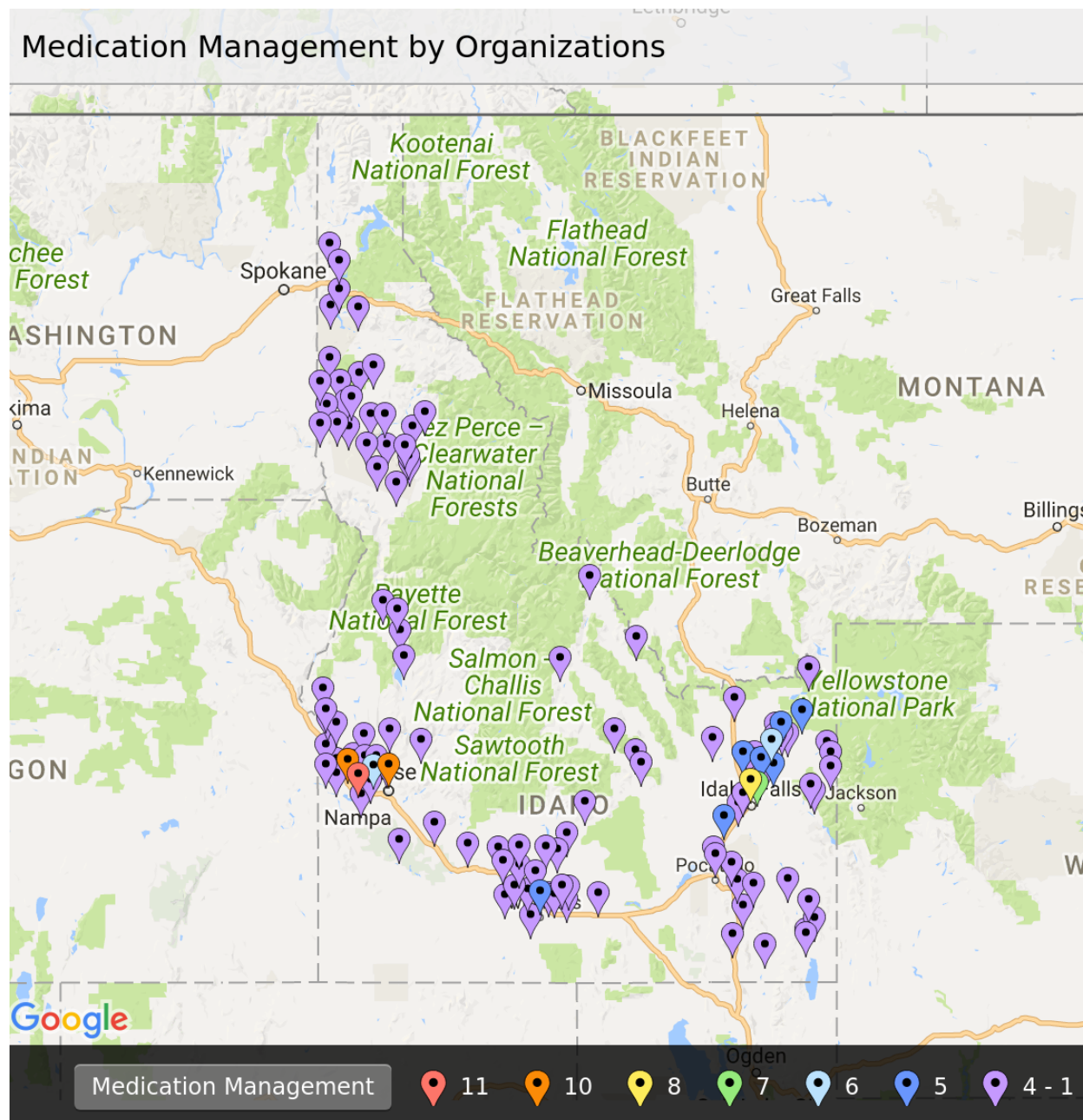
## Medication Management

### Organizations

Nampa (11, 10.78%), Boise (10, 9.8%), Caldwell (10, 9.8%), Idaho Falls (8, 7.8%), and Ammon (7, 6.8%) are served by the most respondents that provide medication management.

Fifty (49%) communities have access to medication management by one organization. Sixty-five communities (36%) have no medication management access from respondents.

Figure 44 Medication management provided by organizations



The map of this service is detailed community by community. The number of providers serving each

community is indicated by the key below the map showing the colors of each peg and the number of responses. The web link for this map is found here:

<https://batchgeo.com/map/67ab268910f5be194ff1d2975ec2dbcb>

#### *Solo practitioners*

Solo practitioners stated that they provide medication management. The communities they serve are Boise, Nampa and Caldwell (1 each).

## **Planning for future services**

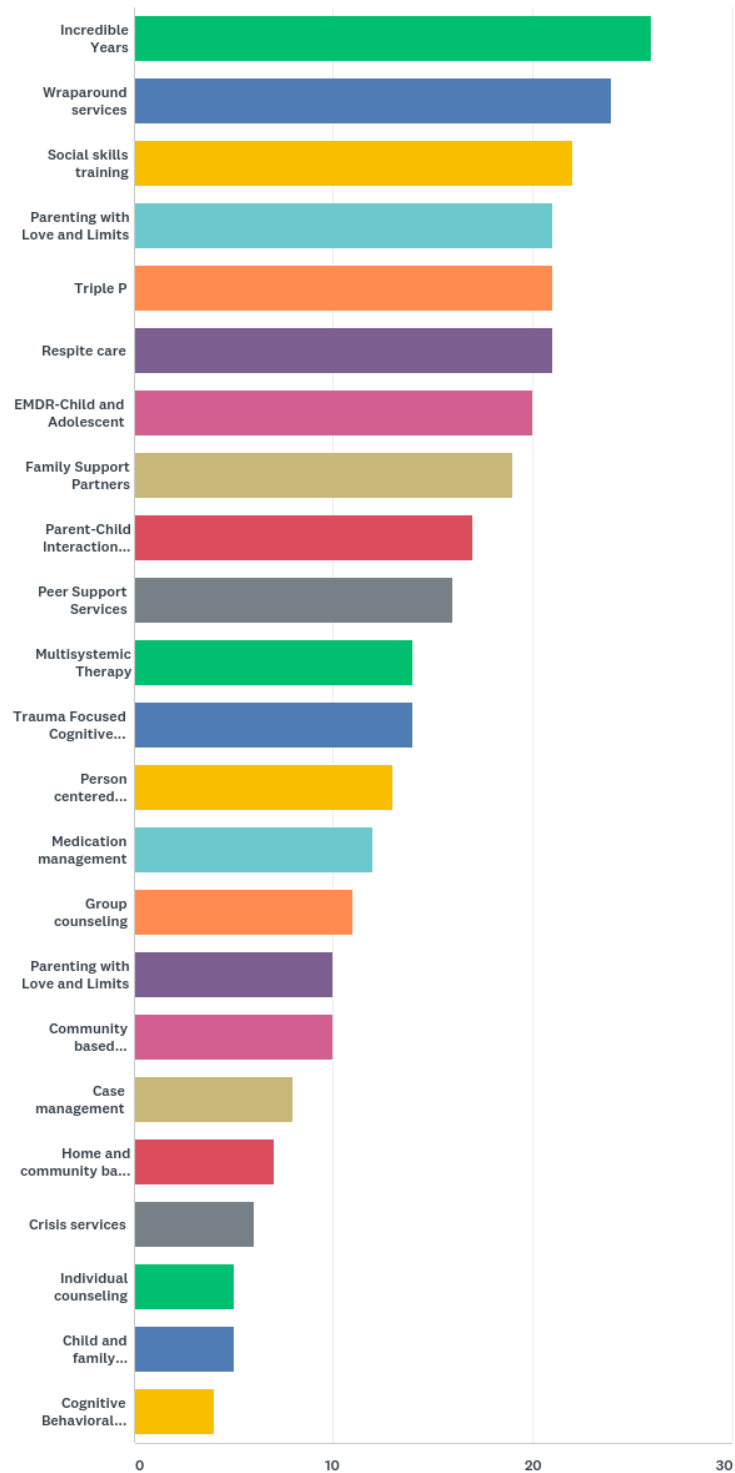
The surveys asked respondents about services that their organizations or solo practices would like to provide, and what it might take for them to expand.

### **Organizations**

Sixty-four organization respondents (51.2%) stated that their organization does not currently provide additional services, and would like to. Other services they would like to provide include services to people with intellectual disabilities, psychological evaluations, and life coaching (1 each).

Figure 45 Services that organizations would like to expand

Q29 From the following list, please indicate which services your organization does not currently provide to youth and their families, but is interested in providing.



Fifty-six respondents (87%) stated how they could expand services. Their answers are grouped in categories:

#### Training should be affordable and delivered locally.

- Funding to pay for training/low cost for training (overwhelmingly consistent response)
- Affordable training in the local area
- Financial resources, affordable training opportunities
- Local affordable training
- Funding to certify staff
- Offer credentialed training in North Idaho for all the above
- Access to cost efficient training in services
- Training in how to appropriately provide and bill for the services
- Education and training.
- Educational materials and funding in order to take the proper classes to earn certifications
- Training materials, manuals
- Not driving to training that is more than 2 hours away

#### Training in specific models: EMDR, Trauma-focused CBT, PCIT, Peer and Family Supports

- EMDR certification is costly and time consuming. We have several staff who are interested in receiving this training, but the cost has been our biggest barrier.
- It is financially difficult to pay for certification of an EMDR therapist
- We need certification in EMDR and training in Trauma Focused CBT.
- PCIT: Training on methodology and resources for equipment
- More family support trainings
- Training for Peer Supports or Family supports in Bonners Ferry

#### Adequate reimbursement rates

- Adequate reimbursement
- Medicaid would need to approve and of course service providers would need to be willing
- Reimbursement rates that support recruitment and retention of staff in those areas.
- Reimbursement rates would need to be high enough to make it financially viable to expand to more services.
- Sustainable reimbursement rates that account for the training, collaboration, and administration it takes to provide high quality services.
- Increased reimbursement rates
- Paid collateral time
- Better reimbursement to pay for the providers wages, the referrals and paperwork that come with patients as well as the simple management of them.
- Reasonable reimbursement rates that justify acquiring professionals qualified to perform requested services (in example, psychiatrists/med managers often charge an agency more than the State of Idaho's reimbursement rate for the service).
- Recovery in cash flow from the Optum implementation \$20,000 in capital.
- If I was reimbursed more for providing PCIT services, that would help. It costs substantially more, the 1-year long post masters training, the additional observation room/window and

recording, audio equipment, the standardized measurements, treasure box toys. I would love to expand to a larger space to provide more PCIT if I knew I had referrals coming in and ideally if I was getting paid a little more for the specialized service.:-)

#### Infrastructure support

- I would need information on how to credential for these programs or available training for staff.
- Reasonable and not overwhelming and cost-prohibitive requirements for documentation and oversight.
- Support through credentialing agency with easy access to appropriate credentialing agency representatives.
- Easily accessible audit tools to ensure program documents, policies, and procedures meet requirements.
- We need the State to provide this opportunity to the Tribes.
- State rules
- Get rid of Optum category 3 service authorization process. Its clearly a cost avoidance strategy for this managed care company
- Need to understand what the services are, and what certifications and regulation compliance are required.
- Understanding what resources are approved by Optum, better resource access

#### Staffing

- We need more med management as well as child psychs. We also live in a pretty rural area so it is much more difficult to recruit qualified workers that can afford to live here
- Qualified Staff... Nobody is applying right now.
- Trained staff and additional support staff.
- Staff and funding to do so
- Providers
- More counselors
- More Staff

#### Telehealth

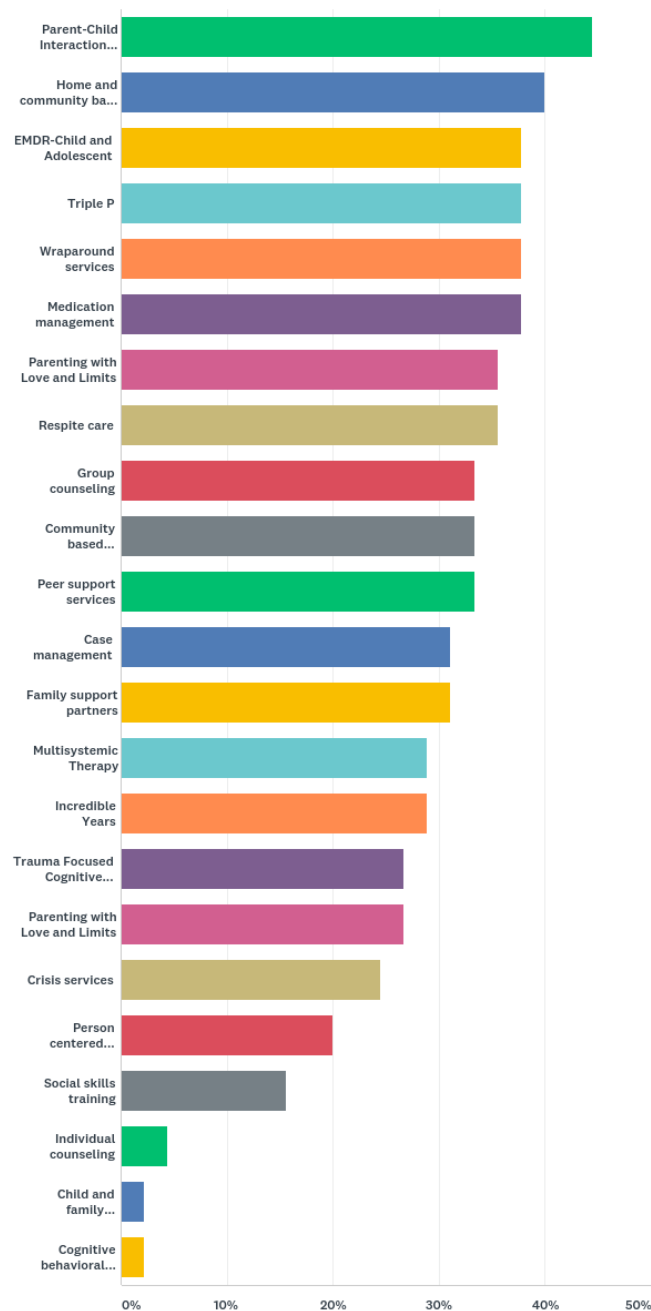
- For medication management, a system for telehealth
- Tele-health is also a component that could be utilized, however it is very costly to set up and maintain.
- Other issues identified were: client demand, home-based counseling services, case management.
- If I had a steadier flow of referrals, I could expand into a bigger building in order to provide more PCIT as well as a bigger room for group therapy and parent education courses.

### Solo practitioners

Forty-five solo practitioners (65.2%) answered this question. They are largely interested in expanding their credentials and their practices, including in home and community-based care.

Figure 46 Services that solo practitioners would like to expand

Q22 From the following list, please indicate which services you do not currently provide to youth and their families but are interested in providing



Thirty-five solo practitioners (77%) had similar recommendations, particularly around training.

#### Training should be affordable and delivered locally.

- Training: local, affordable
- Training and/or Certification. I am also not familiar with some of the above options so may be in the future.
- Training in the curriculum and referrals for a parenting group.
- Training, staff
- Need information on available trainings.
- Affordable training in EMDR

#### Adequate reimbursement rates

- Reasonable reimbursement rates for time spent in not just direct service but also in coordination of care with wraparound partners.
- Recognition of other models perhaps.
- Funding for single case agreement when family needs the in home program and the training

#### Infrastructure support

- Transportation
- Access to large enough area to facilitate groups
- Additional funding to afford expansion at location and expansion in staff members.
- Help with structuring
- Minimal paperwork/reporting requirements

#### Staffing

- I would have to have other workers that I am not able to pay for right now.

#### Other notes

- I refer a lot of my clients out to organizations in Nampa for family based interventions.
- I'm hoping as my agency grows I'm able to add on some of these much needed resources.
- I am a sole practitioner and an Substance use disorder assessment only agency
- I am a solo practitioner in private practice. To offer most ancillary services I would need to be part of a group. I use the REACH protocol with my ADHD population.
- I feel there also needs to be more service based organizations in Caldwell for the other ones.
- i have several areas of specialty including advanced trainings in several interventions but only two are listed there. The methods ethan (sic) use to determine evidence based is not effective.



## The Behavioral Health Workforce

### Job titles

Ninety-two respondents (73.6%) reported having staff with the job titles or responsibilities listed as potential answers to this question. Almost all reported having jobs with the title “counselor (84, or 91 percent). Most had jobs titled Clinical Supervisor (73, 79%), Mental Health Professional (62, 67%), Social Worker (61, 66%), and Case Manager (58, 63%). Fifty percent of respondents report having social work or counseling interns.

Other job titles include:

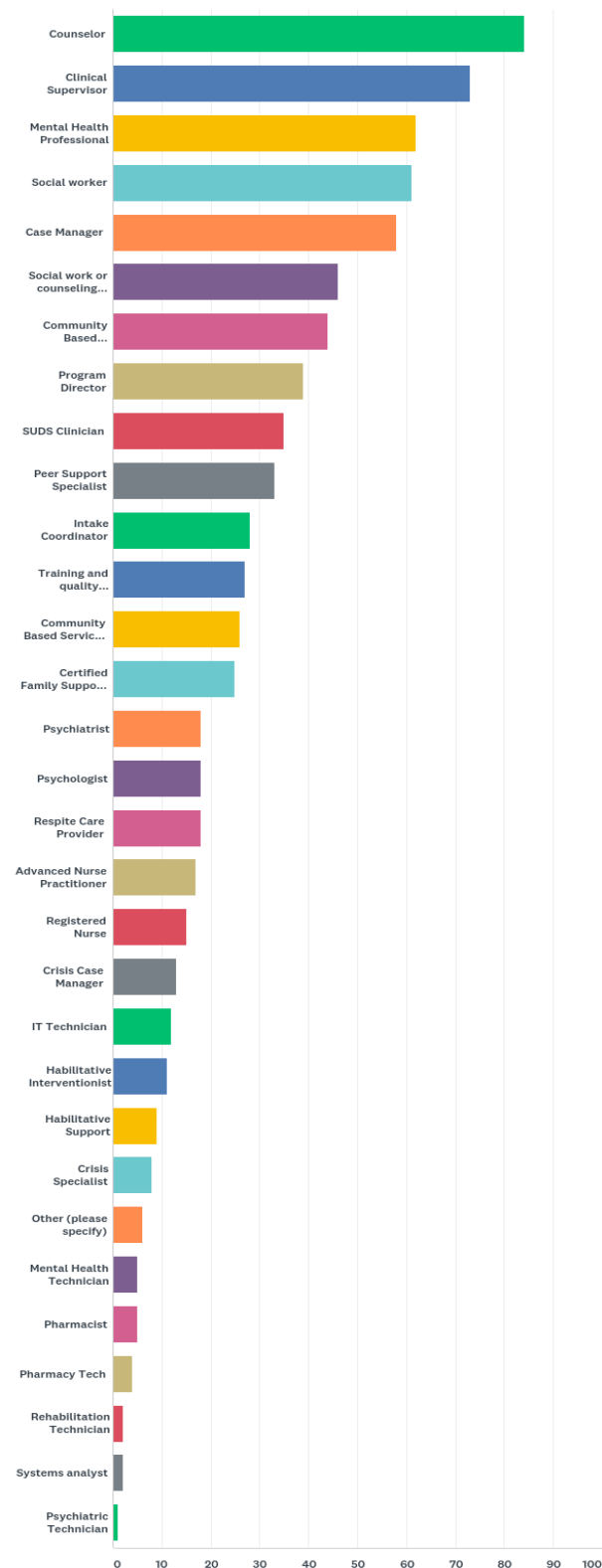
- Support Counselors and Forensic Interviewers
- Office Manager
- Clinical Director
- Physician Assistant
- General Manager
- Independent Contractors (Interpreters)

No respondents reported having employees with these titles:

- Activity Aide
- Psychiatric Aide
- Medical Resident

Figure 47 Organization staff titles

Q31 Do you have staff with these job titles/responsibilities?

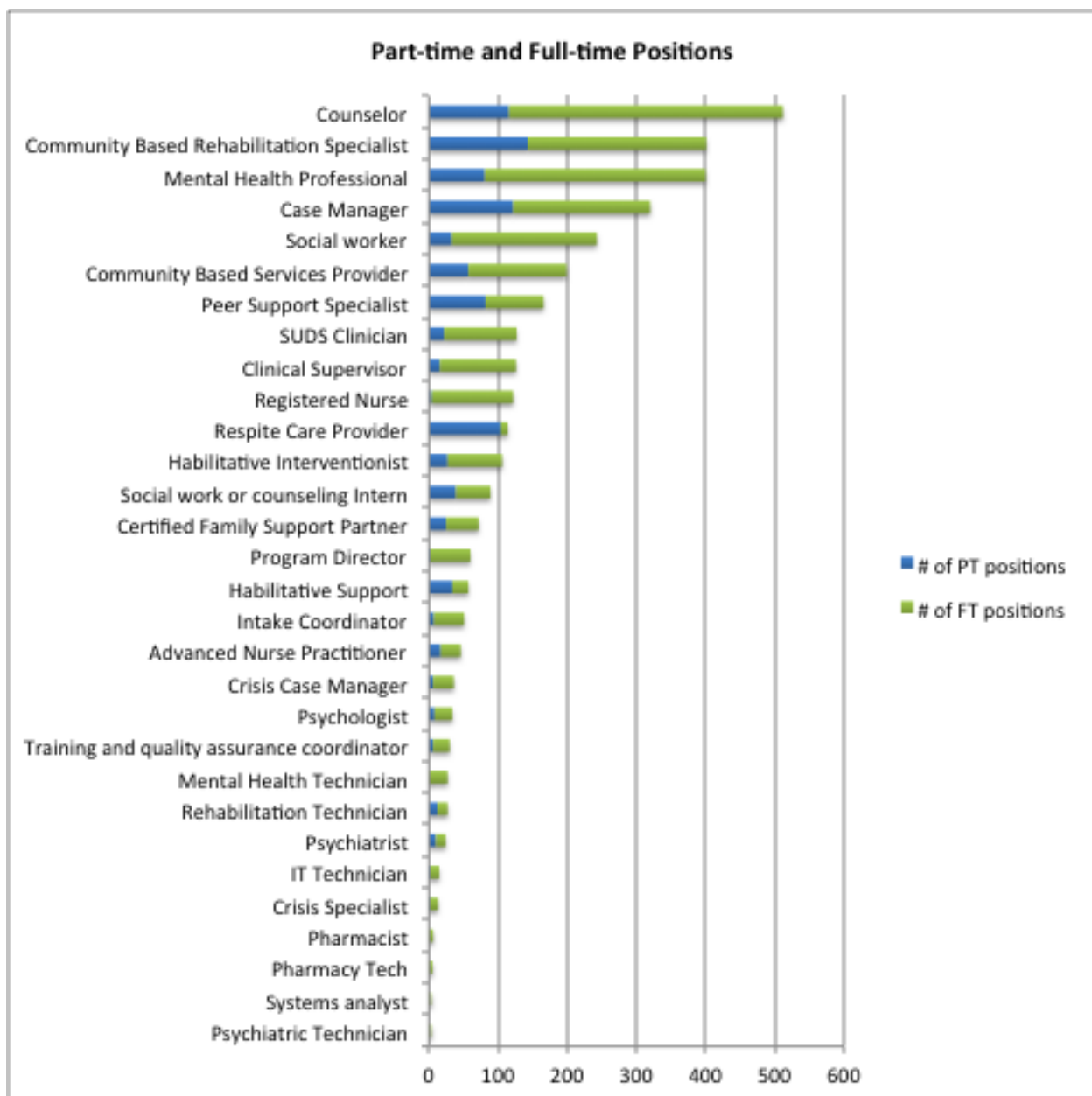


### Staffing: full-time and part-time

Eighty-seven respondents (69.6%) reported that full-time employees worked in their organizations, and sixty-seven (53.6%) reported on part-time employees. Counselors, mental health professionals, community based rehabilitation specialists, and social workers comprise the bulk of the positions in the workforce, as reported by respondents.

Respite Care positions are reported as part-time for over 90 percent of positions (104 of 114). Habilitative Support positions are slightly more likely to be part-time (34) than full-time (23), and Peer Support Specialists are equally likely to be part-time (82) as full-time (84). Certified Family Support Partners are more likely to be full-time (47) than part-time (25).

Figure 48 Part-time and full-time positions



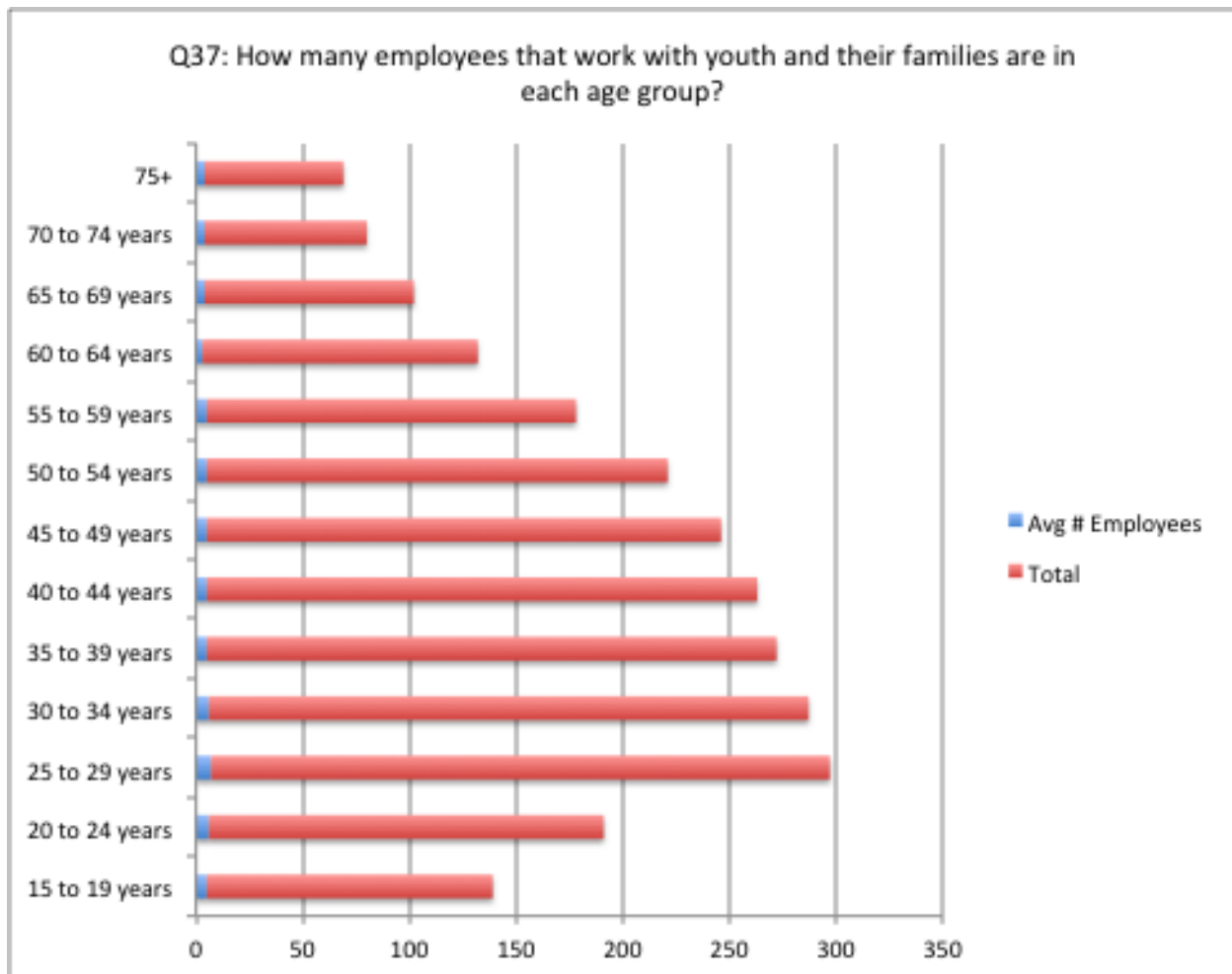
## Demographics

### Age

#### Organizations

Sixty-six responded (52.8%). Organizations are staffed by individuals of all ages, including young adults under age 19.

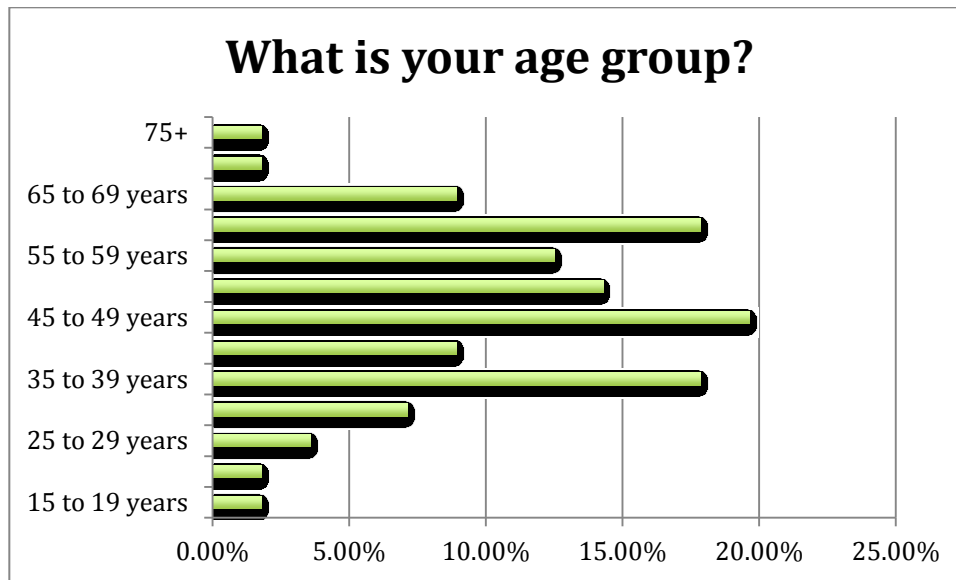
Figure 49 Organization employees by age group



## Solo practitioners

Fifty-six responded (60.8%) Most respondents are 45 to 49 (11, 19.64%), 35 to 39 (10, 17.86%), and 69 to 64 years old (10, 17.86%).

**Figure 50 Solo practitioners age groups**



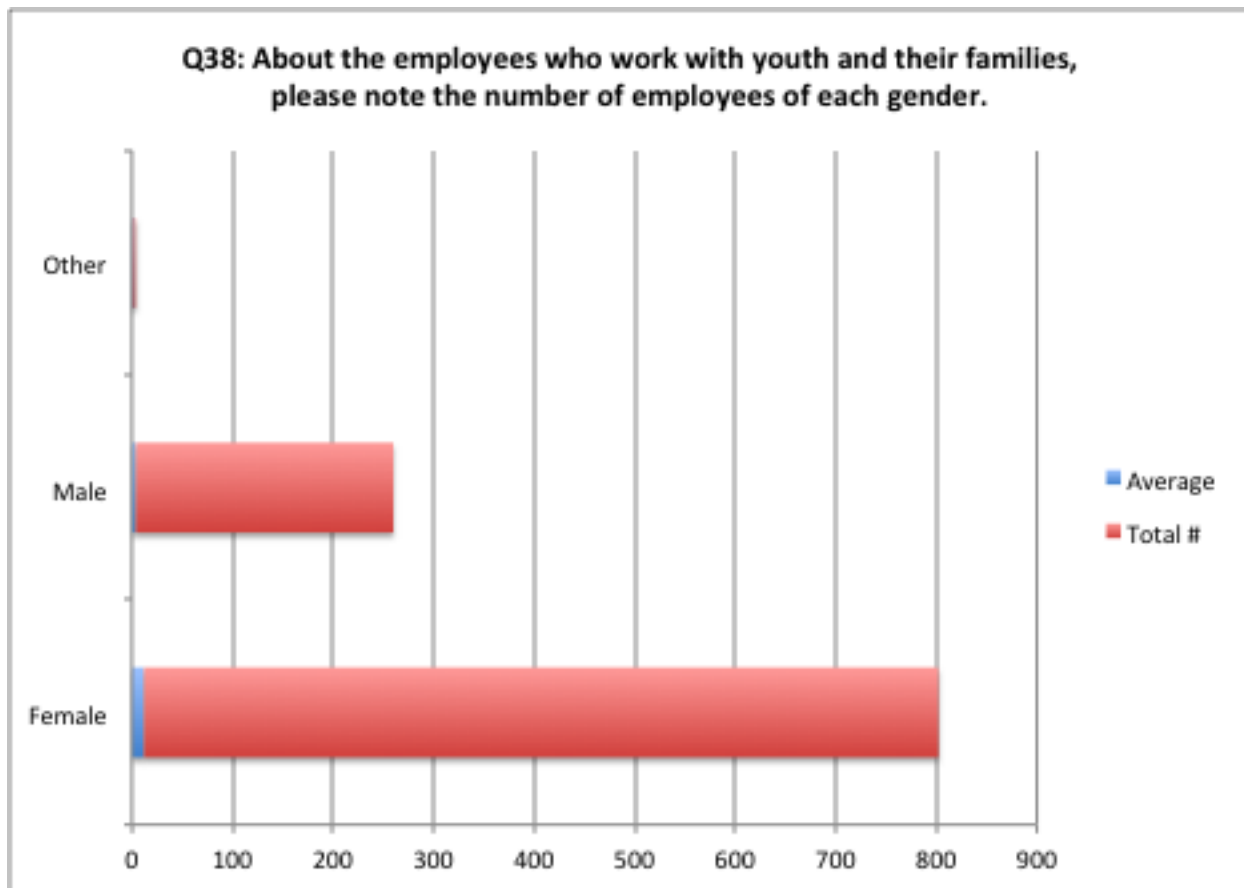
## Gender

### Organizations

Sixty-seven (53.6%) responded a question of the gender of their employees. They reported a staffing pattern with an average of 12 female and 4 male staff.

The total number of staff by gender was 1048. Of these, 790 (75.38%) were identified as female and 256 (24.4%) as male. One organization identified two staff (0.19%) whose gender was neither female nor male.

**Figure 51 Organization employees by gender**



### Solo practitioners

Fifty-eight responded. Fifty are female; eight are male.

### **Race and Ethnicity**

The researchers asked about the race/ethnicity of employees who work with youth and their families. If employees identify as multiple races/ethnicities, they were asked to mark more than one as appropriate. The researchers used the categories identified in the U.S. Census as the answers for this question, and prepared the question so that respondents could choose more than one ethnicity.

**Table 4 Race and ethnicity of organizations and solo practitioners**

<b>Race &amp; Ethnicity</b>	<b>Idaho population</b>	<b>Organization employees</b>	<b>Solo providers</b>
White	93.70%	92.94%	98.2
Black or African American;	1.10%	0.45%	0
American Indian and Alaska Native	2.40%	1.36%	7%
Asian	2.10%	0.34%	0
Native Hawaiian and other Pacific Islander	0.30%	0.45%	0
Other	3.10%	0.68%	0
Hispanic/Latino	12%	3.70%	0

### **Organizations**

Sixty-one respondents (49.6%) answered this question. They reported an average of 14 white employees, two Hispanic or Latino, one American Indian or Alaska Native, and two “other” employees. On average, there were no Black or African American, Native Hawaiian or other Pacific Islander, or Asian employees.

The volume of employers responding reveals a stark characteristic of the children’s behavioral health workforce: Of 878 people employed by the responding 61 organizations, 816 (92.94%) are white. 12 (1.36%) are American Indian or Alaska Native; four (0.45%) are Black or African American; four (0.45%) are Native Hawaiian or Other Pacific Islander; and three (0.34%) are Asian. Six (0.68%) are identified as Other. Thirty-three (3.7%) are Hispanic or Latino, regardless of race.

### **Solo practitioners**

Fifty-seven responded. Fifty-six (98.2%) are White, and three also identified as American Indian or Alaska Native. One is American Indian.



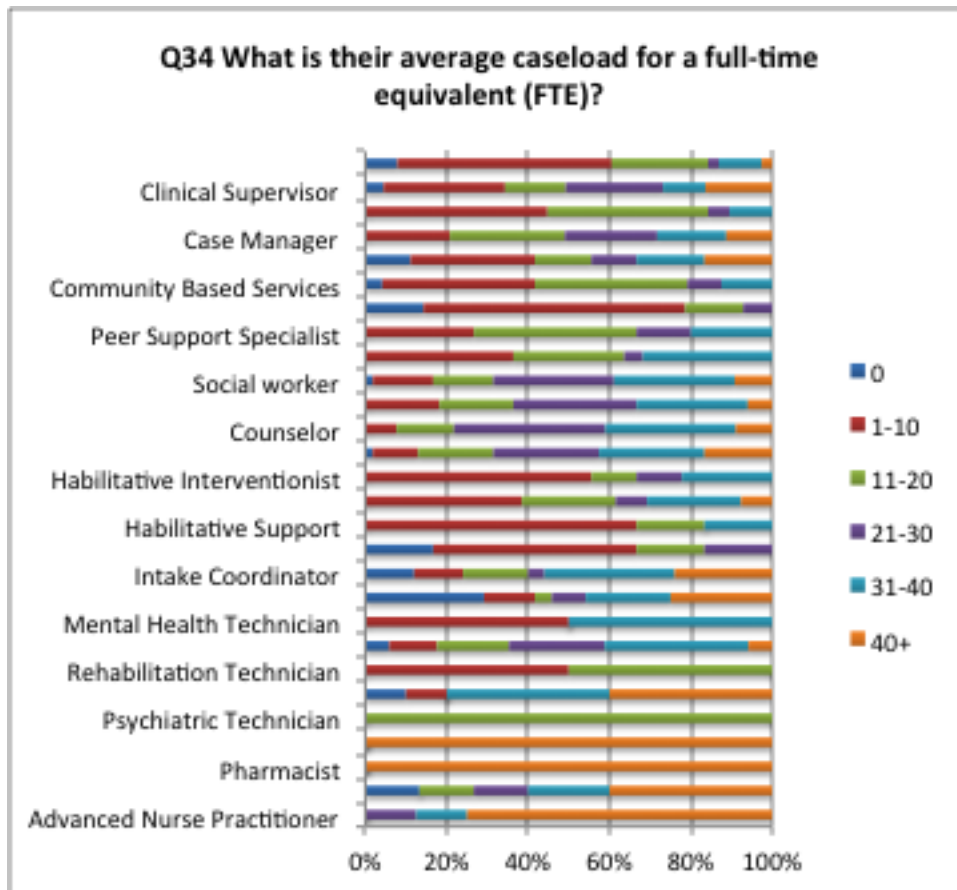
## Caseloads

### Organizations

Eighty-five respondents reported the average caseload for a full-time equivalent position.

- Overall, caseloads are highest for Advance Nurse Practitioners, Psychiatrists, Pharmacists, and Pharmacy Technicians at 40 or more.
- Organizations that have employees with the title Counselor, Mental Health Professional, SUDS Clinician, and Social Worker reported mostly caseloads of 21-30 and 31-40. Psychologists have reported caseloads of 31-40.
- Intake coordinators have reported caseloads of 31-40 and 40 or more.
- Employees with the titles Habilitative Support, Habilitative Interventionist, Certified Family Support Partner and Respite Care Provider have caseloads of 10 to 20.
- Community Based Service Providers and Community Based Rehabilitation specialists carry reported caseloads of 1 to 10 and 11 to 20.
- Peer Support Specialists have reported caseloads of 21-30, with fewer carrying caseloads of 11 to 20.
- Case Managers have reported caseloads of anywhere from 1 to 40, with the highest reported number of 11 to 20.
- Training and Quality Assurance Coordinators carry high caseloads of 31 to over 40 or none at all.

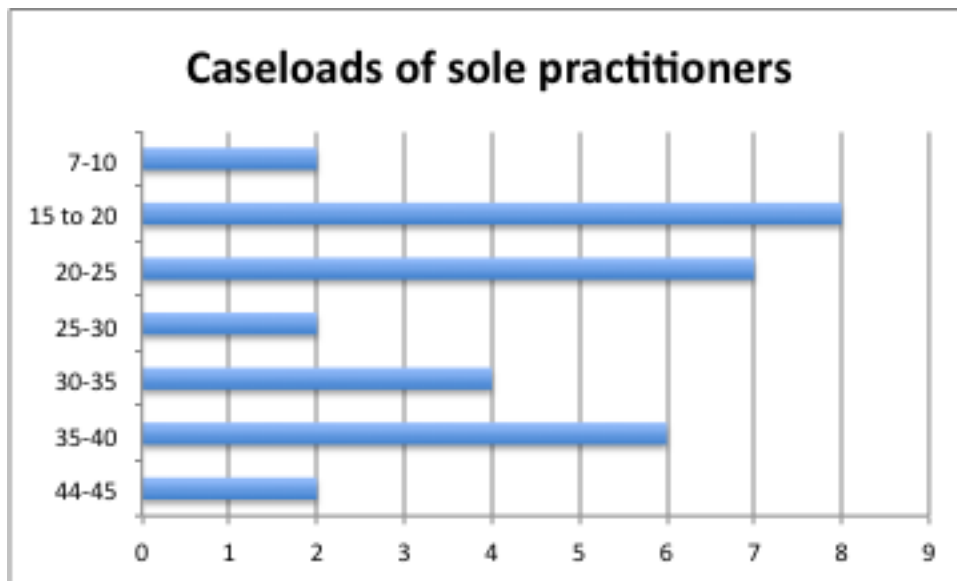
Figure 52 Average caseloads by position



#### *Solo practitioners*

Fifty-seven (61.9%) responded to this question. The reported range of caseloads was precise and quite broad, from seven to 40. The most frequent caseloads noted were 15-20 as a range (8) and 20-25 (7). One noted that they see 20 in groups each week.

Figure 53 Caseloads of solo practitioners



## Licensure

### Organizations

Organizations have these expectations for licensure or certification. The number of providers requiring the certification or licensure is in parentheses for each.

#### Paraprofessional certifications

**Certified Family Support Partners** are expected to have certification from the State of Idaho (16 organizations), Family Support Specialist training (2), or LSW (1).

**Peer Support Specialists** are expected to have certification as Peer Support Specialists from the State of Idaho (23 organizations).

**Habilitative Support** workers are expected to have a Habilitative Support certification (3 organizations), training in habilitative support (2), or no certification (1).

**Mental Health Technicians** are expected to have a bachelor's degree (1) or a BSW or LSW (1).

**Psychiatric Technicians** are expected to have a master's degree (1), while **Rehabilitation Technicians** are expected to have a bachelor's degree (1).

**Respite Care Providers** have minimal requirements. Three respondents reported a high school diploma with experience; two require a master's degree. One each requires training as a respite care provider, first aid training, certification by the Coalition for Children and Families, or "meets qualifications". Three have no requirements.

#### Clinical positions

**Advance Nurse Practitioners** are expected to have licensure as an Advance Practice Registered Nurse (7), certification as a Psychiatric Nurse Practitioner (3), Certified or Family Nurse Practitioner (1 each), registration with the Idaho Board of Pharmacy, and DEA registration (1 each).

**Registered Nurses** are expected to have their licensure as Registered Nurses (RN), with a bachelors preferred (3). One organization requires a licensed practical nurse (LPN).

**Case Managers** are largely seen as bachelors-prepared professionals (23), preferably with a degree in a related field (6). Six respondents report that their organizations prefer an LMSW or LSW, and four prefer a Certified Psychiatric Rehabilitation Practitioner. Three organizations expect no particular certification or licensure for case managers. A graduate degree is preferred by two. One each prefers a Masters in psychology or social work, Children's Psychiatric Certificate, CADC, CCM, LCPC or LPC.

**Crisis Case Managers** are expected to have a Bachelors degree (4). One each organization requires a CBRP, LCSW, Masters degree, relevant certification, or crisis training.

**Crisis Specialists** are expected to have a clinical license (3), bachelor's degree (2), or children's psychiatric certificate or CPRP (1).

**Habilitative Interventionists** are expected to have a bachelor's degree and Habilitative Interventionist Certification (7).

**Intake Coordinator** positions vary widely in requirements. Some organizations view this as an administrative role (1) with no requirements (4) or an associate degree (1); others require an LCSW (4), LPC or LCPC (3 each), or LMFT (1). Four require a bachelor's degree.

**Social Workers** are generally expected to hold a Masters-level degree and LMSW or LCSW (28), a bachelor's level degree and LSW (17). Other respondents stated they require some licensure but did not specify bachelors or masters level (6). More require a master's degree in social work (3), an MS (1), or a social work degree (1).

**Counselors** are expected to hold an LCPC or LPC (28 and 27, respectively); LMSW or LCSW (22 and 20, respectively) any master-level licensed professional (13); LMFT (12); a masters in counseling, social work or marriage and family therapy (8); a CADC (2); license in psychology (1); or MD (1).

**Mental Health Professionals** are expected to hold an LPC or LMSW (14 each); LCPC (13); LCSW (12); or masters in counseling, social work or marriage and family therapy (11). Four respondents reported requiring an LMFT; licensed masters or higher; bachelors in psychology, social work or more. One each requires a licensed psychologist or a psychological service extender, CPRP, Children's psychiatric certificate, nurse practitioner, MD, or CADC. One was unsure, and another notes that it is different for each position.

**Community Based Rehabilitation Specialists** are generally expected to have a Children's Certificate in Psychiatric Rehabilitation (CPRP, 25) or a bachelor's degree in a qualified field of study (9). Of those that expect a CPRP, three organizations expect employees to have secured a CPRP or CFRP after 30 to 36 months of employment. Four organizations require a Certificate in Community-Based Rehabilitation, and two prefer an LMSW or LSW.

**SUDS Clinicians** are expected to have the CADC or ACADC (18). Masters-level licenses are preferred: LPC (7); LCSW (6); LCPC and LMSW (5 each); LMFT by one; or any masters level license (3). Non-specified licenses are required by two. The ISAS is preferred by four, and QP or QP-T by three. One each requires CADC-II or ISAS 2 or higher.

**Social work or counseling interns** are expected to be in an accredited masters- or bachelors degree-seeking program (30). Three respondents mentioned LSWs.

#### Supervisory and management positions

**Clinical Supervisors** are mostly LCSWs (28) or LPCs (25). Nine respondents require clinical supervisor training or certification such as LPC-S or RPT-S.

**Program Directors** are largely expected to hold a license in clinical social work (LCSW, 11). Other licensure and degree requirements include LCPC (5); Masters level clinical license (5); Bachelor's degree (4); LMFT or LMSW (2 each). One organization each prefers five years' experience; another Clinical Endorsement and Supervisor Training; licensure at the BA or MA level; a nurse practitioner; Ph.D.; or a bachelor's degree at minimum. One states that there is no requirement.

**Training and quality assurance coordinators** are preferred to have a masters-level licensure: LCSW, LCPC, or LMFT (7), closely followed by a bachelors (6). One each prefers a licensed clinical psychologist, master's degree, or associates. Two require no specific degree or licensure.

**Systems Analysts and IT Technician positions** had few known qualifications except for training in their fields.

#### Prescribing professionals

**Pharmacists** are expected to be licensed as such (2). **Pharmacy technicians** are expected to be working towards licensure (1).

**Psychiatrists** are preferred to be state-licensed MDs (13) or DOs (3). One organization prefers a Board Certified Child and Adolescent Psychiatrist. Another prefers a nurse practitioner.

**Psychologists** are preferred to be state-licensed clinical psychologists with PhDs (7) or PsyDs (5).

### **Solo practitioners**

Fifty-eight responded (63%). Solo practitioners are most likely to be LCPCs and LCSWs with additional credentialing.

**Table 5 Solo practitioners licensing and certification**

<b>License</b>	<b>Number</b>
LCPC	11
LCSW	11
LPC	4
LCPC, EMDR Certified	3
LCPC, NCC	3
LMFT	3
LCPC with Supervision endorsement.	1
LCPC, CS	1
LCPC, ICADC, DBTC	1
LCPC, LMFT	1
LCPC, LSMW	1
LCPC, NCC, RPT-S	1
LCPC, RPT	1
LCPC, School Psychologist	1
LCSW (clinical supervisor)	1
LCSW and working on CBT certification	1
LCSW RPT-S	1
LCSW State Supervisor for LMSWs; Registered Play Therapist-Supervisor; Provider of Play Therapy Education Services	1
LCSW TF CBT and TBRI	1
LCSW, CISD	1
LCSW, grief and loss, trauma	1
LCSW, certification in EMDR within 2 months	1
LPC, CRC	1
LPC, NCC	1
LPC, NCC, CCTP, Parent-Child Interaction Therapy certified	1
LPC, NCC, RRT, RPSGT	1
MSW	1
DNP	1

## Cultural Competence and emphases in service

### Organizations

Sixty-eight responded. Of these, the following reported a particular cultural competence or emphasis in service:

**Figure 54 Cultural competencies and emphases in service: organizations**

Competence	Organizations
LGBTQI	41
Tribes	21
Refugees	14
Deaf and Hard of Hearing	5

Under “other”, nineteen respondents reported these emphases:

- Addiction Treatment Services and COD
- Adoption, children in foster care system
- Christian Counseling
- College Students
- Hispanic Population. We have a Spanish speaking counselor.
- LDS community, faith-based cultures
- LDS, Military Service Members, Native American, Hispanic, Chamorro and Pacific Islanders, Women and Girls
- Low income, SUD
- PTSD, sexual abuse
- Rural, very low income
- Trauma, disabilities, DD, children, family systems approach
- Veterans and their Families
- Vision Impaired
- Young children with SED ages 2-8
- We see all cultural populations.
- Any patient is served

Eighteen reported offering gender-specific services. These are described in the next question.

### Solo practitioners

Thirty-seven solo practitioners said they have a particular cultural competence or an emphasis in service.

**Figure 55 Cultural competence and emphases of service: solo practitioners**

Population	Providers
LGBTQI	22
Refugees	8
Tribes	6
Deaf and Hard of Hearing	4
Adoptive/foster care families	3
Trauma-impacted individuals and families	2
Children	1
Disadvantaged Life Circumstances	1
Individuals with autism	1



Self Harm/ suicidal thinking	1
Veterans, First Responders	1
Victims of abuse	1

One respondent notes: “I am culturally competent and trained with most populations.”

### *Gender-specific services*

#### **Organizations**

Of the 30 organization respondents (24%) who stated that their organization offers gender-specific services, 15 (50%) offer services specific to girls and women and 3 (1%) offer services specific to boys and men. Eight more offer gender-specific services to male and female populations, and two offer gender-specific services to transgender people.

#### **Solo practitioners**

Sixteen offer gender-specific services. Thirteen (81.25%) offer services specific to girls and women and nine (56.25%) offer services specific to boys and men. One solo practitioner (0.33%) offers gender-specific services to transgender people.

## Languages

### *Languages that organization employees speak and understand*

Ninety-one organizational respondents (72.8%) answered this question. All have staff that speak and understand English. Forty-four (48.35%) also have staff that speak and understand Spanish.

### *Languages in which services are offered to youth and their families, other than English*

#### Organizations

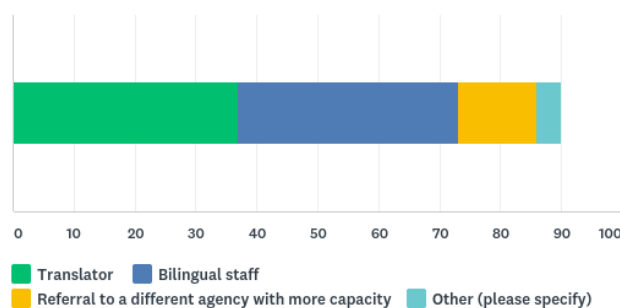
Seventy-seven respondents (61.6%) answered this question. Thirty-seven (48%) offer services in Spanish. Forty (51.9%) state that they offer services in no other language than English. However, they have some strategies for addressing language barriers. They use translators slightly more often than bilingual staff. They refer to some other organizations. They also offer some innovative solutions:

- Phone service
- Translation program (telephonic) and staff that speak Mandarin and Spanish
- iPad translator

One reports: “We have several independent contractors who offer interpreting services for a variety of languages, as well as have access to many others who can provide additional language translator services when/if needed; we refuse to let language be a barrier.”

**Figure 56 Strategies that organizations use for serving non-English speakers**

Q28 What strategies does your organization use for working with youth and their families who do not speak English?



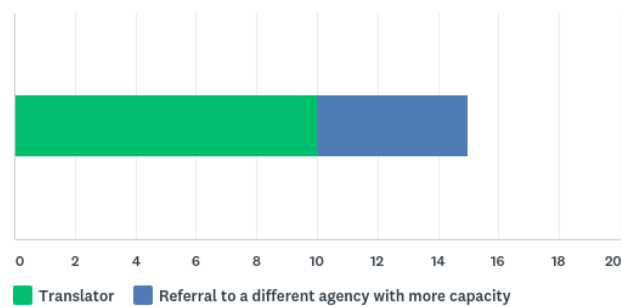
#### Solo practitioners

Fifty-eight (63%) solo practitioners speak English only. Six of 51 solo practitioners (11.76%) offer services in Spanish. Others offer services in Arabic (2), Kinyarwanda, Nepalese, and Swahili.

**Figure 57 Strategies that solo practitioners use in working with non-English speakers**

Thirteen (10.4% of respondents) offered the strategies they use to provide services outside of English. Ten (76.9%) use a translator. Five (38.4%) refer to another organization.

Q21 What strategies do you use for working with youth and their families who do not speak English?



### Metrics for future use: NAICS codes

In part, this work identified some metrics that are easily replicable for future analysis using [Idaho Department of Labor data systems](#). The Department of Labor regularly analyzes workforce demand and workflow using employer data relating to NAICS codes.

Should IDHW decide to work with the Department of Labor to identify trends in workforce, the IDHW could ask the Department of Labor to search these codes. This allows IDHW to quickly assess employer needs and issues using data regularly collected by a different department.

The researchers provided a list of NAICS codes that could be associated with a range of children's behavioral health positions, and asked the provider to match the code with a job title they had already identified for their organization.

### *Solo practitioners*

Forty-eight solo practitioners (52%) responded to this question. Slightly over half use the NAICS code for Mental Health Counselors. Because solo practitioners set their own NAICS codes and these are stated on their business licenses, this data is probably accurate.

**Table 6 Solo practitioners NAICS codes**

NAICS Code	Percent	Number
21-1014 Mental Health Counselors	52.08%	25
21-1029 Social Workers, All Other	18.75%	9
19-3031 Clinical, Counseling, and School Psychologists	10.42%	5
21-1013 Marriage and Family Therapists	8.33%	4
21-1023 Mental Health and Substance Abuse Social Workers	6.25%	3
21-1015 Rehabilitation Counselors	2.08%	1
29-1171 Nurse Practitioners	2.08%	1

## Organizations

The respondents were able to identify codes for a range of staff positions. A table follows on the next page.

The metrics did not yield clear answers, but the data could be of some use. The state can monitor certain NAICS codes as proxy data for a series of positions employed by behavioral health providers, but not necessarily for specific positions.

As an example, the title “social worker” was coded *21-1029 Social Workers, All Other* by ten respondents and as *21-1023 Mental Health and Substance Abuse Social Workers* by another three. The title “counselor” was coded as *21-1014 Mental Health Counselors* by thirteen; *19-3031 Clinical, Counseling, and School Psychologists* by five; *21-1029 Social Workers, All Other* by two respondents and as *21-1023 Mental Health and Substance Abuse Social Workers* by another two. The same position was coded as *21-1011 Substance Abuse and Behavioral Disorder Counselors*; *21-1099 Community and Social Service Specialists, All Other*; *21-1022 Healthcare Social Workers*; and *21-1013 Marriage and Family Therapists*.

Figure 47 Organizations NAICS codes

Position	19-3031 Clinical, Counseling, and School Psychologists	19-3039 Psychologists, All Other	21-0000 Community and Social Service Occupations	21-1011 Substance Abuse and Behavioral Disorder Counselors	21-1013 Marriage and Family Therapists	21-1014 Mental Health Counselors	21-1021 Child, Family, and School Social Workers	21-1022 Healthcare Social Workers	21-1023 Mental Health and Substance Abuse Social Workers	21-1029 Social Workers, All Other	21-1093 Social and Human Service Assistants	21-1094 Community Health Workers	21-1099 Community and Social Service Specialists, All Other	29-0000 Healthcare Practitioners and Technical Occupations	29-1051 Pharmacists	29-1066 Psychiatrists	29-1141 Registered Nurses	29-1171 Nurse Practitioners	29-2053 Psychiatric Technicians	29-2071 Medical Records and Health Information Technicians	31-9099 Healthcare Support Workers, All Other	Other code
Pharmacy tech	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Psychiatric Aide																					1	
Systems analyst	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Mental Health Technician													1								1	
Pharmacist	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0
Rehabilitation Technician													1								1	
Medical resident	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0
Psychiatric technician																			1			

Activity Aide	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0
IT technician																					2	1
Registered Nurse	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0
Training and quality assurance coordinator				1					1												2	
Psychiatrist	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	5	0	0	0	0	0	0
Social work or counseling Intern									1				2								2	
Advanced Nurse Practitioner	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	5	0	0	0	0
Psychologist	3	2											1			1						
Respite Care Provider	0	0	2	0	0	0	0	0	1	0	1	0	2	0	0	0	0	0	0	0	1	0
Family Support Partner			3						2				2								1	
Family Support Specialist	0	0	3	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	0	0	1	0
SUDS Clinician			0	5					1	1			1								1	
Peer Support Specialist	0	0	4	0	0	0	0	0	2	0	0	0	2	0	0	0	0	0	0	0	1	0
Program Director	1		1	2		2			2	1											1	
Crisis case manager	0	0	5	0	0	0	0	0	2	1	0	0	1	0	0	0	0	0	0	0	1	0



Crisis specialist			4				1	1	1	1			1								1	
Intake coordinator	0	0	2	1	0	0	1	0	0	0	0	1	0	1	0	0	0	0	0	2	2	1
Community Based Services Provider			4						2		1		4								1	
Community Based Rehabilitation Specialist	0	0	7	0	0	0	0	0	4	1	1	1	1	0	0	0	0	0	0	0	1	0
Social worker			1					1	3	10			1									
Mental Health Professional	3	0	4	0	0	7	0	0	2	1	0	0	0	0	0	0	0	0	0	0	1	0
Case Manager			8						4	3			3								1	3
Clinical supervisor	8	0	0	1	1	8	0	0	2	1	0	0	0	0	0	1	0	0	0	0	1	1
Counselor	5			1	1	13		1	2	2			1									1

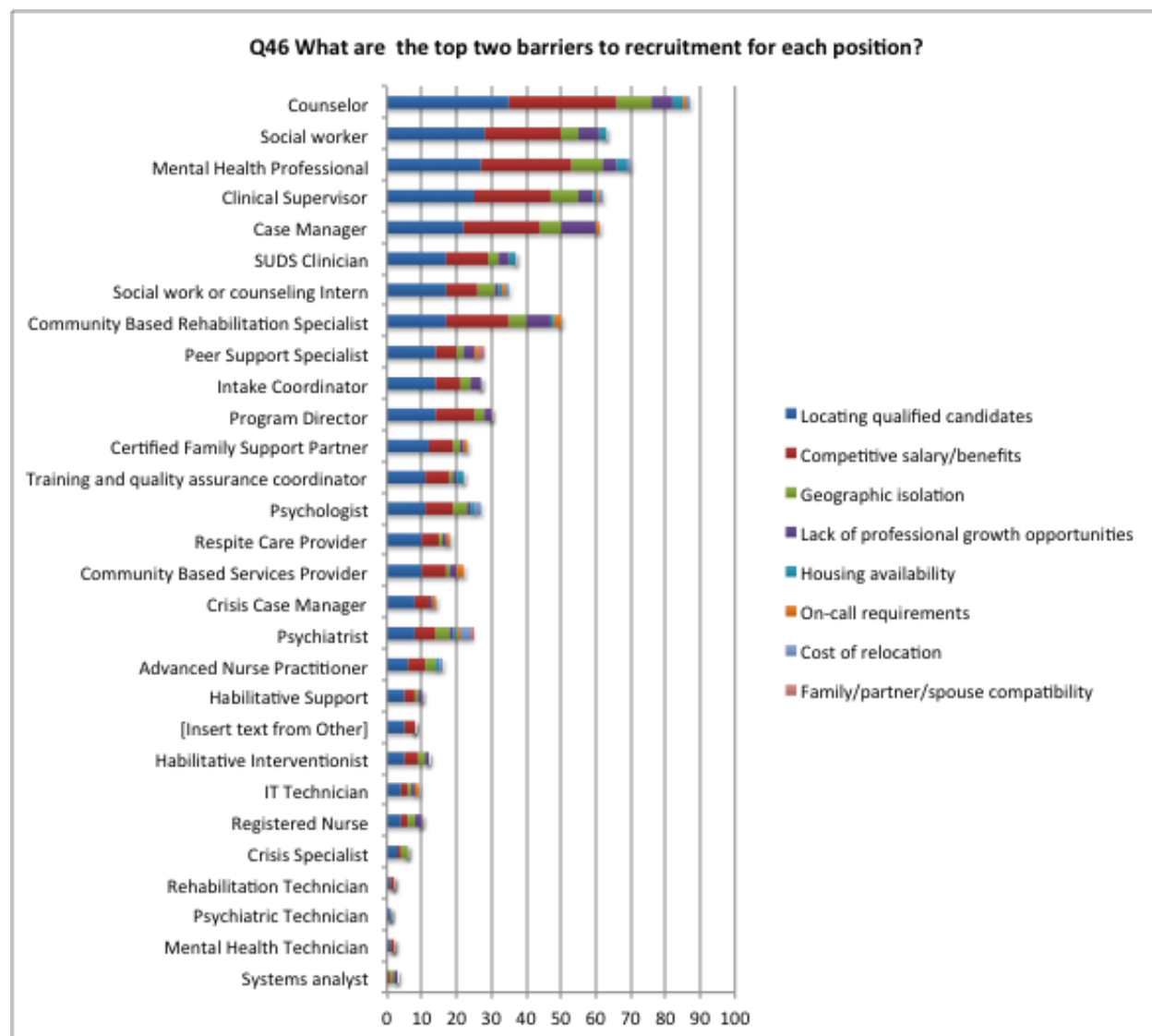
## Recruitment and hiring: Workforce gaps and Strategies

Only organization representatives were asked about their organization's recruitment and hiring gaps and strategies. Seventy-one respondents participated in this section.

### Barriers to recruiting

The researchers asked what the top two barriers to recruitment for each position were. Sixty responded, and the trends by position are similar: locating qualified candidates and offering competitive salary and benefits. To a much smaller degree, geographic isolation plays a part for recruiting counselors, mental health professionals, clinical supervisors, case managers, and social workers. In recruiting psychologists and psychiatrists, geographic isolation is a larger barrier than it is for these other positions.

Figure 58 Two top barriers to recruiting employees by position



No respondents reported recruiting strategies for these positions:

- Pharmacist
- Pharmacy Tech

### *Recruiting strategies*

The researchers asked three questions about recruiting and hiring strategies:

- The two job recruiting strategies your organization has found to be most effective for each position
- The value of family and community strategies, if any; and
- The top financial incentives that organizations used.

### *Job recruiting strategies*

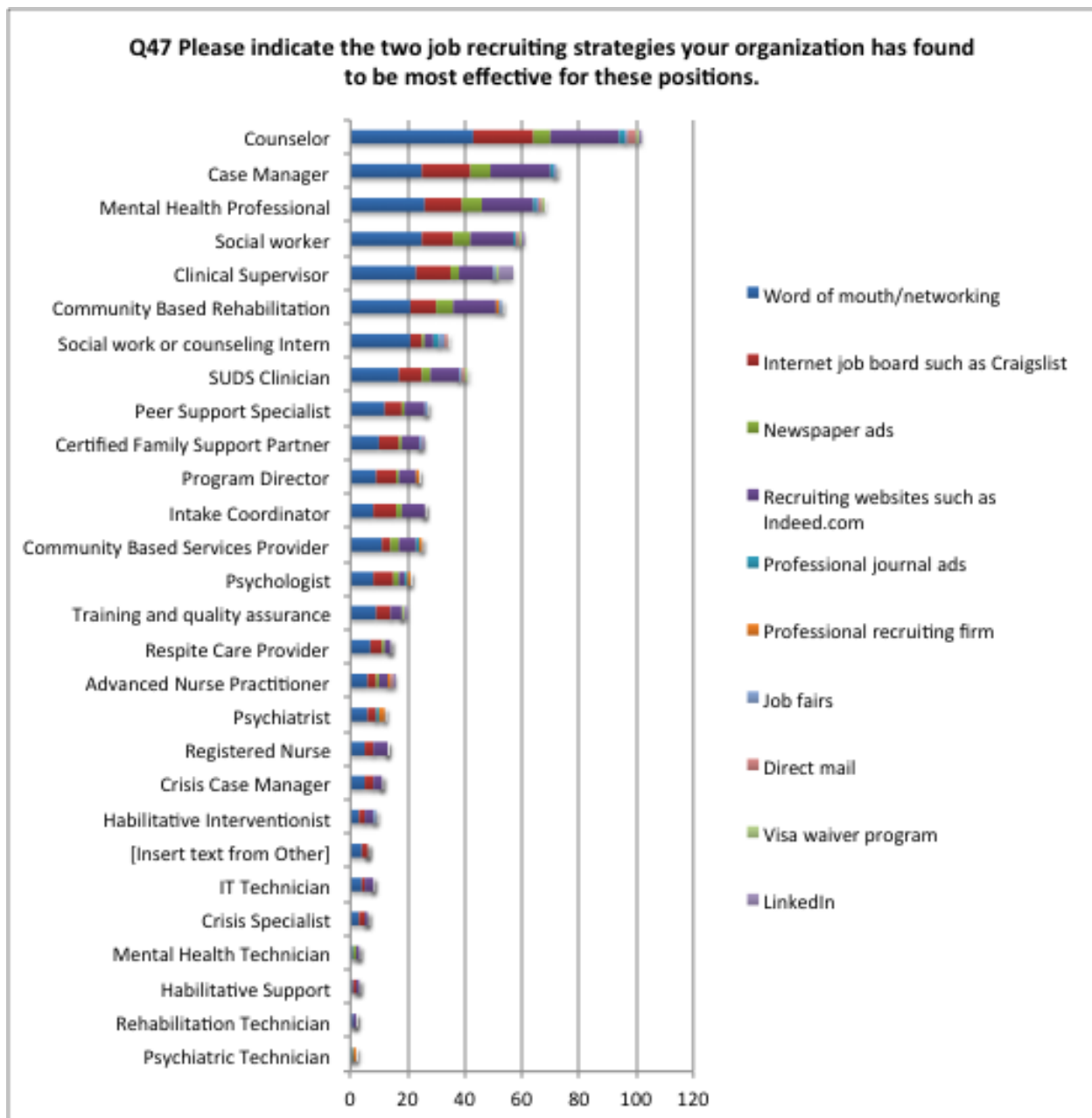
Sixty-one respondents reported their top two recruiting strategies for positions. Overwhelmingly, these are word of mouth and networking, followed by recruiting websites such as Indeed.com. Craigslist and similar internet job boards follow closely. Few respondents reported using LinkedIn, an international professional networking database.

Of note, some respondents reported using a U.S. Visa waiver program to recruit for six positions that are clinical and supervisory. If federal law on visas changes, this could be a limited strategy for the future.

No respondents reported recruiting strategies for these positions:

- Pharmacist
- Pharmacy Tech
- Systems analyst

Figure 59 Two most effective recruiting strategies by position



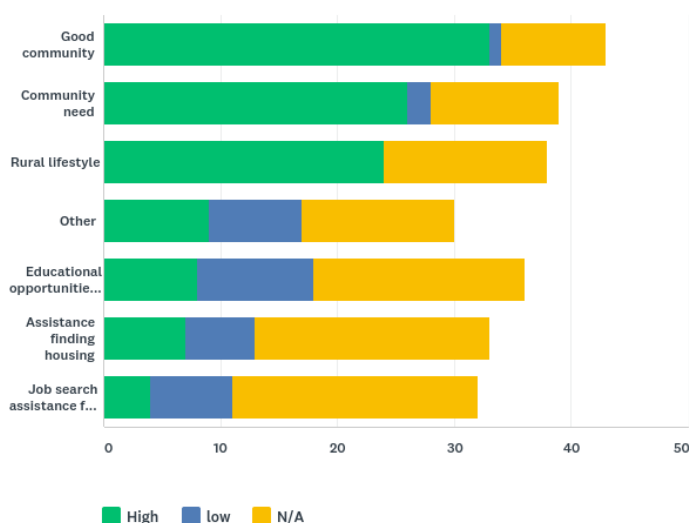
### Family and community strategies

Forty-seven respondents (37.6%) reported using family and community strategies to recruit and hire employees. Having a good community is the top-ranking strategy of 33 respondents (70.2%), followed by community need and rural lifestyle.

Ten respondents (4.7%) report that educational opportunities for children is the lowest-ranking strategy, although it is still found useful by eight respondents. Assistance with securing housing and job search assistance for spouses and partners are highly valued by very few respondents.

**Figure 60 Effective family and community strategies used in recruiting**

Q48 What family and community strategies has your organization found effective in filling positions? Please rank them, with 1 as the best. You can click and move the choices to rank them if you like.



## Financial incentives

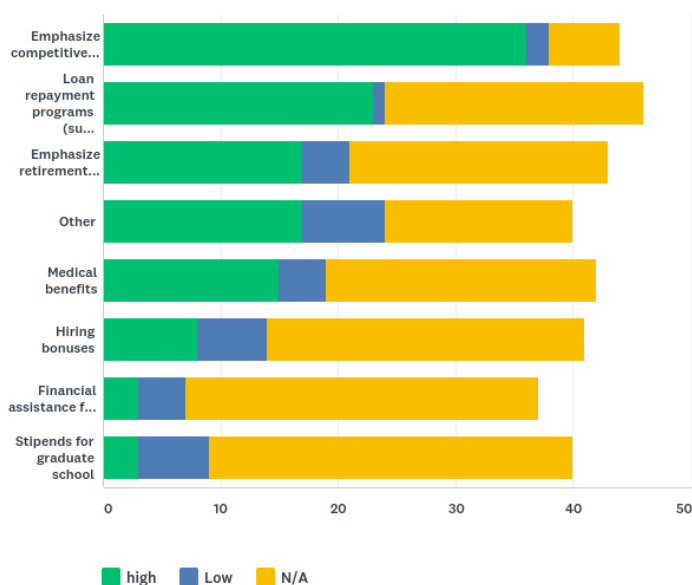
Fifty-six respondents (44.8%) reported using financial incentives to recruit and hire employees. Competitive wages and loan repayment programs were reported by 44 (78.5%) and 46 (82%) organizations respectively as the best incentives.

Thirty-one (77.5%) do not use stipends for graduate students, and 30 (81%) do not use financial assistance for relocation. Twenty-seven (65.85%) do not use hiring bonuses. Twenty-three (54.75%) responded Not Applicable about offering medical benefits as a financial incentive, and 22 (51.16%) do not emphasize retirement plans.

While the choice of “other” was offered, no other strategies were reported.

**Figure 61 Financial incentives used in recruiting**

Q49 What financial incentives has your organization used? Please rank them, with 1 as the best. You can click and move the choices to rank them if you like.

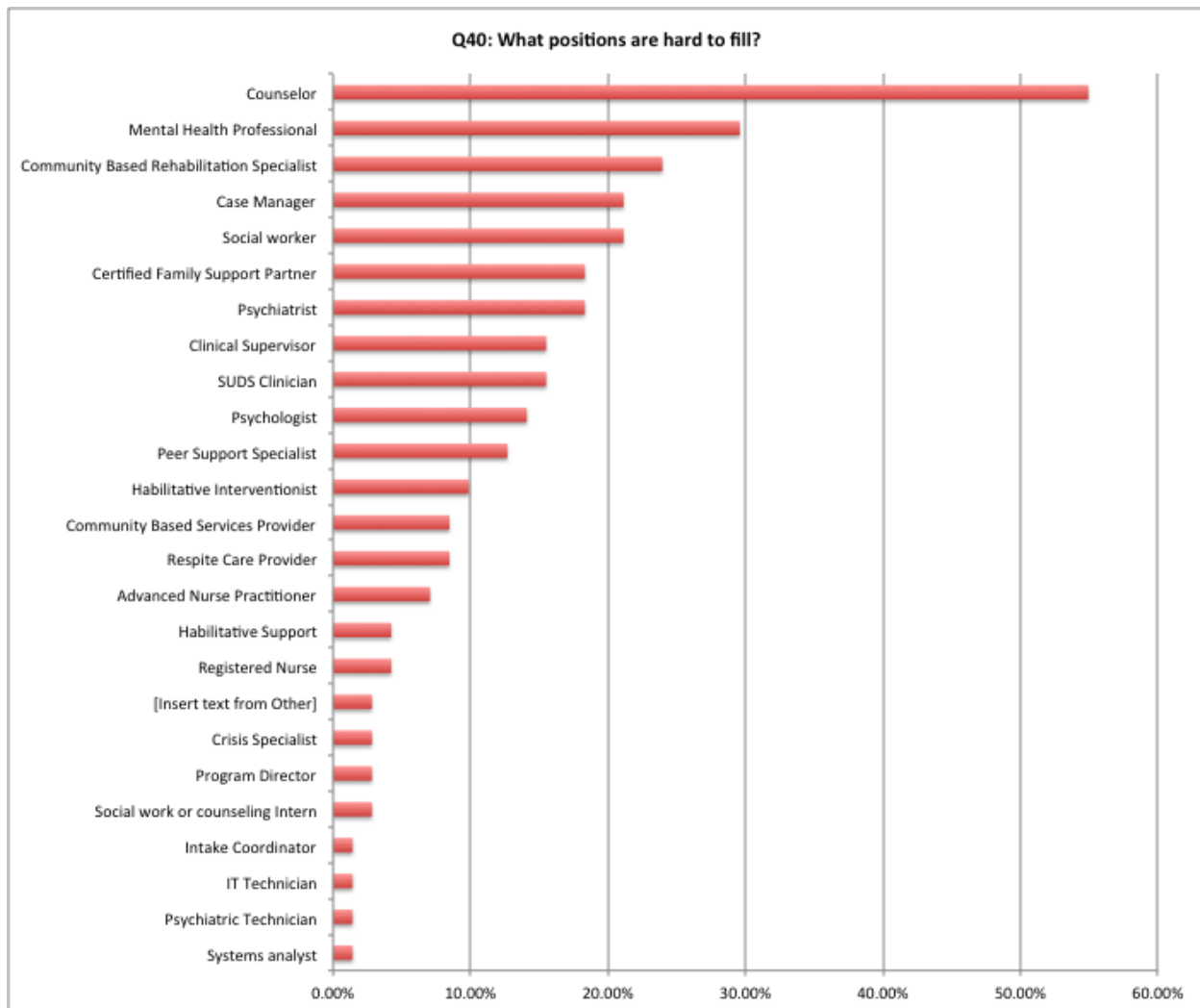


### Hard-to-fill positions

The survey asked about positions that are hard to fill.

Seventy-one respondents (56.8%) answered this question. They report that counselors are the most difficult positions to fill, followed by and mental health professionals and community-based rehabilitation specialists. However, the number of days that those positions are vacant shows that these positions may be easier to fill than some others.

Figure 62 Hard-to-fill positions



Respondents did not report that these positions are hard to fill:

- Training and quality assurance coordinator
- Rehabilitation Technician
- Pharmacy Tech
- Pharmacist
- Mental Health Technician
- Crisis Case Manager



### Managing vacancies

Seventy-five respondents answered this on hiring interim/temporary contractors (locum tenens) to keep services available while searching for permanent hires. Thirteen hire temporary contractors to continue services while searching for permanent hires. 82.7% do not.

### Vacancy rates

Forty-three respondents (34.4%) reported on the average number of days for vacant employee positions. While the shortage of psychiatrists is a national issue and the 151 days for a vacancy is not a surprise, the gap in crisis specialists is: the number of vacancy days reported is 162. In an earlier question, only two providers responded that crisis specialists are “hard to fill”.

Although clinical positions have a relatively shorter number of vacancy days, the number of providers identifying vacancies reveals a significant shortfall among respondents. Each counselor vacancy represents 87 days of no services. If each of the 125 respondents had one single vacancy in a counselor position in a year, there would be 10,875 fewer days of clinical service in the communities they serve in that year. Each Advance Nurse Practitioner vacancy represents 124 days without services. In combination, these days of vacancy represent system issues.

Figure 63 Average days of vacancy by position



One respondent reported that the mental health technician position was vacant an average of 365 days in a year.

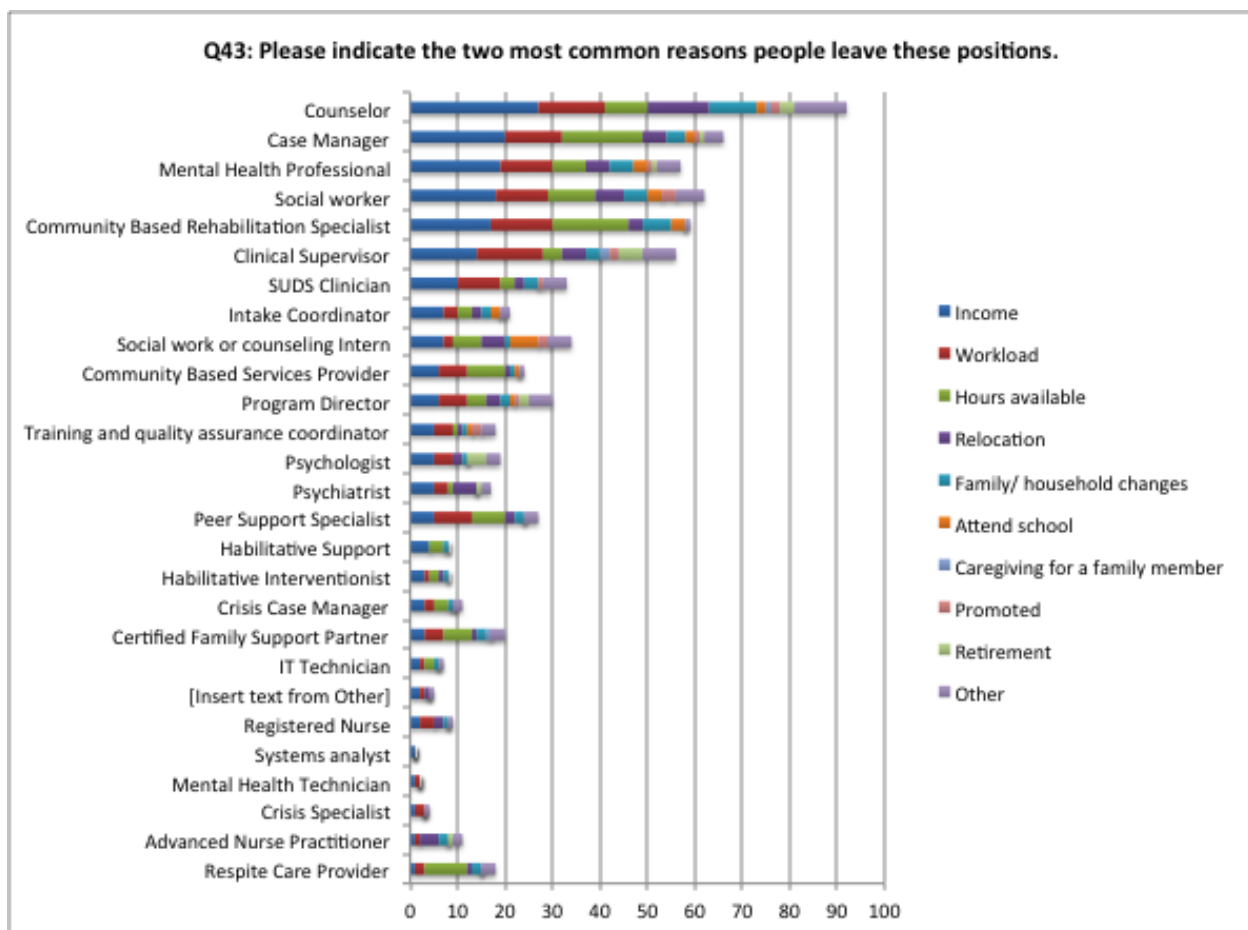
Respondents did not report vacancy rates for these positions:

- Pharmacist
- Pharmacy Tech
- Psychiatric Technician
- Rehabilitation Technician

### Reasons for turnover

Sixty-two respondents reported reasons for turnover. For clinical positions, the reasons are largely the same: income, workload, and hours available. For respite providers, the overwhelming reason is hours available. For peer support providers, it is workload and hours available. For certified family support partners, hours and workload are issues as well, followed closely by income. Habilitative specialists leave because of income. The issues for these five job classes have a direct impact on the capacity of community-based services in Idaho.

Figure 64 Two most common reasons for leaving each position



Respondents offered these other reasons for people leaving their positions:

- Benefits
- Can't compete with government on benefits.
- The unpaid admin hours
- Burnout
- Graduated and full time position not available
- Paying up to \$1,000 to obtain the CPRP
- Sometimes management is difficult.
- The majority of people leave because decrease in services offered due to state cutbacks.
- Since our pay is based on hourly pay, when a client does not show, our staff lose pay for non-billable time. Inconsistency of clients can be very hard for a person to count on making a decent living
- Flaking out of respite
- Termination of counselors related to capability or reliability
- We have not had anyone leave their position
- We have high retention rate.

Respondents did not report reasons people leave these positions:

- Pharmacist
- Pharmacy Tech
- Psychiatric Technician
- Rehabilitation Technician

### ***Sought-after characteristics***

Outside of minimum requirements, respondents report that there are other characteristics they prefer in hiring for a new position.

Comments include:

- Will they be good practitioners.
- We base it on experience, knowledge, and personality.
- College graduate, experience, faith based
- People who will do a good job and fit into the existing staff personality wise.
- People who have the skills to engage with clients and be successful, not necessarily the most experienced
- Willingness to learn
- Good documentation/computer abilities
- One respondent states: *"I could care less about evidence based. it is a joke and a myth. Every few years someone will slap a different label on the same techniques and call it a new evidence based program."*

### Gaps between education and readiness to practice

The researchers asked if there were gaps between education and readiness for practice that could be addressed by post-secondary education, such as credentials in specific types of services.

### Organizations

31 participants responded to this question. Five responded that there was no gap, or that it did not apply. Twenty-six responded that there were gaps.

These were:

#### Credentialing and certification

- Certification is specific evidence-based practices
- TBCBT
- DBT
- MBSR
- EMDR
- PRA - HI Certificate
- Classes for HI professionals
- There is a huge gap for HI providers as the certification requires 3 very specific classes for certification. Most graduates do not have all of the required classes even with an ABA degree
- If the employee is not licensed they need their CPRP, which is a difficult barrier to overcome. (2,000 hours of experience and nearly \$1,000 in cost with classes and exam.)
- Time it takes to get credentialed
- Only if the potential graduate knows he or she is going into the field; furthermore, knowing which position he or she is seeking. Then, offering ease of access to necessary additional certifications would benefit any gaps that do exist between academia and field application.

#### Training

- More easy, local, scheduled access to Peer support and Family support trainings
- More trauma focus in training counselors
- Trauma counseling skills
- There are many additional trainings that are highly valuable and effective that most clinicians do not get in school, i.e. EMDR, PCIT, Theraplay, EFT, etc. It seems all they get is CBT and intros to various models.
- More emphasis on providing community based services

#### Practical experience in the field

- Practicum placements
- Practicum. Mental health is a hard population to work with in-vivo, that can't be "learned" in a classroom
- EBT actual practice with skills
- More expertise in the field
- Observation in a wider variety of situations
- There is a growing gap in regards to therapists and application of theory in practice. New graduates are requiring a greater amount of training to independently apply theoretical concepts

in therapy.

#### Documentation skills

- Gaps in clinicians knowing how to write progress notes, write diagnostic assessments and write client centered master treatment plan goals, objectives and intervention
- Learning the true amount of paperwork involved in this practice

#### Business issues

- Emphasis on the real job market and how to navigate it
- The volatility of mental health services supported by the state make applicants hesitant to apply because there is no job security with services coming and going. Why invest in getting certified in a job you're not sure will exist next year?
- Culture shock about productivity required to reach income goals in our fee for service environment, characterized by a managed care company that expects several critical activities to be non-billable. Example collateral contacts necessary to coordinate care.
- The workforce was decimated by policies of the State of Idaho and its vendor, Optum Idaho beginning in 2013.

#### *Solo practitioners*

Twenty-one solo practitioners responded (22.8%). They state:

#### Credentialing and certification

- I would like to become certified in DBT and EMDR
- Credentialing takes waayyy too long. I had to pay out of pocket for office space and other business expenses for about six months before i got credentialed. Ridiculous!
- None are necessary, but many additional certifications are beneficial.

#### Training

- Yes, trainings would be fantastic.
- Billing and coding
- Trauma intervention
- Telehealth
- CBT, DBT, EMDR
- EMDR training
- EMDR training is difficult to access.
- I would like EMDR training but it's limited in Idaho and expensive.
- Suicide assessment and treatment
- Child-Centered Play Therapy
- Child-Parent Relationship Therapy
- Play Therapy
- Yes, training in the identified models is a gap such as trauma informed CBT, person centered planning, etc.
- Yes, more focus on therapy with children and teens
- Yes, huge gaps in the training of children's therapists. The local (Idaho-specific) counseling and social work graduate programs would be well advised to offer a unique training track for individuals who hope to work with traumatized children, and fast track, guided, post-graduation support for becoming a registered play therapist.

- Working with insurance
- Mental Health Billing; Training in business development; Navigating the system of insurance payers while advocating for fair reimbursements and easier access to extended sessions for clients; Contract negotiations as an Independent Contractor; Maintaining Sanity as a Provider While Navigating Medicare should be an entire semester!

#### Other

- Need standards for trauma therapy. Would like to see a trauma informed profession.
- Yes. There is a lack of networking and communication.

## Implications for Idaho's Youth Empowerment Services

### Services

It appears that services are generally made available Monday through Friday between 8 a.m. and 5 p.m., and to a degree, from 5 to 8 p.m. After 8 p.m. and on weekends, few services appear to be available in much of the state.

### Recommendation

- Expand certain services, particularly for times of day and days of week.
- The state can explore financial incentives such as rate differentials to encourage businesses to provide services in evenings, overnight, and on weekends.

### Crisis services

Most crisis services are not available during the evening, night, and on weekends—and almost 20 percent of communities appear to have no access to crisis services from respondents. Crisis services may not be available during the times and days that children, youth and their families experience crises.

Slightly less than one-third of organizations report providing crisis services via text, and two provide web-based services.

### Recommendations

- The state can target resources for crisis services. Data on crisis care needs may be best identified by engaging emergency service agencies statewide. When crises are not addressed at a behavioral health level, local emergency service providers (police, fire, and hospitals) generally end up addressing the crisis.
- Technology such as text and web-based services can provide better access to crisis services for youth and young adults.

### Medication management

Nampa, Boise, Caldwell, Idaho Falls, and Ammon are served by the most respondents that provide medication management.

Fifty communities have access to medication management by one organization. Sixty-five communities have no medication management access from respondents.

### Recommendation

Work with providers and prescribers to expand access to medication management.

### Case management

43 communities receive no case management services. 51 communities receive case management services by one organization each.

Most organizations reported that they provide case management services in Boise, Meridian, Nampa, Caldwell, Idaho Falls, Blackfoot and Eagle. Nine solo practitioners report providing services in the earlier question. When asked where they provide services, they report delivering case management in 27 communities, mainly in regions 1, 3, and 4.

### Recommendation

Watch for conflict-free case management requirements. The federal Center for Medicaid and Medicare Services (CMS) has required senior and disability services to move into conflict-free case management, in

which the case management agency is separate from the service delivery agencies used by the individual. If CMS were to expand this requirement for conflict-free case management into behavioral health, these organizations would not be able to provide case management as well as direct services.

### Critical community-based services

Very few respondents stated that their organizations provide respite care, wraparound services. More provide social skills training and community-based rehabilitation services. For families who have children and youth with severe emotional disturbances, this lack of critical services could be a barrier to keeping their children home.

For wraparound services particularly, providers point to barriers in billing for service. Coordination and non-clinical services take time that is not clearly billable to the respondents.

### Recommendations

- Support providers in developing services statewide.
- Confirm and clarify billing practices for wraparound services, including coordination and other non-clinical services.

### Evidence-based practices

Many of the providers—organizations and solo practitioners—express interest in expanding services using evidence-based practices. They would like local, low-cost training and credentialing so they can provide these services.

### Recommendation

Ensure that low-cost training in evidence-based practices is offered frequently and locally to providers around the state.

### Telehealth

Very few providers of any kind stated that their practice or organization uses technology in providing services. This may be an issue of state licensing boards or of reimbursement.

Children and youth use technology at high rates. Telehealth modalities offer flexibility and discretion for the user, and can allow for services to be offered from a distance when transportation is a barrier.

Idaho reimburses certain providers for a series of behavioral health services, whether delivered by telehealth or face-to-face. Providers must be physicians working in a mental health clinic; working under a managed care contract; supervising community-based rehabilitation services delivered in an educational environment. (State of Idaho, Department of Health and Welfare, Division of Medicaid, 2016) These codes are:

Code Description	Reimbursement
90791 Psychiatric Diagnostic Evaluation	\$115.28
90792 Psychiatric Diagnostic Eval W/Medical Services	\$128.66
90832 Psychotherapy Patient & / Family 30 Minutes	\$56.25
90833 Psychotherapy Pt & /Family W/E & M Services 30 Min	\$58.03
90834 Psychotherapy Patient & / Family 45 Minutes	\$74.76
90836 Psychotherapy Pt & /Family W/E & M Services 45 Min	\$73.44
90837 Psychotherapy Patient & / Family 60 Minutes	\$112.09
90838 Psychotherapy Pt & /Family W/E & M Services 60 Min	\$96.80



96150 Health & Behavior Assessment, Each 15 Min W/Pt 1st Assessment	\$19.10
96151 Health & Behavior Assessment, Each 15 Min W/Pt Re- Assessment	\$18.45
96152 Health & Behavior Intervention, Each 15 Min Individual 96153 Health & Behavior Intervention, Each 15 Min Group 2/Gt Patients	17.51
96154 Health & Behavior Intervention, Each 15 Min Family W/Pt	17.19
97110 Therapeutic procedure, 1 or more areas, each 15 minutes	
H2011 Therapeutic consultation	Medicaid reimbursement for this code is not listed on Medicaid website 4/15/18
H2019 Crisis intervention	Medicaid reimbursement for this code is not listed on Medicaid website 4/15/18
T1013 Language Interpretive – Oral Services, per 15 minutes	\$12.50
T1013 – CG Sign Language Interpretive Services, per 15 minutes	\$12.50

(State of Idaho, Department of Health and Welfare, 2016)

The following behavioral health service codes are not reimbursable if delivered by telehealth but are reimbursable if delivered face-to-face:

Code	Code Description	Amount
90853	Group psychotherapy	\$22.58
90853	Group psychotherapy	\$8.89
90863	Pharmacologic management w/psychotherapy	\$50.22
90885	Psychiatric eval hospital records dx purposes	\$34.50
90887	Interpj/explnaj results psychiatric exam family	\$48.59
90889	Prep report pt psych status agency/payer	\$48.55

(State of Idaho, Department of Health and Welfare, 2016)

### Recommendation

- Educate providers on billing codes that are available for telehealth.
- Consider reviewing reimbursement parameters for telehealth to expand the number of clinical professionals who can bill for telehealth services.

### Small business development training and funding: infrastructure and start-up

The solo practitioners are small business owners. They have interest in expanding their practices and in hiring employees to deliver services, subject to demand for services. They express concerns about the financial and business infrastructure needed to expand into some of the services that the state may be interested in providing.

### Recommendations

- Support small behavioral health businesses in securing development training and funding to increase their ability to meet the needs of Idaho's youth. There are federal and potentially state funds available for this, outside of IDHW.
  - The U.S. Small Business Administration offers business development training and loans to businesses that are starting up or growing. (U.S. Small Business Administration) (U.S. Small Business Administration)

- The Idaho Workforce Development Council advises the Governor on investing in Idaho's workforce. (State of Idaho, Department of Labor)
- Health care and social services is the top major industrial sector in Idaho, and the highest demand industry. (State of Idaho, Department of Labor, Workforce Development Council, 2018)
- Some of these small businesses could benefit from training on clinical documentation and billing practices.

### Confirm reimbursement rate-setting regularly

It appears that reimbursement rates are a concern for some providers, both organizations and solo practitioners. The majority of Idaho's behavioral health providers appear to be for-profit businesses. They do not have access to charitable donations and grants as non-profits do.

### Recommendations

- The state should regularly confirm the competitiveness of reimbursement rates for services.
- The for-profit business provider community should be engaged in the rate-setting process to confirm consistency with costs for services.

### Workforce

Idaho appears to be on track to addressing its shortage of counselors, mental health professionals, and social workers. In the past five years, Idaho has almost doubled the number of LPCs and LCSWs in the state. The university systems in Idaho have done an excellent job in producing more clinical workforce, and can continue to do so.

Even so, survey respondents report that counselors and mental health professionals are the hardest employees to recruit. In the North Central Idaho, vacancy rates are reported at 45% and in the North Idaho, 24% (State of Idaho, Department of Labor, Communications & Research Division, 2018)

Respondents reported that the gender of staff is overwhelmingly female (86% for solos, 75.38% for organizations). The state's mix is 49.9% female to 50.1% male.

While the diversity of organization employees appears similar to statewide population, there are opportunities to expand diversity of the field overall—particularly in recruiting Hispanic and Latino and American Indian employees in Tribes. Idaho has high population density communities that are specifically American Indian, including the four federally recognized Tribes, as well as communities that are half or more Hispanic or Latino.

Hispanic and Latino people comprise 12% of people in Idaho, according to the U.S. Census, and organizations reported only 3.7% of employees who are Hispanic or Latino of any race.

The percentage of American Indian and Alaska Native employees is just more than half the percentage of Indian and Native people in the state. The percent of employees who are Black or African American is just less than half the state population. The percent of Asian employees is 1/7 the percent of the state's Asian population, and the percent of employees of "other" races is 79% lower than the rest of the state

Almost half of the organizations responding reported that they have staff that speak and understand Spanish, and can deliver services in Spanish. Only 11% of solo practitioners speak and understand Spanish.

Idaho has high population density communities that are specifically American Indian, including tribal communities, as well as communities that are almost half Hispanic or Latino.

### Recommendations

- The state, educators and providers can look at the reported demographics as an opportunity to grow the field in targeted ways: educating and placing more Hispanic and Latino, Indian and Native people specifically.
- The state and university systems can work directly with tribes to ensure that tribal communities have access to culturally appropriate services delivered by American Indian providers.
- The state and university systems can work with predominant Hispanic and Latino communities to recruit Hispanic or Latino workers into the field, particularly those who speak Spanish.
- The state and university systems can encourage men to study and work in the field to balance the gender mix of providers.

### Recruitment & Retention

#### Barriers to recruiting

The biggest barriers are locating qualified candidates and offering competitive salary and benefits. To a much smaller degree, geographic isolation plays a part for recruiting counselors, mental health professionals, clinical supervisors, case managers, and social workers.

In recruiting psychologists and psychiatrists, geographic isolation is a larger barrier than it is for these other positions.

#### Recruiting strategies

Respondents reported their top two recruiting strategies for positions:

- Word of mouth and networking
- Recruiting websites such as Indeed.com
- Craigslist and similar internet job boards follow closely.

Few respondents reported using LinkedIn, an international professional networking database.

Of note, some respondents reported using a U.S. Visa waiver program to recruit for six positions that are clinical and supervisory. If federal law on visas changes, this could be a limited strategy for the future.

Respondents reported using family and community strategies to recruit and hire employees.

- Good community
- Community need
- Rural lifestyle.

Slightly fewer than half of organizational respondents said they use financial incentives to recruit and hire employees.

- Loan repayment programs
- Competitive wages

Respondents do not use these strategies for recruiting:

- Stipends for graduate students
- Financial assistance for relocation
- Hiring bonuses
- Medical benefits

- Retirement plans

#### *Recommendations*

- The state can regularly examine reimbursement rates and profitability so organizations can hire and keep employees.
- The state can encourage employers to use most current methods of recruiting. Word of mouth may not enough when there is a shortage of workers.
- The state can encourage employers to consider financial incentives to recruit and retain employees, such as
  - Medical benefits
  - Retirement benefits
  - Hiring bonuses and
  - Graduate stipends
- Monitor U.S. Visa waiver program changes. If federal law on visas changes, this could be a limited recruitment and hiring strategy for the future.

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## Appendix A

### Organizational provider survey instrument

A view of the survey instrument may be found here:

[https://www.surveymonkey.com/r/Preview/?sm=codcKAOiB5xsnLO4A\\_2BgkvKAqIpM\\_2FNfy80lKKE\\_T4OqUKVDaWBNj8AYPYApg59qI0U](https://www.surveymonkey.com/r/Preview/?sm=codcKAOiB5xsnLO4A_2BgkvKAqIpM_2FNfy80lKKE_T4OqUKVDaWBNj8AYPYApg59qI0U)

The survey is closed. Clicking through the survey does not alter survey responses.

### Solo provider survey instrument

A view of the survey instrument may be found here:

[https://www.surveymonkey.com/r/Preview/?sm=2Bjo9RhNuf1\\_2F7uhrfpNsNKVLprhfYA78wFg8ARhVzrnmEyZ6PjzUvy9LvSFye\\_2BkO](https://www.surveymonkey.com/r/Preview/?sm=2Bjo9RhNuf1_2F7uhrfpNsNKVLprhfYA78wFg8ARhVzrnmEyZ6PjzUvy9LvSFye_2BkO)

The survey is closed. Clicking through the survey does not alter survey responses.

## DHW introduction letter



# IDAHO DEPARTMENT OF HEALTH & WELFARE

C. L. "BOBBI" OTTER - Governor  
RUSSELL S. BARRON - Director

ROSS EDMUNDS - Administrator  
DIVISION OF BEHAVIORAL HEALTH  
453 West Blaine Street, 3rd Floor  
P.O. Box 83720  
Boise, Idaho 83720-0016  
PHONE: 208-334-6997

Date: January 9, 2018

### IDAHO DEPARTMENT OF HEALTH AND WELFARE INFORMATION RELEASE

To: Chief Executives/ Executive Directors of Idaho Mental Health Provider Agencies  
From: Ross Edmunds, Administrator  
Subject: YES Workforce Development Survey

Dear Idaho Mental Health Provider,

I am writing to request your help with an important study being conducted by Boise State University and Rider Consulting on behalf of the Idaho Department of Health and Welfare to better understand the strengths and needs of Idaho's mental health services workforce. As you know, the State of Idaho will soon be implementing a children's mental health system transformation called Youth Empowerment Services or YES (<http://youthempowermentservices.idaho.gov/>). In order to effectively implement this system transformation, it is critical that we begin with a clear understanding of the services our State's workforce provides, the types of services they could provide with the proper resources, and challenges to maintaining the workforce. Your responses are critical to helping YES succeed.

Within the next few days you will receive an email inviting you or your designee to participate in an online survey that asks about these issues. We would like to do everything we can to make it easy and enjoyable for you or your designee to participate in this study. This research can only be successful with the generous help of providers like you.

The results of this research will be presented in aggregate to the Idaho Department of Health and Welfare and will be used to help make system-level changes that support providers in delivering services to youth. I hope you will take 20 minutes of your time to help us. Most of all, I hope that you enjoy the opportunity to share your experiences and voice your ideas regarding Idaho's mental health workforce.

Best wishes,



Ross Edmunds, Administrator  
Division of Behavioral Health  
Department of Health and Welfare

## Follow-up email #1

### Organizations

Reminder: Idaho DHW Workforce Survey

Dear \*\*\*,

We recently emailed and requested your participation in a survey we are conducting on behalf of the Idaho Department of Health and Welfare regarding workforce needs in Idaho's children's mental health service system. Your responses to this survey are important as they will help guide the development and implementation of new community-based services in Idaho as part of its Youth Empowerment Services (YES) system re-design.

This survey is relatively short and should take only twenty to twenty-five minutes to complete. If you have already completed the survey, we greatly appreciate your participation. If you have not yet responded to the survey, we encourage you to take a few minutes and complete the survey.

Please click on the link below to go to the survey website (or copy and paste the survey link into your internet browser) and begin the survey. The survey will remain open until XXXXXXXX.

Survey Link: [https://www.surveymonkey.com/r/IdahoBSU\\_Workforce](https://www.surveymonkey.com/r/IdahoBSU_Workforce)

Your responses are critically important because as a provider you fill a particular and important niche in your community. Understanding your specific experiences is necessary for developing a complete picture and supporting providers with the new YES service array. Thank you for your help by completing this survey.

Sincerely,

Dr. Nate Williams  
Assistant Professor  
Boise State University  
School of Social Work

Mary Elizabeth Rider  
Principal  
Rider Consulting Group



### Solo providers

Reminder: Idaho DHW Workforce Survey

Dear \*\*\*,

We recently emailed and requested your participation in a survey we are conducting on behalf of the Idaho Department of Health and Welfare regarding workforce needs in Idaho's children's mental health service system. Your responses to this survey are important as they will help guide the development and implementation of new community-based services in Idaho as part of its Youth Empowerment Services (YES) system re-design.

This survey is relatively short and should take only ten minutes to complete. If you have already completed the survey, we greatly appreciate your participation. If you have not yet responded to the survey, we encourage you to take a few minutes and complete the survey.

Please click on the link below to go to the survey website (or copy and paste the survey link into your internet browser) and begin the survey. The survey will remain open until 2/22/18.

Survey Link: Survey Link: <https://www.surveymonkey.com/r/IdahoBSUworkforce>

Your responses are critically important because as a provider you fill a particular and important niche in your community. Understanding your specific experiences is necessary for developing a complete picture and supporting providers with the new YES service array. Thank you for your help by completing this survey.

Sincerely,

Dr. Nate Williams  
Assistant Professor  
Boise State University  
School of Social Work

Mary Elizabeth Rider  
Principal  
Rider Consulting Group

## Follow-up email #2

### Organizations

Dear \*\*\*,

The beginning of the year is a particularly busy time for mental health providers, and we understand how valuable your time is as you try to meet your clients' needs. We are hoping that you may be able to share some of your time with us to help us better understand the strengths and needs of Idaho's mental health services and workforce. Would you please help us develop a more complete picture of the breadth and depth of Idaho's services, workforce, and ways that the State can support providers in delivering care?

If you have already completed the survey, we greatly appreciate your participation. If you have not yet responded, we would like to urge you to complete the survey. Please click on the link below to go to the survey website (or copy and paste the survey link into your internet browser) before 2/22/18.

Survey Link: [https://www.surveymonkey.com/r/IdahoBSU\\_Workforce](https://www.surveymonkey.com/r/IdahoBSU_Workforce)

Thank you in advance for completing the survey. Your responses are critical for helping guide the State in implementing the new Youth Empowerment Services (YES).

Sincerely,

Dr. Nate Williams  
Assistant Professor  
Boise State University  
School of Social Work

Mary Elizabeth Rider  
Principal  
Rider Consulting Group

### Solo providers

Dear \*\*\*,

The beginning of the year is a particularly busy time for mental health providers, and we understand how valuable your time is as you try to meet your clients' needs. We are hoping that you may be able to share some of your time with us to help us better understand the strengths and needs of Idaho's mental health services and workforce. Would you please help us develop a more complete picture of the breadth and depth of Idaho's services, workforce, and ways that the State can support providers in delivering care?

If you have already completed the survey, we greatly appreciate your participation. If you have not yet responded, we would like to urge you to complete the survey. Please click on the link below to go to the survey website (or copy and paste the survey link into your internet browser) before 2/22/18.

Survey Link: Survey Link: <https://www.surveymonkey.com/r/IdahoBSUworkforce>

Thank you in advance for completing the survey. Your responses are critical for helping guide the State in implementing the new Youth Empowerment Services (YES).

Sincerely,

Dr. Nate Williams  
Assistant Professor  
Boise State University  
School of Social Work

Mary Elizabeth Rider  
Principal  
Rider Consulting Group

## Telephonic follow-up protocol and script

Goal: to secure participation in the survey.

### Instructions for calls

#### Location for the call

- Boise State University offices.

### Instructions for the interviewer

#### Preparation

- Have the interview tool link available to share with the organization representative.

#### Principles for interviews

- We want to help you and the State of Idaho have a clear picture of statewide workforce strengths and gaps to better serve children in the state and help guide the implementation of the YES Youth Empowerment Services that the State is developing.

#### Use effective call techniques

- Use appropriate vocal language: open, engaged, and not closed.
- The respondent's reaction often mirrors that of the caller. The caller's pleasant, positive, well-informed approach will be reflected in the respondent's readiness to participate.

### Instructions for conducting the call

#### Intro Script

Hi, my name is \_\_\_\_\_ and I am a graduate research assistant with the Department of Social Work at Boise State University. I am calling on behalf of Dr. Nate Williams to follow-up about a survey we are conducting for the Idaho Department of Health and Welfare on Idaho's mental health services workforce. The survey is part of the new Youth Empowerment Services or YES initiative that the State is launching.

FOR GROUP PRACTICES:

Dr. Williams emailed the survey to several contact persons at \_\_\_\_\_ (agency name) \_\_\_\_\_ on \_\_\_\_\_ (date) \_\_\_\_\_. We've not heard back yet, so I wanted to check in to see if the survey had gotten through, answer any questions, and encourage a representative from \_\_\_\_\_ to respond.

The survey should be completed by an HR Director, the Executive Director, or someone else with thorough knowledge of your agency. Is there someone available that I could talk to about this? I understand how valuable time is, so the conversation will take no more than two minutes.

FOR SOLO PRACTICES:

Dr. Williams emailed the survey to \_\_\_\_ (contact person) \_\_\_\_ on \_\_\_\_ (date) \_\_\_\_\_. We've not yet heard back, so I wanted to check in to see if the survey had gotten through, answer any questions, and encourage \_\_\_\_ (contact person) \_\_\_\_ to respond if they're interested in participating.

Would it be possible to talk with \_\_\_\_ (contact person) \_\_\_\_ briefly? I understand how valuable time is, so the conversation will take no more than two minutes.

IF UNAVAILABLE: Is there a better time I could call back? Would it be ok to send a follow-up by email? What is \_\_\_\_ (contact person) \_\_\_\_ preferred email address?

### During the call

- Tell the respondent about the survey opportunity, and that organizations like theirs are under-represented. Can they complete the survey today?
- Be ready to email the survey link directly to the person on the phone. Have the internet browser open and the email primed and ready. If the person requests it, send them the Telephone Follow-up Email with the link embedded. **Be sure to enter the person's name in the greeting before sending the email.**
- Be ready to answer questions:
  - The survey is anonymous because the SurveyMonkey software automatically separates their responses from any email address. It is not possible for anyone to know how they responded.
  - The raw, de-identified data will only be handled by Boise State University and Rider Consulting. IDHW will receive only aggregate reports. No report will ever be made that links responses to any identifiable information.
  - The goal of the survey is to better understand Idaho's existing children's mental health service capacity and workforce, including areas of strengths and needs, as well as services providers are interested in delivering and their suggestions for how to improve service delivery and workforce capacity in Idaho.
  - Even if a provider only serves adults we request that they open the survey and indicate this. The third question specifically asks if they serve persons ages 18 and under; if they don't they can indicate this and the survey will be concluded. This is extremely important information for us because it helps us know what percentage of the network is interested in or has the capacity to serve youth. Understanding this can help identify gaps where the State needs to support providers.
  - Dr. Williams would be very happy to talk with anyone about the survey if they would like. They should email him directly at [natewilliams@boisestate.edu](mailto:natewilliams@boisestate.edu) or they can call him and leave a message at 208-426-3145.

### Concluding the call

- Thank the respondent for their help.
- We will have a draft analysis to share before completing the final report. Would they like to help us by reviewing the draft?

## Final follow-up reminder

### Organizations

Dear \*\*\*,

We're reaching out one final time to encourage you to share your responses to the Idaho Department of Health and Welfare YES Workforce Survey. This important survey closes soon—at midnight on February 23—and we want to ensure that your practice is represented in the results. This will be our last reminder.

Here is a direct link to the survey: [https://www.surveymonkey.com/r/IdahoBSU\\_Workforce](https://www.surveymonkey.com/r/IdahoBSU_Workforce)

Thank you very much in advance for your participation!

Warm regards,

Nate Williams

Mary Elizabeth Rider

### Solo providers

Dear \*\*\*,

We're reaching out one final time to encourage you to share your responses to the Idaho Department of Health and Welfare YES Workforce Survey. This important survey closes soon—at midnight on February 23—and we want to ensure that your practice is represented in the results. This will be our last reminder.

Here is a direct link to the survey: <https://www.surveymonkey.com/r/IdahoBSUworkforce>

Thank you very much in advance for your participation!

Warm regards,

Nate Williams

Mary Elizabeth Rider

## Appendix B: NAICS codes and occupational titles

NAICS codes are assigned by the federal Bureau of Labor Statistics. Each employment in the United States is assigned such a code at the beginning of employment. Self-employed people assign their own codes in the process of licensing their businesses.

The codes below were selected for use in this survey based on the job titles selected for the surveys. The profiles for each occupational title are available by clicking through the title.

Occupation code	Occupation title
19-3031	<a href="#">Clinical, Counseling, and School Psychologists</a>
19-3039	<a href="#">Psychologists, All Other</a>
21-0000	<a href="#">Community and Social Service Occupations</a>
21-1011	<a href="#">Substance Abuse and Behavioral Disorder Counselors</a>
21-1013	<a href="#">Marriage and Family Therapists</a>
21-1014	<a href="#">Mental Health Counselors</a>
21-1015	<a href="#">Rehabilitation Counselors</a>
21-1021	<a href="#">Child, Family, and School Social Workers</a>
21-1022	<a href="#">Healthcare Social Workers</a>
21-1023	<a href="#">Mental Health and Substance Abuse Social Workers</a>
21-1029	<a href="#">Social Workers, All Other</a>
21-1093	<a href="#">Social and Human Service Assistants</a>
21-1094	<a href="#">Community Health Workers</a>
21-1099	<a href="#">Community and Social Service Specialists, All Other</a>
29-0000	<a href="#">Healthcare Practitioners and Technical Occupations</a>
29-1051	<a href="#">Pharmacists</a>
29-1066	<a href="#">Psychiatrists</a>
29-1071	<a href="#">Physician Assistants</a>
29-1141	<a href="#">Registered Nurses</a>
29-1171	<a href="#">Nurse Practitioners</a>
29-1199	<a href="#">Health Diagnosing and Treating Practitioners, All Other</a>
29-2053	<a href="#">Psychiatric Technicians</a>
29-2061	<a href="#">Licensed Practical and Licensed Vocational Nurses</a>
29-2071	<a href="#">Medical Records and Health Information Technicians</a>
31-9099	<a href="#">Healthcare Support Workers, All Other</a>

## Appendix C: Idaho cities with populations of 100 or more, by population

City Name	2014 Census Population
Boise	214,237
Nampa	86,518
Meridian	83,596
Idaho Falls	58,292
Pocatello	54,350
Caldwell	48,957
Coeur d'Alene	46,402
Twin Falls	45,981
Lewiston	32,401
Post Falls	29,357
Rexburg	26,520
Moscow	24,534
Eagle	21,646
Kuna	16,532
Ammon	14,460
Chubbuck	14,125
Mountain Home	13,805
Hayden	13,681
Blackfoot	11,854
Garden City	11,260
Jerome	11,038
Burley	10,456
Hailey	8,014
Sandpoint	7,577
Payette	7,430
Rathdrum	7,090
Star	6,623
Emmett	6,519
Middleton	6,003
Rupert	5,617
Weiser	5,333
Preston	5,168
Fruitland	4,754
Shelley	4,396
American Falls	4,376
Buhl	4,214
Rigby	4,043
Gooding	3,475

City Name	2014 Census Population
St. Anthony	3,465
Kimberly	3,432
Heyburn	3,170
Grangeville	3,123
Orofino	3,087
Salmon	3,027
Soda Springs	2,975
McCall	2,925
Wendell	2,709
Ketchum	2,706
Homedale	2,610
Filer	2,602
Montpelier	2,543
Bonn timers Ferry	2,473
Dalton Gardens	2,361
St. Maries	2,333
Bellevue	2,286
Kellogg	2,117
Malad	2,063
Parma	2,043
Spirit Lake	2,001
Aberdeen	1,954
Victor	1,938
Iona	1,880
Priest River	1,720
Driggs	1,657
Pinehurst	1,619
Wilder	1,577
Osburn	1,545
New Plymouth	1,513
Shoshone	1,494
Sun Valley	1,408
Sugar City	1,377
Kamiah	1,320
Marsing	1,316
Glenns Ferry	1,253
Hansen	1,212
Paul	1,191



<b>City Name</b>	<b>2014 Census Population</b>
Lapwai	1,146
Ucon	1,124
Ponderay	1,111
Challis	1,085
Ashton	1,084
Plummer	1,017
Genesee	952
Arco	910
Cottonwood	910
Cascade	904
Grace	899
Troy	882
Greenleaf	875
Inkom	856
Hagerman	851
Council	805
Potlatch	800
McCammon	797
Wallace	781
Oakley	777
Hazelton	747
Menan	741
Kootenai	736
Franklin	729
Teton	712
Moyie Springs	696
Mullan	692
Athol	689
Hauser	672
Horseshoe Bend	666
Ririe	635
Downey	622
Smelterville	621
Carey	600
Kooskia	598
Dubois	596
Hayden Lake	589
Roberts	584
Juliaetta	572
Dover	553
Notus	544

<b>City Name</b>	<b>2014 Census Population</b>
Clark Fork	527
Melba	526
Craigmont	515
Paris	510
Deary	508
Mackay	494
Pierce	494
Richfield	494
Nezperce	476
Lewisville	471
Firth	469
Georgetown	469
New Meadows	469
Idaho City	459
Dayton	457
Grand View	447
Weston	432
Weippe	414
Riggins	413
Lava Hot Springs	404
Eden	402
Basalt	392
Fairfield	384
Culdesac	382
Bancroft	369
Mud Lake	366
Arimo	358
Declo	349
Winchester	344
Dietrich	334
Cambridge	315
Newdale	314
Bliss	307
Kendrick	300
Parker	296
Rockland	294
Clifton	279
Island Park	276
Hollister	273
Albion	272
Tetonia	266

<b>City Name</b>	<b>2014 Census Population</b>
Bovill	256
Worley	254
Castleford	230
Irwin	222
Stites	216
Swan Valley	214
Harrison	210
East Hope	207
Bloomington	205
Malta	196
Peck	195
Wardner	185
Onaway	183
Oldtown	180

<b>City Name</b>	<b>2014 Census Population</b>
Fernan Lake	172
Moore	169
Ferdinand	160
Midvale	160
Crouch	156
Donnelly	137
St. Charles	136
Acequia	125
Elk River	122
Murtaugh	118
Tensed	116
Minidoka	113
Leadore	102
Huetter	101

## Appendix D Maps

Table 7 List of BatchGeo maps and urls

Map Title	Updated	URL
All cities served: organizations & solo providers	04/15/18	<a href="https://batchgeo.com/map/b2e0131e15aae0622d20e145f9d15f31">https://batchgeo.com/map/b2e0131e15aae0622d20e145f9d15f31</a>
American Indian population of Idaho 2016	04/16/18	<a href="https://batchgeo.com/map/01a5688f2a24e4dff499c8ed567a9421">https://batchgeo.com/map/01a5688f2a24e4dff499c8ed567a9421</a>
Case Management by Organizations	04/15/18	<a href="https://batchgeo.com/map/25ff7204509eaa53dd12790c17b6a67a">https://batchgeo.com/map/25ff7204509eaa53dd12790c17b6a67a</a>
Case Management by Solos	04/15/18	<a href="https://batchgeo.com/map/bcd4ebb04976f5331b3e05d12bd58091">https://batchgeo.com/map/bcd4ebb04976f5331b3e05d12bd58091</a>
Child and Family Counseling by Organizations	04/13/18	<a href="https://batchgeo.com/map/7804275e2538d823911428beb38c0433">https://batchgeo.com/map/7804275e2538d823911428beb38c0433</a>
Child and Family Counseling by solos	04/13/18	<a href="https://batchgeo.com/map/d732265b05f392094e7787aab0a102f1">https://batchgeo.com/map/d732265b05f392094e7787aab0a102f1</a>
Cities Served by Organizations	04/13/18	<a href="https://batchgeo.com/map/f52f39a6577153cae9620f452eb17982">https://batchgeo.com/map/f52f39a6577153cae9620f452eb17982</a>
Cities Served by Sole Practitioners	04/13/18	<a href="https://batchgeo.com/map/4f2d045101ff9e8042ae5d8c07009703">https://batchgeo.com/map/4f2d045101ff9e8042ae5d8c07009703</a>
Community-based Rehab Services by Organizations	04/15/18	<a href="https://batchgeo.com/map/f5c93da23582f547c8918d32e88dda26">https://batchgeo.com/map/f5c93da23582f547c8918d32e88dda26</a>
Community-based Rehabilitation Services by Solos	03/30/18	<a href="https://batchgeo.com/map/0f6cb5d5cad1b3925551a71ad4c78dc5">https://batchgeo.com/map/0f6cb5d5cad1b3925551a71ad4c78dc5</a>
Crisis Services by Organizations	04/13/18	<a href="https://batchgeo.com/map/2147ff16e2fbfa660d0e7cc8bca51818">https://batchgeo.com/map/2147ff16e2fbfa660d0e7cc8bca51818</a>
Crisis Services by Solos	04/15/18	<a href="https://batchgeo.com/map/75b86cf5f2d096cd8240b8a0b11e3b06">https://batchgeo.com/map/75b86cf5f2d096cd8240b8a0b11e3b06</a>
Days services provided by Organizations	04/13/18	<a href="https://batchgeo.com/map/70438fedba0707943a9eb5d69f104abc">https://batchgeo.com/map/70438fedba0707943a9eb5d69f104abc</a>
Days services provided by Solos 2017	04/13/18	<a href="https://batchgeo.com/map/878a4b6bd4e28a682427f8eb039b9077">https://batchgeo.com/map/878a4b6bd4e28a682427f8eb039b9077</a>
Est. Idaho Population under 18 2016	04/16/18	<a href="https://batchgeo.com/map/9519df1247b56ca365455ae486e0da66">https://batchgeo.com/map/9519df1247b56ca365455ae486e0da66</a>
Group counseling by orgs	04/13/18	<a href="https://batchgeo.com/map/53abb353c879740677fbb574485227f0">https://batchgeo.com/map/53abb353c879740677fbb574485227f0</a>
Group counseling by solos	04/13/18	<a href="https://batchgeo.com/map/a8f80de5199efe6fb141e03aa714a56c">https://batchgeo.com/map/a8f80de5199efe6fb141e03aa714a56c</a>
Hispanic or Latino population 2016	04/16/18	<a href="https://batchgeo.com/map/4780cccde43c9f20923ac72e8a63b688">https://batchgeo.com/map/4780cccde43c9f20923ac72e8a63b688</a>
Idaho 2014 population by city	03/30/18	<a href="https://batchgeo.com/map/ccc9d8d0ebacc05510cdf950f3dfe30b">https://batchgeo.com/map/ccc9d8d0ebacc05510cdf950f3dfe30b</a>
Individual counseling by Organizations	04/13/18	<a href="https://batchgeo.com/map/ae63c7f1e70ed0b545a20c482a79351b">https://batchgeo.com/map/ae63c7f1e70ed0b545a20c482a79351b</a>
Individual Counseling by Solos	04/13/18	<a href="https://batchgeo.com/map/6f080b1ebd9de5b48bf965bd5335e7db">https://batchgeo.com/map/6f080b1ebd9de5b48bf965bd5335e7db</a>
Locations of Optum Providers Jan 2018	04/13/18	<a href="https://batchgeo.com/map/0be160082cf641b6d10b9841068797d5">https://batchgeo.com/map/0be160082cf641b6d10b9841068797d5</a>
Medication Management by Organizations	04/13/18	<a href="https://batchgeo.com/map/67ab268910f5be194ff1d2975ec2dbcb">https://batchgeo.com/map/67ab268910f5be194ff1d2975ec2dbcb</a>

Prescriber days available in each community	04/13/18	<a href="https://batchgeo.com/map/4cd7c475c81ad07cf14c798880877cf4">https://batchgeo.com/map/4cd7c475c81ad07cf14c798880877cf4</a>
Respite Care by Organizations	04/13/18	<a href="https://batchgeo.com/map/ff542ec8812dbc8167bf6c453283e2bf">https://batchgeo.com/map/ff542ec8812dbc8167bf6c453283e2bf</a>
Social Skills Training by Organizations	04/13/18	<a href="https://batchgeo.com/map/e8c3714980ef17911aff418848947f7f">https://batchgeo.com/map/e8c3714980ef17911aff418848947f7f</a>
Social Skills Training by Solos	04/15/18	<a href="https://batchgeo.com/map/98659b089308084e3660327fa7e748f2">https://batchgeo.com/map/98659b089308084e3660327fa7e748f2</a>
Wraparound Services by Organizations	04/13/18	<a href="https://batchgeo.com/map/2ac0a50dc95578fc41c364aa89afbeb5">https://batchgeo.com/map/2ac0a50dc95578fc41c364aa89afbeb5</a>

## Appendix E

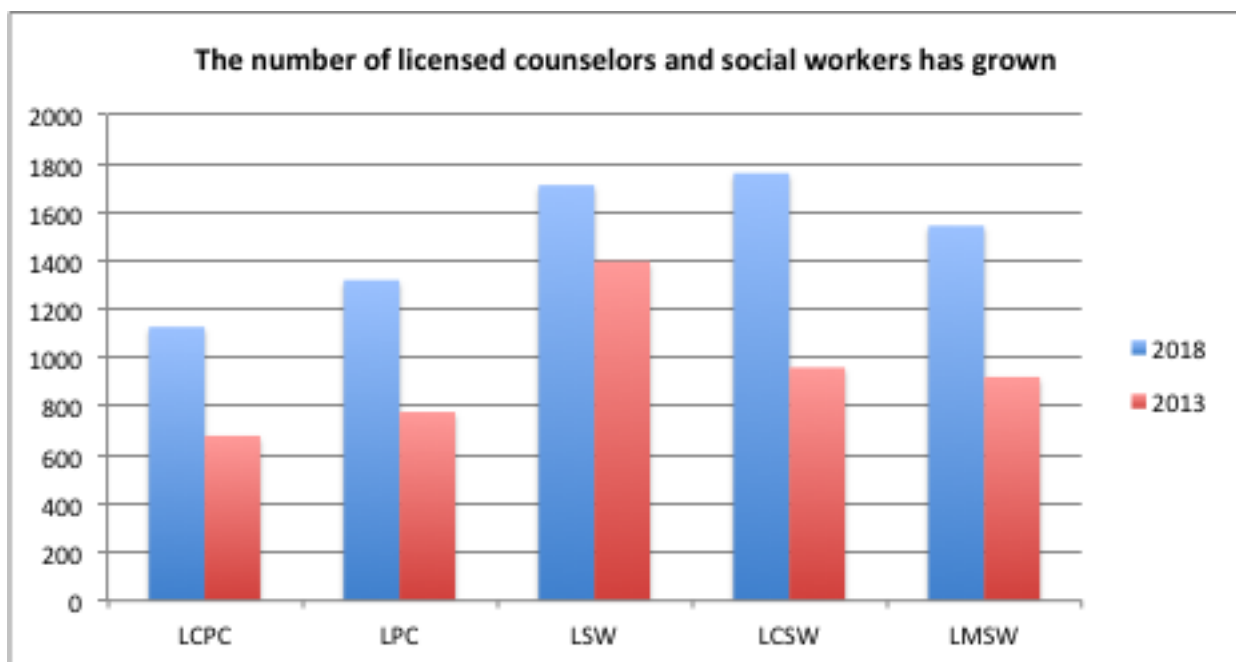
### Comparison with IDOLWD employment demand projections

Idaho appears to be on track to addressing its shortage of counselors, mental health professionals, and social workers. In the past five years, Idaho has almost doubled the number of LPCs and LCSWs in the state.

The state of Idaho completed an overview of mental health professionals in 2013, and confirmed the numbers of licensed professionals and the schools offering degrees leading to licensure.<sup>1</sup>

A review of the Idaho Bureau of Occupational licenses reveals the numbers of current active licensees for some of the same professions.

**Figure 65 The number of licensed counselors and social workers**

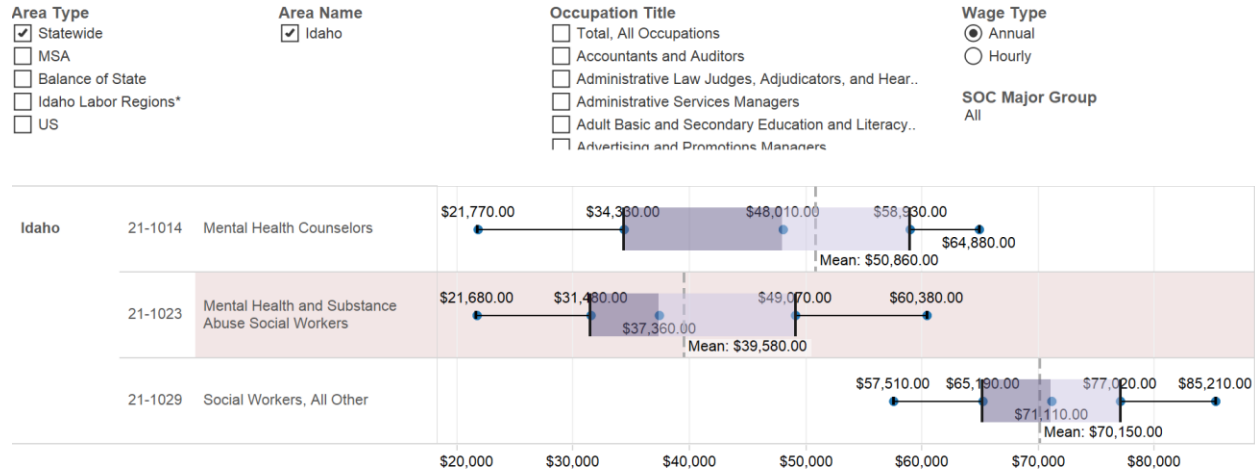


Wages for mental health counselors, mental health and substance abuse social workers, and “all other” social workers varies significantly. The Department of Labor and Workforce Development’s 2013 report includes wages, and notes that social workers that are administrators have higher incomes. In 2018, this may still be the case.

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<sup>1</sup> [http://labor.idaho.gov/publications/mental\\_health.pdf](http://labor.idaho.gov/publications/mental_health.pdf),

## Occupational Employment & Wage Survey - May 2016 (2017 Release) - Wage Range



Source: Idaho Labor Market Information <https://lmi.idaho.gov/>

## Post-secondary Education system

### *Paraprofessionals*

Certified family support partners are certified by the State of Idaho. Certification requires an interview, completion of training and an evaluation.

<http://healthandwelfare.idaho.gov/Medical/MentalHealth/PeerSpecialistsFamilySupportPartners/tabid/2935/Default.aspx>

Certified peer support specialists are certified by the State of Idaho. Certification requires an interview, completion of training and an evaluation.

<http://healthandwelfare.idaho.gov/Medical/MentalHealth/PeerSpecialistsFamilySupportPartners/tabid/2935/Default.aspx>

### *Certificates*

Habilitative Interventionists are certified by the State of Idaho. This certificate requires a bachelor's degree in a human service field, coursework in Applied Behavior Analysis, child development and learning and a year of supervision.

<https://healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/HabilitativeInterventionistApplicationForCertificateOfCompletion3-17.pdf>

Community-based Rehabilitation Specialists must be certified through the Psychosocial Rehabilitation Association. Candidates for the CPRP must meet eligibility requirements in three categories: education, work experience [related to providing psychiatric rehabilitation (recovery-oriented) for adults and/or transition-age youth (16+ years old)] and Continuing Education and Training in psychiatric rehabilitation

<https://www.psychrehabassociation.org/certification/cprp-certification>

### *Bachelor degrees in Social Work*

The BSW degree leads a candidate towards the LSW licensure.

- Boise State University
- Brigham Young University-Idaho
- Idaho State University
- Lewis Clark State College
- Northwest Nazarene University

### *Masters in Counseling or Social Work*

#### *Counseling*

The Masters in Counseling degree leads the candidate towards an LPC or LCPC degree.

- Boise State University
- Idaho State University
- Northwest Nazarene University
- University of Idaho

#### *Social Work*

The MSW degree leads a candidate towards the LCSW or LMSW licensure. The LCSW is a clinical license.

- Boise State University
- Northwest Nazarene University