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Quality Review

of

Youth Empowerment Services (YES)

For additional information about this process and its uses, please contact:

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interviewing, coding, and making sense of a mountain of interview and practice information.

A special thank-you goes to the Idaho Federation of Families for nimbly recruiting for, hosting, facilitating and coding three focus groups with caregivers. These results are summarized in a related brief.

The agency providers in three regions who participated in the intensive review, as well as the providers statewide who completed the provider survey amply demonstrated a commitment to youth and family-driven quality that YES seeks to encourage. Without them this would not have been possible.

Most of all, we wish to thank the youth and caregivers who continue to pursue the common dream of a healthy, successful life in the community. Your willingness to share your stories and trust us with your experiences, perspectives, and hope is motivation to all of us.

Executive Summary

Youth Empowerment Services (YES) - Quality Review

for the

Idaho Department of Health and Welfare

Procedure

This report summarizes the findings of the Quality Review process, which included youth and family interviews, file review, focus groups, and a provider survey. The results represent youth with at least six months of care, and includes youth served in typical outpatient care as well as a subset of youth served in Wraparound care.

The report has three main foci: **outpatient care, Wraparound care, and care equity.** Recommendations focus on key care processes experienced by persons in these analyses.

Idaho behavioral health providers are to be commended for their openness to engage in this intensive review of current practices and outcomes. This review does not provide a fully representative sample of care practices, experiences, or outcomes at each participating agency. Rather, it provides a starting point for identifying potential practice strengths and areas for practice development, consistent with the YES practice model and principles.

Executive Summary

Key Findings

Outpatient Care

Youth and caregivers indicated a strong belief that their therapists provided helpful care

Access to care and matching care to goals are identified as processes in need of improvement

Wraparound Care

Wraparound may have improved access to treatment for some youth, as seen in greater care doses

Youth and caregivers rated practices at four of seven care processes (Goal-Setting, Selecting Care, Progress Review, Crisis Care) as significantly less helpful than the Outpatient average

Care Equity

Youth who were non-majority culture had higher rates of sessions that included skill-building

Non-majority culture youth experienced half the dose of treatment and half as many sessions in which a supporter was engaged to help them, as their majority-culture peers

Recommendations

For system practices to be consistently fair, engaging, and effective, they need to be adapted with human differences in mind. Youth, caregivers, and providers need to be actively involved in the design and continuous improvement of care processes. This report serves as an initial set of practice and outcome benchmarks, which can be used to track practice improvement efforts and their outcomes. High priority action steps include:

- Work with diverse youth, advocates and providers to create standards for new care requirements
- Create and publicly report on care helpfulness, timeliness, dose, and duration standards
- Address the need for more appropriate care by developing higher intensity, evidence based community treatment services
- Identify root causes of current, serious concerns about Wraparound care before scaling it further

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Care Benchmarks

Overview. Throughout this review, care benchmarks are provided for reference. Benchmarks are displayed on the graphs of Outpatient Treatment Characteristics (3-month and 6-month cohorts), and in the Wraparound Treatment Characteristics and Care Coordination graphs. There are currently no well-established, federally recognized practice benchmarks for behavioral health care quality in America. In lieu of these being created and promulgated, we turn to what we know from the literature on care effectiveness in real-world (community) settings. The findings tell us how the frequency and type of treatment and care coordination practices improve outcomes for youth and their families.

How to understand these benchmarks. These benchmarks are our current best estimate of what it take to routinely achieve youth and family treatment goals. Because everyone is different some youth might do better, and some worse, with care that meets these benchmarks. But on the whole, youth experiencing care meeting these standards are substantially more likely to experience improvement in symptoms and functioning than when care does not meet these standards.

The standards are not absolute – they are probabilistic. This means that getting closer to a standard makes it more likely that a person will meet their goals. Also, meeting multiple standards makes it more likely that a person will meet their goals than when only one practice standard is met.

Care Benchmarks

How to use these benchmarks. These benchmarks provide a reference for when care merits attention. Care which consistently meets and exceeds the benchmarks may signal an exceptional practitioner or organization. Care which consistently fails to meet benchmarks indicates a need for individual or organizational supports to improve the quality and outcomes of care. When care is consistently below standard across organizations it signals a need to examine system policy and practice supports. They may be inadequate to provide high-quality care, or may be inadvertently creating a barrier to high-quality care.

For more information and literature regarding specific benchmarks used in Union Point Quality Reviews, see the report entitled, "Care Benchmarks: Overview and Sources."

Outpatient Care Characteristics

These analyses describe the care outcomes, practices and experiences of the youth in typical outpatient care across the three participating agencies. As with all analyses in the review, these analyses are designed to **point to aspects of care which bear further understanding and action**. The sample of youth represented are ages 14-18 years old and were in care for at least six months at the time of these analyses. All youth had to have a completed Initial CANS and a completed 90-day CANS at the same agency. They represent older, longer-standing clients than would be found in a randomized, representative sample of system youth.

As such, we would expect that persons in care for shorter periods of time, or in locales with a less accessible continuum of services would experience care as less helpful and effective than the youth represented in this review. This is especially important to keep in mind as, historically, approximately 20% of the Idaho population has resided in counties designated as 'frontier.' Frontier counties have very low population density and potentially reduced service availability.

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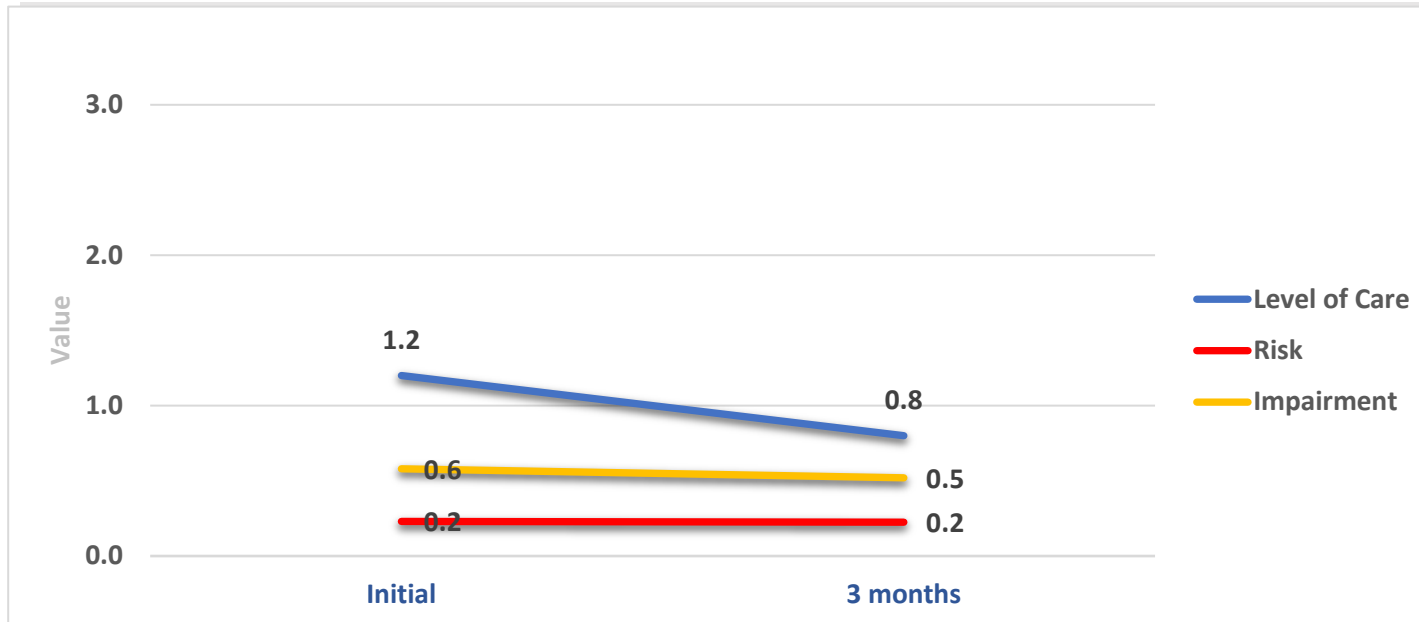
Initial Outpatient Outcomes

Change in **Risk**, **Impairment** *and* **Level of Care**

The Risk, Impairment, and Level of Care scores are created from sets of CANS items. A decrease in scores over time indicates improvement. Twenty individuals are represented in these representations of change after 90 days.

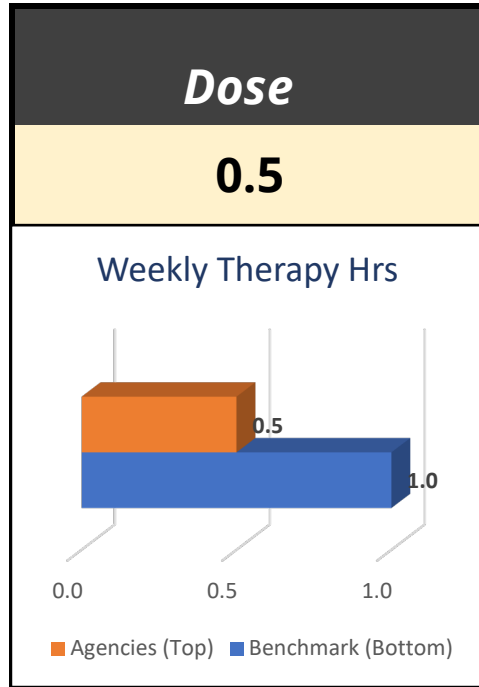Idaho Department of Health and Welfare

Initial Outpatient Outcomes (cont.)
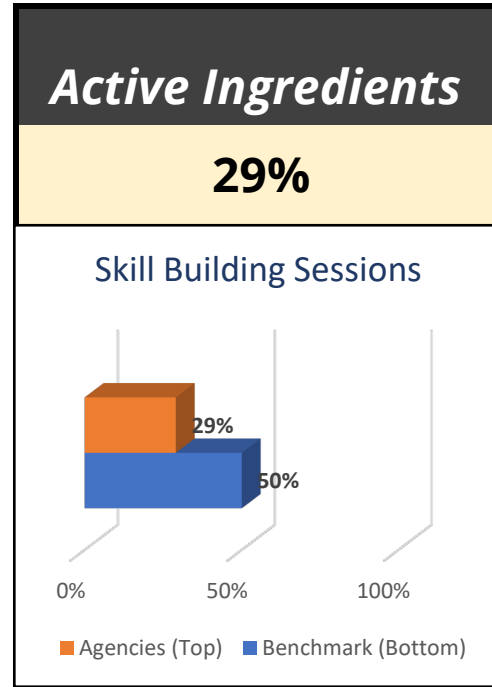
Change in Strength Development

Strength development is represented by a line that goes 'up' (towards 0). Because the CANS Strength items are reverse scored, **lower** numbers indicate more Strengths being developed. Increasing values would indicate the loss of Strengths.

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Outpatient Treatment Characteristics (3-Month Cohort)

Dose	*Active Ingredients*	*Supporters*
0.5	**29%**	**20%**
Weekly Therapy Hrs	Skill Building Sessions	Sessions w/ Supporter

Dose — Weekly Therapy Hrs

- Agencies (Top): 0.5
- Benchmark (Bottom): 1.0
- Scale: 0.0, 0.5, 1.0

■ Agencies (Top)   ■ Benchmark (Bottom)

Active Ingredients — Skill Building Sessions

- Agencies (Top): 29%
- Benchmark (Bottom): 50%
- Scale: 0%, 50%, 100%

■ Agencies (Top)   ■ Benchmark (Bottom)

Supporters — Sessions w/ Supporter

- Agencies (Top): 20%
- Benchmark (Bottom): 50%
- Scale: 0%, 50%, 100%

■ Agencies (Top)   ■ Benchmark (Bottom)

Dose refers to the average hours per week spent between a client and therapist in treatment activities.

This captures the percent of sessions in which new ways of addressing concerns are taught.

This is the percent of sessions in which a supporter is present or actively recruited to help with a concern or skill.

Summary. These graphs compare treatment characteristics of youth. Benchmarks are derived from literatures on predictors of functional improvement in real-world care settings. Meeting each benchmark does not guarantee treatment success. Together, an effective dose of care, consistent focus on skill-building, and the recruitment of supporters who encourage using new skills consistently predicts more functional improvement while in care.

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Six-Month Outpatient Outcomes

Change in Risk, Impairment *and* Level of Care

The Risk, Impairment, and Level of Care scores are created from sets of CANS items. A decrease in scores over time indicates improvement. Nine youth had usable 180-day outcome data.

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Six-Month Outpatient Outcomes (cont.)

Change in Strength Development

Strength development is represented by a line that goes 'up' (towards 0). Because the CANS Strength items are reverse scored, **lower** numbers indicate more Strengths being developed. Increasing values indicate the loss of Strengths.
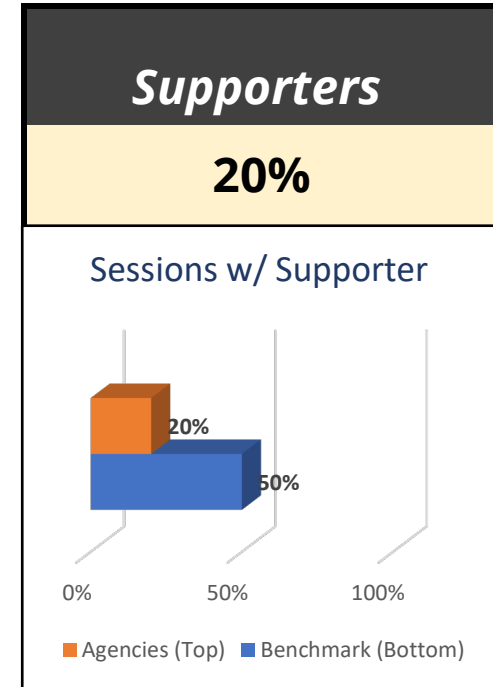
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Outpatient Treatment Characteristics (6-Month Cohort)

Dose	*Active Ingredients*	*Supporters*
0.4	**43%**	**13%**
Weekly Therapy Hrs	Skill Building Sessions	Sessions w/ Supporter

Dose refers to the average hours per week spent between a client and therapist in treatment activities.

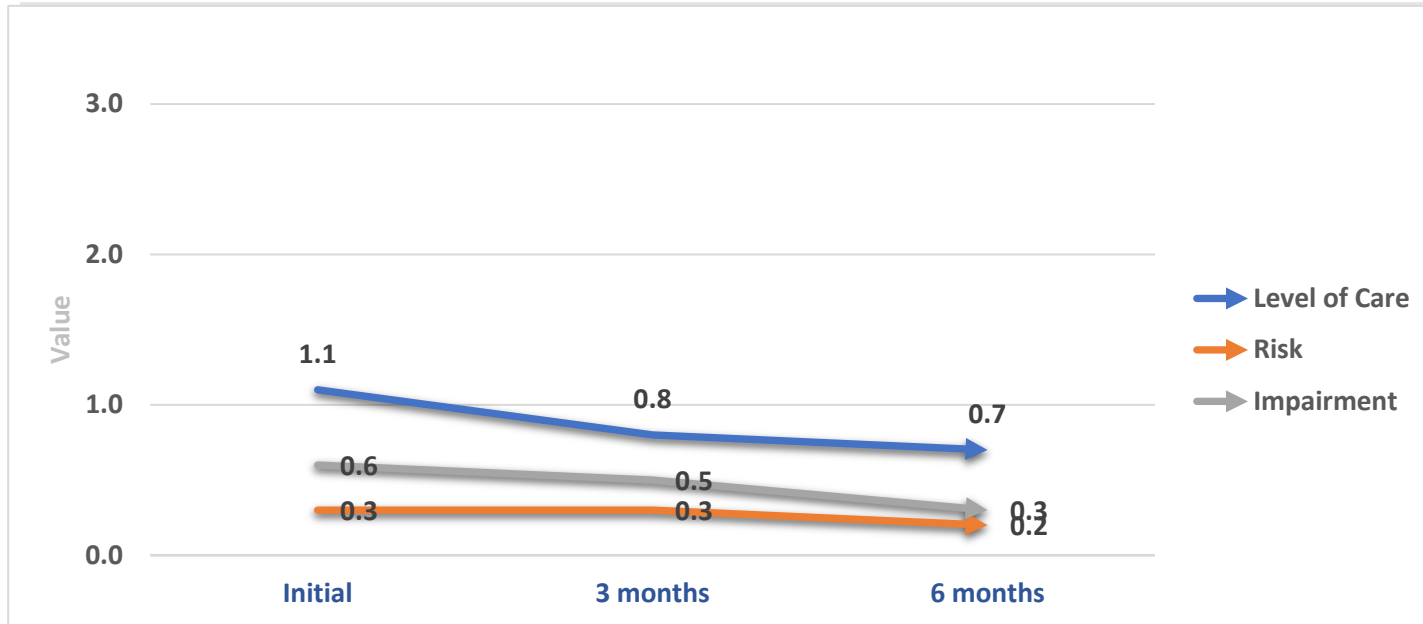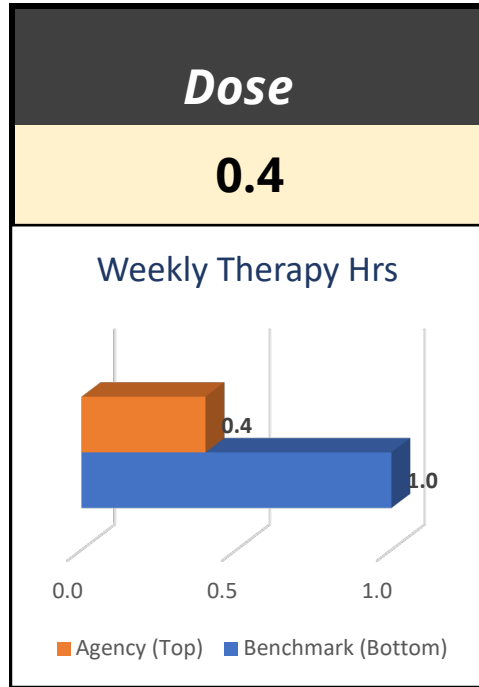This captures the percent of sessions in which new ways of addressing concerns are taught.

This is the percent of sessions in which a supporter is present or actively recruited to help with a concern or skill.

Summary. These graphs compare treatment characteristics of youth. Benchmarks are derived from literatures on predictors of functional improvement in real-world care settings. Meeting each benchmark does not guarantee treatment success. Together, an effective dose of care, consistent focus on skill-building, and the recruitment of supporters who encourage using new skills consistently predicts more functional improvement while in care.

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Helpfulness of Outpatient Practices

	Agency 1	Agency 2	Agency 3	All Agencies	Refers to:
Access	50%	78%	69%	**66%**	...the process of initially getting access to needed services.
Assessment	63%	90%	83%	**79%**	...the initial assessment process.
Goal-Setting	80%	100%	71%	**84%**	...the process of setting self-directed goals.
Selecting Care	50%	60%	85%	**65%**	...how care was described and chosen to meet the youth's goals.
Therapist Alliance	78%	100%	100%	**93%**	...the experience of working with the therapist.
Progress Review	78%	89%	91%	**86%**	...formally checking in and adjusting care based on progress.
Crisis Care	57%	78%	100%	**78%**	... crisis care received by all individuals who experienced a mental health crisis.
Transition	50%	100%	83%	**78%**	...transition process of all individuals who had an experience of leaving care.
Average	**63%**	**87%**	**85%**	**78%**	**...helpfulness across all practices.**

Summary. This chart provides us with the percentage of interviewed participants (youth and caregivers) who experienced particular care processes as helpful. This information allows us to identify strengths and needs at the practice and policy levels.

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Equity Analyses

These analyses describe the care outcomes, practices and experiences of majority culture and non-majority culture youth in typical outpatient care. Youth in this report are defined as non-majority culture if they self-identify as being part of a non-majority group. As the Centers for Disease Control[1] has indicated, some examples of groupings include:

- race or ethnicity,
- gender,
- education or income,
- disability,
- sexual orientation.

[1] Retrieved at: https://www.cdc.gov/healthyyouth/disparities/index.htm

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Equity Analyses: Initial Outcomes

Change in Risk, Impairment and Level of Care
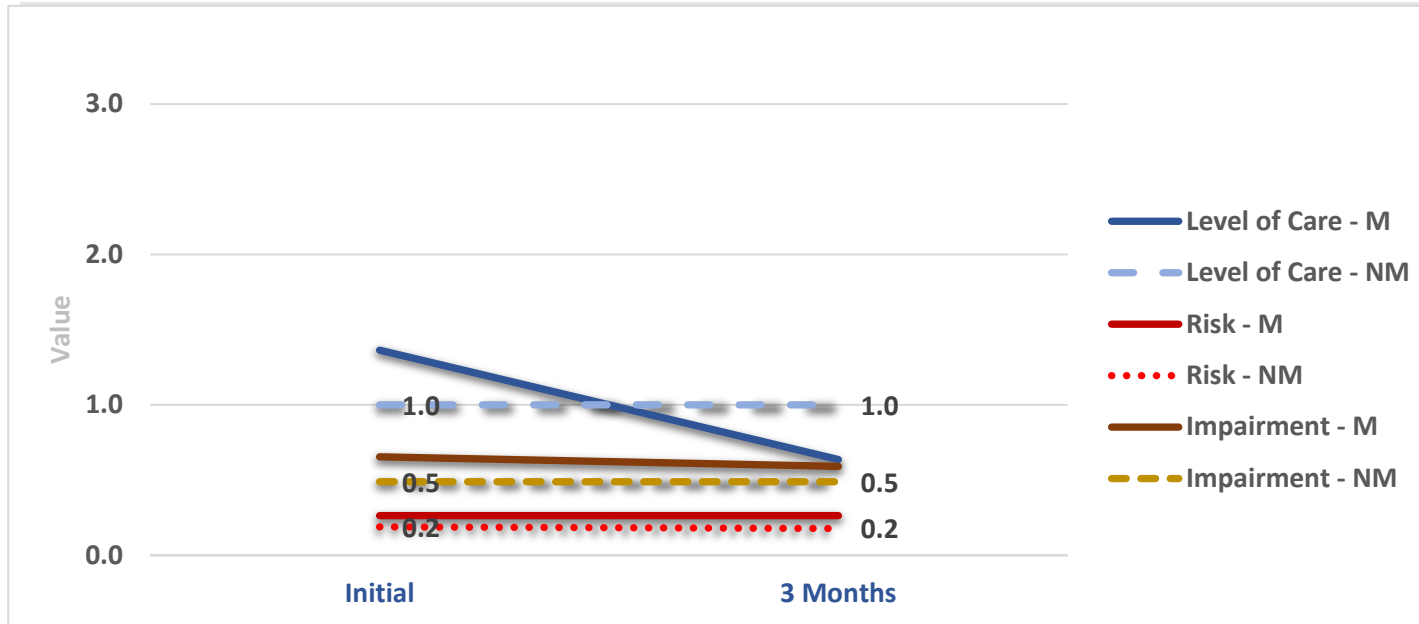
The Risk, Impairment, and Level of Care scores are created from sets of CANS items. A decrease in scores over time indicates improvement. Twenty individuals are represented in these representations of change. Eleven individuals were identified as 'majority culture,' and nine individuals as 'non-majority culture.'

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Equity Analyses: **Initial Outcomes** (cont.)

Change in **Strength Development**

Strength development is represented by a line that goes 'up' (towards 0). Because the CANS Strength items are reverse scored, **lower** numbers indicate more Strengths being developed. Increasing values indicate the loss of Strengths.

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Equity Analyses: Treatment Characteristics
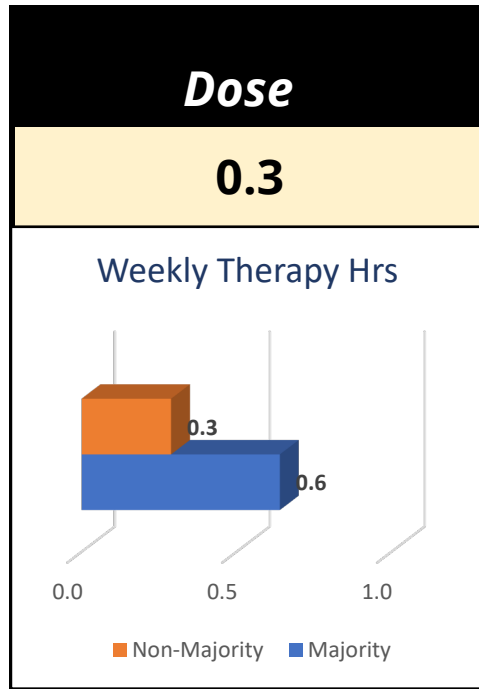
Dose

0.3

Weekly Therapy Hrs

0.3
0.6

0.0   0.5   1.0

■ Non-Majority   ■ Majority

Dose refers to the average hours per week spent between a client and therapist in treatment activities.

Active Ingredients

40%

Skill Building Sessions

40%
20%

0%   50%   100%

■ Non-Majority   ■ Majority

This captures the percent of sessions in which new ways of addressing concerns are taught.

Supporters

12%

Sessions w/ Supporter

12%
26%

0%   50%   100%

■ Non-Majority   ■ Majority
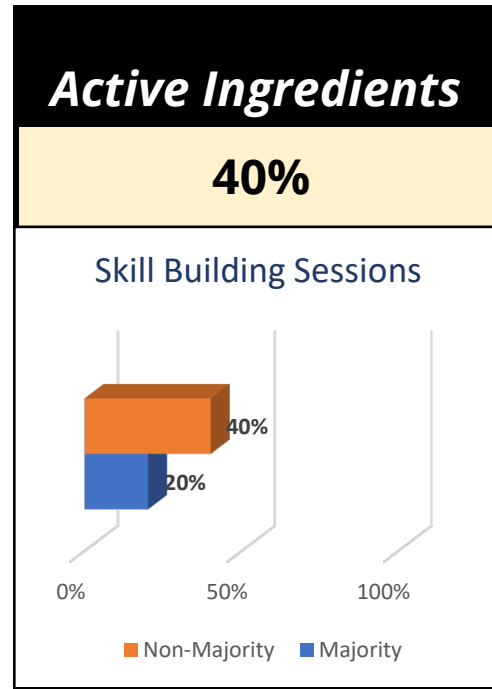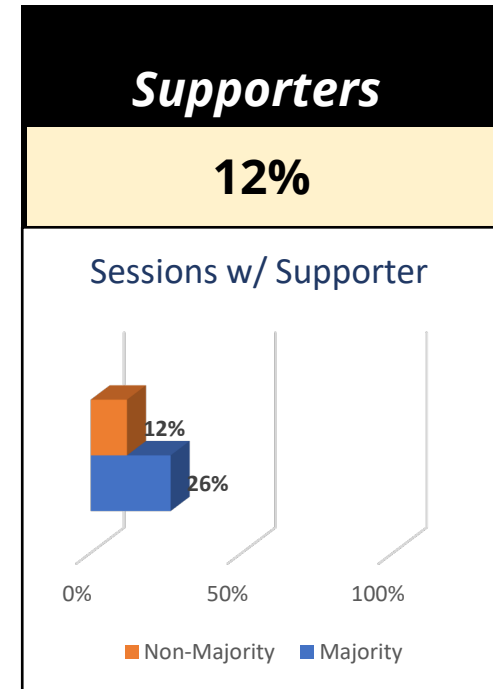
This is the percent of sessions in which a supporter is present or actively recruited to help with a concern or skill.

Summary. These graphs compare treatment characteristics of majority-culture and non-majority culture youth. Benchmarks are derived from literatures on predictors of functional improvement in real-world care settings. Meeting each benchmark does not guarantee treatment success. Together, an effective dose of care, consistent focus on skill-building, and the recruitment of supporters who encourage using new skills consistently predicts more functional improvement while in care.

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Equity Analyses: Helpfulness of Practices

	Non-Majority Youth	Majority Youth	*Refers to:*
Access	50%	67%	...the process of initially getting access to needed services.
Assessment	78%	80%	...the initial assessment process.
Goal-Setting	93%	82%	...the process of setting self-directed goals.
Selecting Care	55%	69%	...how care was described and chosen to meet the youth's goals.
Therapist Alliance	100%	94%	...the experience of working with the therapist.
Progress Review	91%	86%	...formally checking in and adjusting care based on progress.
Crisis Care	78%	77%	... crisis care received by all individuals who experienced a mental health crisis.
Transition	83%	79%	...transition process of all individuals who had an experience of leaving care.
All Practices	78%	78%	**...helpfulness across all practices.**

Summary. This chart provides us with the percentage of youth and caregivers who experienced each care process as helpful. This allows us to identify practice and policy strengths and needs. Three considerations emerge:

1. **Non-majority culture youth and their caregivers indicated that care is substantially more difficult to access than experienced by majority-culture youth and their caregivers;**
2. **Once in care, selecting care appropriate to their goals is also an area in which there is a substantial disparity in experience;**
3. **Youth and caregivers describe very positive experiences with therapists. Identifying how this process is different may be a starting point for creating more equitable care.**

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Wraparound Analyses

Several characteristics of the Idaho public behavioral health treatment system are noted for context in these analyses. Wraparound facilitation was provided by coordinators from Idaho's Regional Clinics. However, treatment services for these youth are provided primarily by contracted providers from disparate community agencies. Treatment services are subject to authorization and utilization review by a separate Managed Care entity (Optum Idaho). The provider survey in this Quality Review identifies a dearth of available intensive outpatient treatment services. Each of these characteristics indicate that coordination services are not yet embedded in an accessible continuum of care.

In part because of these coordination, treatment, and administration silos, it proved quite difficult to recruit participants for the Quality Review, and then to obtain their coordination and treatment documentation. Six youth and their caregivers are represented in these analyses; for two of these youth we were unable to obtain any treatment practice data.

Wraparound Analyses: Initial Outcomes
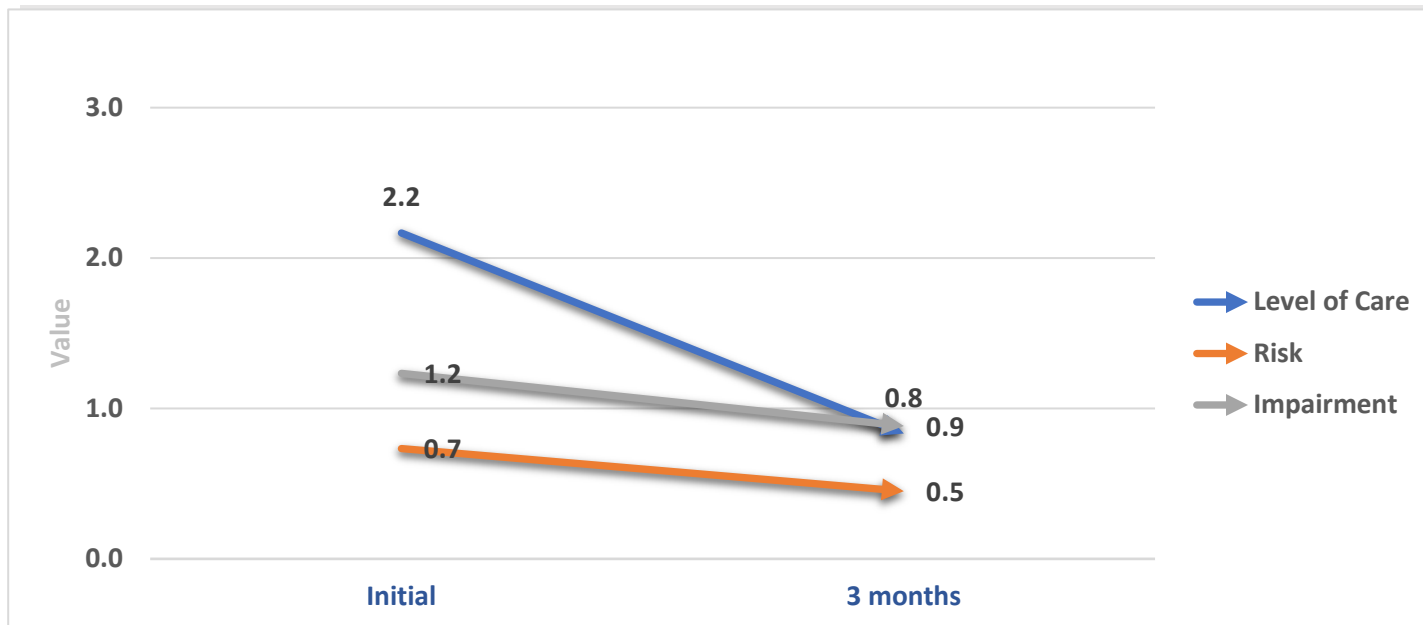
Change in Risk, Impairment *and* Level of Care

The Risk, Impairment, and Level of Care scores are created from sets of CANS items. A decrease in scores over time indicates improvement. Six individuals are represented in these representations of change after 90 days; only four youth had 180-day outcome data.

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Wraparound Analyses: **Initial Outcomes (cont.)**

Change in **Strength Development**

Strength development is represented by a line that goes 'up' (towards 0). Because the CANS Strength items are reverse scored, **lower** numbers indicate more Strengths being developed. Increasing values indicate the loss of Strengths.

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Wraparound Analyses: Treatment Characteristics

Dose	*Active Ingredients*	*Supporters*
0.8	**21%**	**70%**

Weekly Therapy Hrs

0.8
1.0

0.0   0.5   1.0

■ Agencies (Top) ■ Benchmark (Bottom)

Skill Building Sessions

21%
50%

0%   50%   100%

■ Agencies (Top) ■ Benchmark (Bottom)

Sessions w/ Supporter

70%
50%

0%   50%   100%

■ Agencies (Top) ■ Benchmark (Bottom)

Dose refers to the average hours per week spent between a client and therapist in treatment activities.

This captures the percent of sessions in which new ways of addressing concerns are taught.

This is the percent of sessions in which a supporter is present or actively recruited to help with a concern or skill.

Summary. These graphs compare treatment characteristics of youth. Benchmarks are derived from literatures on predictors of functional improvement in real-world care settings. Meeting each benchmark does not guarantee treatment success. Together, an effective dose of care, consistent focus on skill-building, and the recruitment of supporters who encourage using new skills consistently predicts more functional improvement while in care. **Because of the small sample size in Wraparound care, averages should be interpreted with great caution.**

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Wraparound Analyses: Care Coordination Characteristics

Dose	*Active Ingredients*	*Supporters*
0.9	**45%**	**75%**

Monthly CFTs

| 0.9 |
| 1.0 |

0.0   0.5   1.0

■ Agencies (Top)   ■ Benchmark (Bottom)

CFT Task Completion

| 45% |
| 75% |

0%   50%   100%

■ Agencies (Top)   ■ Benchmark (Bottom)

CFTs w/ Supporters

| 75% |
| 85% |

0%   50%   100%

■ Agencies (Top)   ■ Benchmark (Bottom)
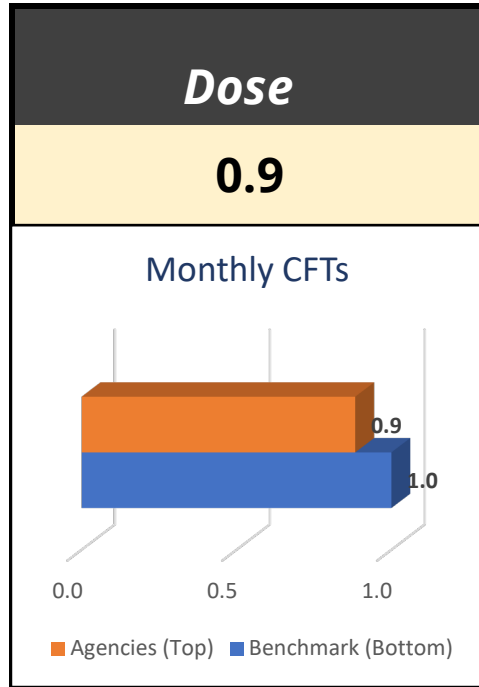
Dose refers to the number of formal CFT meetings held with the family, coordinator, and at least one other stakeholder present.
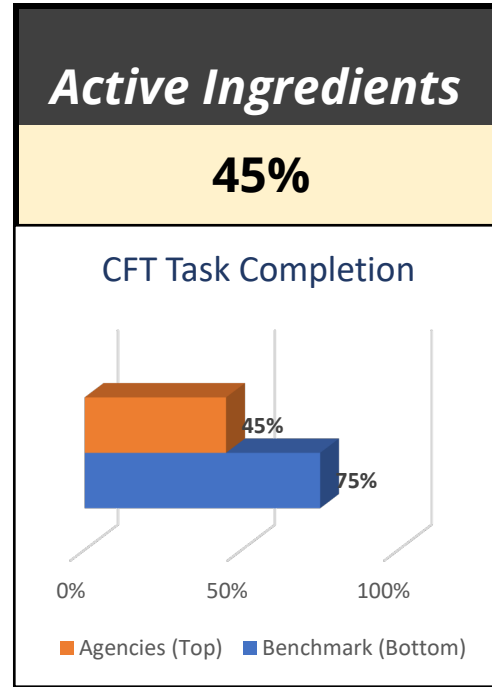
This captures the percent of tasks assigned in each CFT which are subsequently completed before the next CFT.
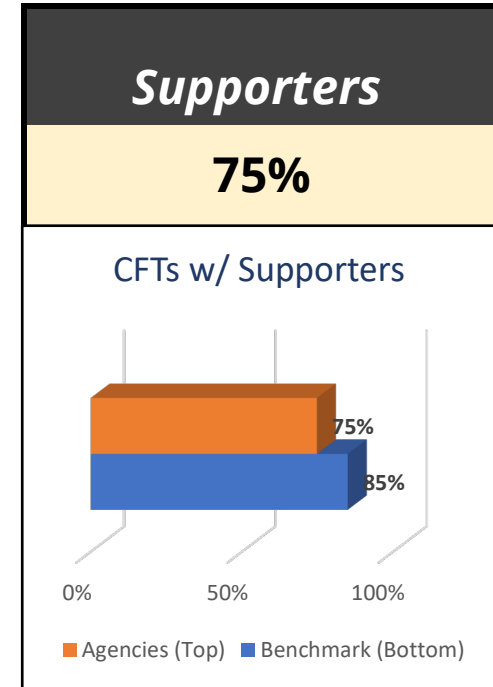
This is the percent of CFTs in which a supporter actively participates.

Summary. These graphs compare treatment characteristics of youth. Benchmarks are derived from literatures on predictors of functional improvement in real-world care settings. Meeting each benchmark does not guarantee treatment success. Together, frequent and consistent CFTs, follow through to complete assigned task, and the recruitment of formal and informal supports to help the youth meet their goals predicts better care outcomes. **Because of the small sample size with Wraparound care, averages should be interpreted with great caution.**

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Wraparound Analyses: Helpfulness of Practices

|	Outpatient	Wraparound	*Difference*
Access	66%	**57%**	**-9%**
Assessment	79%	**83%**	**4%**
Goal-Setting	84%	**40%**	**-44%**
Selecting Care	65%	**33%**	**-32%**
Therapist Alliance	93%	**86%**	**-7%**
Progress Review	86%	**67%**	**-19%**
Crisis Care	78%	**33%**	**-45%**
Transition	78%		*Grey denotes too small a sample to compute percentage.*
All Practices	**78%**	**57%**	**-21%**

Summary. This chart provides us with the percentage of interviewed participants (youth and caregivers) who experienced particular care processes as helpful. This information allows us to identify strengths and needs at the practice and policy levels. There are three considerations from the current data:

1. **Youth and caregivers rated practices while receiving Wraparound, on average, as less helpful than at the three outpatient agencies in this review;**

2. **Practices for which Wraparound would be expected to have high impact (such as Goal Setting and Crisis Care) do not yet appear to be having positive impact;**

3. **Before going to scale with Wraparound services, it is critical to first understand and address why it is not currently experienced as consistently helpful.**

Helpful and Unhelpful / Disengaging Practices

The practices described in the following pages are pulled from 43 interviews with caregivers and youth involved
 in YES services. They are organized in the sequence a person moves through care:

Access;

Initial Assessment;

Care Planning;

Working Together;

Monitoring and Adapting Care;

Crisis Prevention and Response;

Transitioning from Care.

These fine grained descriptions of care provide concrete examples of the practices which work to engage
caregivers and youth in YES services, and practices which disengage caregivers and youth.
As such, they provide clear opportunities for the system to publicize, train on and promote local best practices, and reduce
or curtail ineffective practices.

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Access

Access is defined in terms of the YES Principle of Care Early Identification and Intervention: "Opportunities are available to screen or assess potential Class Members and provide appropriate interventions when mental health issues are first identified."

Helpful Practices

One-step process for accessing services

> It was pretty easy. When I realized he needed to see a counselor, they suggested [Agency]. I got a referral, gave them a call and they set us up right away. He and his brother.

> It really didn't take that long. The school was calling too. They saw he wasn't doing well. They knew he had an issue with bullying. School helped get an appointment too, as soon as possible.

Fast access to care

> Referral from doctor, I called the agency one time and then we got an appointment within two weeks of the referral.

> Actually it went pretty quick. We had discussed her with their physician. When [my child] was having court issues, they recommended that she be seen. It got put together pretty fast.

> It was really quick [to see Counselor].

People are supportive of the care being offered

> My teacher. I was having a bad day, a hard time holding it together. My teacher offered me to talk to someone, a counselor. I got that all set up.

> [It was helpful] how supportive my family and friends were.

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Access *(cont.)*

Unhelpful / Disengaging Practices

Services delayed due to system processes

Early there was contact with the agency but when mom has called to follow up she is told she needs to do something else first or the person she needs to talk to is not available.

[Youth] didn't have a diagnosis at first. It took a whole year for a counselor to say we need to figure out what is going on with [Youth]. When finally a year later they said he should have CBRS, medication, peer support, family support and family counseling.

They had a requirement that [my child / youth] must be seen for counseling at least 3 times before an appointment with a psychiatrist. She did that, though the psychiatrist's appointment had been set out so far - like two months out. By the time we got to see him, the counseling appointments were too far in the past, according to him. The psychiatrist required three more current counseling appointments.   [my child / youth] didn't feel like she needed counseling - it was just [Agency]'s requirement before getting an appointment with the psychiatrist. They said it was because she was under 18.   Too many requirements.

Appropriate / Individualized services not available

Waiting for a list of services or stage from [Counselor] for "quite a long time."

It had been impossible to access services, I couldn't find anything that helped. His needs were big.

Its really important that I am connected to the right person to help, not just someone with availability on their calendar. I need someone with expertise. Not someone who is reading a book on the topic.

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Access *(cont.)*

Unhelpful / Disengaging Practices

Anxiety / ambivalence about care not recognized and addressed

At first I felt nervous and anxious about going to counseling. It took quite awhile to actually go into the counseling.

I was nervous and scared to open up to a stranger.

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Initial Assessment

Assessment is the practice of gathering and evaluating information about the potential Class Member and his or her family in order to assess strengths and needs.

Helpful Practices

Assessing strengths and competencies provided new perspective

I did not realize where her self esteem truly was. I see a beautiful, intelligent girl. She described a different girl.

Very knowledgeable. Learning what [my child / youth] wanted and needed and letting her voice [out].

They talked a lot about things I'm good at.

Comprehensive, in-depth

The questions were digging deeper than I thought which was a pleasant surprise.

I remember being very impressed with how well they covered everything.

In the assessment one of the questions asked about thoughts about dying. [my child / youth] answered yes. Counselor said she had Suicidal Ideation. [my child / youth] disagreed, just thought it would be easier not to be around. Counselor was concerned about that. I think she was right to follow up.

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Initial Assessment *(cont.)*

Assessor's ability to provide persons with assurance and control

> Kind of scary. The people were nice, but I didn't know them. Kind of relieving that I could get all this off my chest.

> Some of them [assessment questions were difficult to answer]. I told him I didn't feel comfortable about some of them. He moved on.

Unhelpful / Disengaging Practices

Deficit based assessment creates tension and unease

> I felt kinda bad. I felt like I was talking bad about my daughter but I knew that's the only way for them to know her.

> It seems like the feedback that I got back were "presenting issues." I think it was all potential issues and problems.

Repetitive, lengthy assessment processes

> [Want] there not being 400+ questions. [It was] too long.

> Assessment with [Counselor] twice. Assessments with others, CANS.

> [They] asked me the same questions everybody else asked me.

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Initial Assessment *(cont.)*

Unhelpful / Disengaging Practices

Perspectives missed or misunderstood

> Most of the time they asked about my trauma, they said "We have to fix this," but didn't ask what it was. They assumed.

> They didn't involve his dad, even though I asked them to. That could have given them a better picture.

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Care Planning

Care planning is the practice of tailoring services and supports unique to each Class Member and family to address unmet needs. This includes both Goal Setting and Care Selection.

Helpful Practices

Participatory goal creation process

They asked questions like what do we want, what do we want to get out of the process. We were very involved in creating the goals.

The second meeting we went over the goals and I thought they were all attainable for [my daughter]. She got a list her goals and to pick the ones she wanted to start with. I was included in talking about and identifying the goals.

I was definitely a part of it, me and the person [Counselor], and a little bit with my mom.

Practical goals created

Goals felt [like] they were helpful.

I was actually pretty pleased with the goals they set up for her, how to deal with frustration, anger. The steps they were taking - I was pleased with.

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Care Planning *(cont.)*

Services offered were clearly explained

> [Counselor] explained the services available to us and then discussed what services we would like and the services he felt would be beneficial.

> She explained the services available and then explained them to us. Family support, peer support, CBRS. Said yes to family counseling, family support, med management and individual counseling.

> [Counselor] explained services that were available. We got a list that we went over and then asked questions as needed.

Meaningful services were provided

> She got approved through the YES program. Anything we needed, we had access to.

> I felt like there was a lot of services offered.

> We were give a lot of choice. Not pressured into anything. They are amazing.

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Care Planning *(cont.)*

Unhelpful / Disengaging Practices

People other than the person in care setting the goals for care.

> I was irritated about PO's [Probation Officer's] goals. We changed the goals to what I wanted, after that it went pretty good.

> My mom made me say I need to work on my grades, I needed to work on other stuff. I was a bit angry. I thought, If I don't get the help I need, I'll scream.

Services offered were not provided

> We were offered Case Management, we got one phone call from a lady who said she was no longer going to work there so someone else would call them but no one did.

> We never heard back about CBRS services.

> But nothing ever came of it. It just never happened. They said it would. Said they would set us up with that and equine therapy. Maybe it had to do with Covid stuff.

Services are not individualized

> I think she might need something more in depth. I think she needs more help.

> I asked that Wraparound be ordered, the judge said no. I felt the suggestion was scoffed at.

> The young lady who was our CBRS worker was nice, she was brand new and very young. We ended those services rather quickly, it was too restrictive and didn't seem to be effective. Bad combination with Covid and the CBRS worker.

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Working Together

Working together is a process that brings together the family, professionals and any other supports to achieve the youth's functional goals.

Helpful Practices

Taught useful skills

> She taught [Youth] how to handle anger/panic attacks. Like to count different colored items to calm down. She would be hyperventilating. She didn't need the meds by doing what [the Counselor] taught her to do.

> She's good, there were a few times I went in there and she was able to help and had me try different techniques. She's really good, she's really nice. If I had any concerns I would approach it to her and she would talk to the kids. She does really well with the kids.

> ....when [my child / youth] shared about tools that they were working on, I changed my mind. She was doing a wonderful job.

> We worked on making a schedule and trying to change my mindset on some things. "By doing this, you are getting closer to your goal." I CAN do this, so I'm closer to be where I want to be.

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Working Together *(cont.)*

Engaging style

> The way she, like how we connect on many things. I feel like I'm talking to someone who really understands.

> That she was openly putting effort to gain my trust.

> She is funny. She has a real connection with [youth]. She is her "go to" person. She's caring, understanding, has a lot patience. Knows how to calm her down. She's just an awesome lady.

> Therapist is straight forward and is good at talking to her and giving life examples. I like the way she talks to [my child] and asks her opinion. I think it has been good. She gives her real life examples and talks to her, person to person. She gets her involved and gives her real advice, not broad examples. She gives her real advice that is good for her and our family.

Unhelpful / Disengaging Practices

Poor communication about care

> It took me a little while to figure out what track [the] counselor was on. First, building trust before he dove into feelings, [my] personal life.

> Did not get a lot of feed back from the first counselor.

> I sometimes felt like there was no progress because I didn't really know what the therapist was doing with him but in the end she helped him.

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Working Together *(cont.)*

Lack of expertise / poor fit

      I think that he doesn't have super deep knowledge of what is going on with my son.

      It doesn't seem to be thorough, he (son) is in and out in ten minutes. I've called [Counselor] with my concerns. He seems to be overwhelmed [Counselor].

      First counselor purposefully had arguments as a way to teach [my youth] about how to manage anger.

      I think he is super nice but I don't think he is the most helpful. All he does is say every week, how are you doing, what are your goals. Bye.

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Monitoring and Adapting Care

Monitoring and adapting is the practice of continually evaluating the effectiveness of the Individualized Treatment Plan, assessing circumstances and resources, and reworking the Plan as needed.

Helpful Practices

Formal goal-setting and reviews

> When they were setting goals, I was open to try. If something work, we stayed with it, if not, we changed the plan.

> The formal review was very thorough.

> The reviews are the times that I have sat in on sessions. The therapist goes over [my child's] progress and what else needs to be worked on. She suggested family counseling. She has been good about keeping us updated on her progress.

Frequent check-ins and adjustments to care

> Every week counselor would ask how [my child / youth] was doing. Every week that we were there. If I told counselor about a problem, he would work on it right away.

> [Each time] we would review the last session and he would ask if I tried the things we talked about.

> I just tell her what I'm working on. We usually talk about success and what isn't. She checks in on me, texts, calling.

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Monitoring and Adapting Care *(cont.)*

Unhelpful / Disengaging Practices

Poor communication about progress

> No. Don't really do anything with the CANS. We do the CANS and they do whatever it is they do with it. I've never seen the results or hear about it until it's time to do it again.

> Wish I was updated more often.

> I wasn't being told anything about the services with [Youth] and I was being told I don't need to know.

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Crisis Prevention and Response

Crisis Prevention and Response refers to the supports available when a person feels overwhelmed or out of control, whether or not they are objectively a danger to themselves or others.

Helpful Practices

Fast access to care

There were times that she was self-harming. I let the counselor know. She saw both of us the next day.

There was one or two times we had an incident and she had her session the same week so we addressed it then. We talked to the therapist about what was going on. If we need anything I can call the therapist and try to get her in or call her whenever.

[Counselor] is really good to text with me and she is really good at getting back to me.

Constructive advice

[Counselor] gave me anger management things. A lot of good advice. Anger Management.

Was given some instructions [for] if or when [youth] becomes symptomatic again.

[Counselor] gave me ideas about how to handle the situation.

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Crisis Prevention and Response *(cont.)*

Unhelpful / Disengaging Practices

Unprepared, unable to find help

I was frustrated, anxious, I was really flustered. Not knowing what to do. Trying to figure out what would work. Lots of frustration on my part. It was rough.

I was terrified, baffled, a parent failure.

I called [Agency] five times for crisis and got no resolution. I stopped calling and would just call the family support partner.

Cost / payment barriers

Without state insurance, you get no help which is stupid. We both work [and didn't qualify for state insurance].

[Youth] was manic, suicidal, self harm[ing]. Police were involved. [Caregiver] was told to go to the emergency room. Has a lot of bills now.

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Transitioning from Care

Transition is the process of moving from formal behavioral health supports and services to informal supports.

Helpful Practices

Planned transition, ability to return to care

Yes, we had discussions on things on while she was in counseling and when she was done. We talked about things to continue to try. If things reverted, we should pick it up.

Everyone has talked to me about the transition plan.

[Therapist] still had some concerns. She agreed with me that there was no use in forcing [my child] to attend, making it hard for all of us. If [my child] started back down the ways, I'd put her right back in.   So far, [my child] has done OK.

Transition as the youth's choice

I got off probation, was adopted, and stopped services on same day. [Probation Officer] said when I was off probation, I could stop counseling. I didn't think I needed it. We talked about a lot.

It has to be [Youth's] decision, or there would not be a benefit.

Relief. I knew I was done and I didn't need it anymore. I have the right resources, more trust and self-esteem.

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Transitioning from Care *(cont.)*

Unhelpful / Disengaging Practices

Abrupt Termination

> I wasn't really asked. She ([my child / youth]) told me and counselor that she was done, now that she wasn't mandated. We could pick it up if needed.

> We didn't discharge. She had a change in counselors. They said we missed an appointment. [Youth] said she didn't get the phone call. Then summer happened, it just ended.

> I loved her, it wasn't my choice. We were making such progress. It hurt my feelings but it wasn't my fault.

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Agency Survey

Purpose

Provider data was collected on both the continuum of care available to YES participants, and on the practices and procedures agencies reported as using, consistent with YES practices and principles.

Sampling

A list of independent practitioners and agency providers was obtained from Optum Idaho. The list was unduplicated and crosswalked with the names of providers and agencies who had completed at least one Child and Adolescent Needs and Strengths (CANS) assessment during the Quality Review sampling period. A resulting list of one hundred and fifty-three unique individual practitioner and agency contacts was generated. One hundred and fifty-three survey invitations were e-mailed to recipients by the Project Coordinator, Michelle Schildhauer. Recipients were twice reminded via e-mail to complete the survey, if they had not already completed it. No additional follow-up methods were used to increase response rates. Eighteen e-mails (12%) bounced back as no longer valid. Eighty of the remaining emails were opened by the recipient (52% of 153). Sixty individuals clicked through to the survey (39% of the 153). One individual indicated that their agency did not serve children or youth in the past year. Two individuals opened the survey, indicated that they or their agency provided behavioral health services to youth in the past year, and then opted out. Thirty-five individuals proceeded to completed the survey (23% of the original 153), including seven individuals who identified as independent practitioners, and twenty-eight individuals who each represented a distinct agency.

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Continuum of Care - Behavioral Health Agencies

Service Array: *Agencies*

■ Currently offer ■ Plan to Offer ■ Do not offer

Service	Currently offer	Plan to Offer	Do not offer
Individual Psychotherapy.	100%		
Family Psychotherapy.	96%	4%	
Case Management.	71%	7%	21%
Skills Building / Community Based Rehabilitative Services.	61%	7%	32%
Crisis Intervention.	54%		46%
Targeted Care Coordination.	50%	14%	36%
Behavior Modification and Consultation.	50%	11%	39%
Peer Support - Youth Support.	50%	11%	39%
Peer Support - Family Support.	50%	14%	36%
Respite Care.	43%	7%	50%
Pharmacologic Management (Medication Management).	43%	14%	43%
Group Psychotherapy.	43%	29%	29%
Psychological / Neuropsychological Testing.	29%	7%	64%
Drug / Alcohol Testing.	25%	4%	71%
Intensive Outpatient Program (IOP).	21%	18%	61%
Intensive Home and Community Based Services.	11%	7%	82%
Day Treatment.	7%	4%	89%
Therapeutic After School and Summer Programs.	7%	14%	79%
Partial Hospitalization.	4%		96%

This Table identifies agencies' self-reported service array. The response choice 'Plan to Offer' refers to services which agencies indicate that they are planning to offer within the next six months.

Of greatest note is the relative unavailability of intensive commmunity based treatment services, including: Intensive Outpatient Program, Intensive Home and Community Based Services, and Day Treatment. These services often buffer against the need for Crisis and Hospitalization services, reducing costs and disruption.

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Continuum of Care - Individual Practitioners

Service Array: *Individual Practitioners*

■ Currently offer　　■ Plan to Offer　　■ Do not offer

Service	Currently offer	Plan to Offer	Do not offer
Individual Psychotherapy.	100%		
Family Psychotherapy.	86%		14%
Group Psychotherapy.	43%	29%	29%
Day Treatment.	14%		86%
Case Management.	14%		86%
Skills Building / Community Based Rehabilitative Services.	14%	14%	71%
Psychological / Neuropsychological Testing.	14%		86%
Targeted Care Coordination.			100%
Intensive Outpatient Program (IOP).			100%
Drug / Alcohol Testing.			100%
Pharmacologic Management (Medication Management).			100%
Crisis Intervention.			100%
Intensive Home and Community Based Services.			100%
Therapeutic After School and Summer Programs.			100%
Behavior Modification and Consultation.			100%

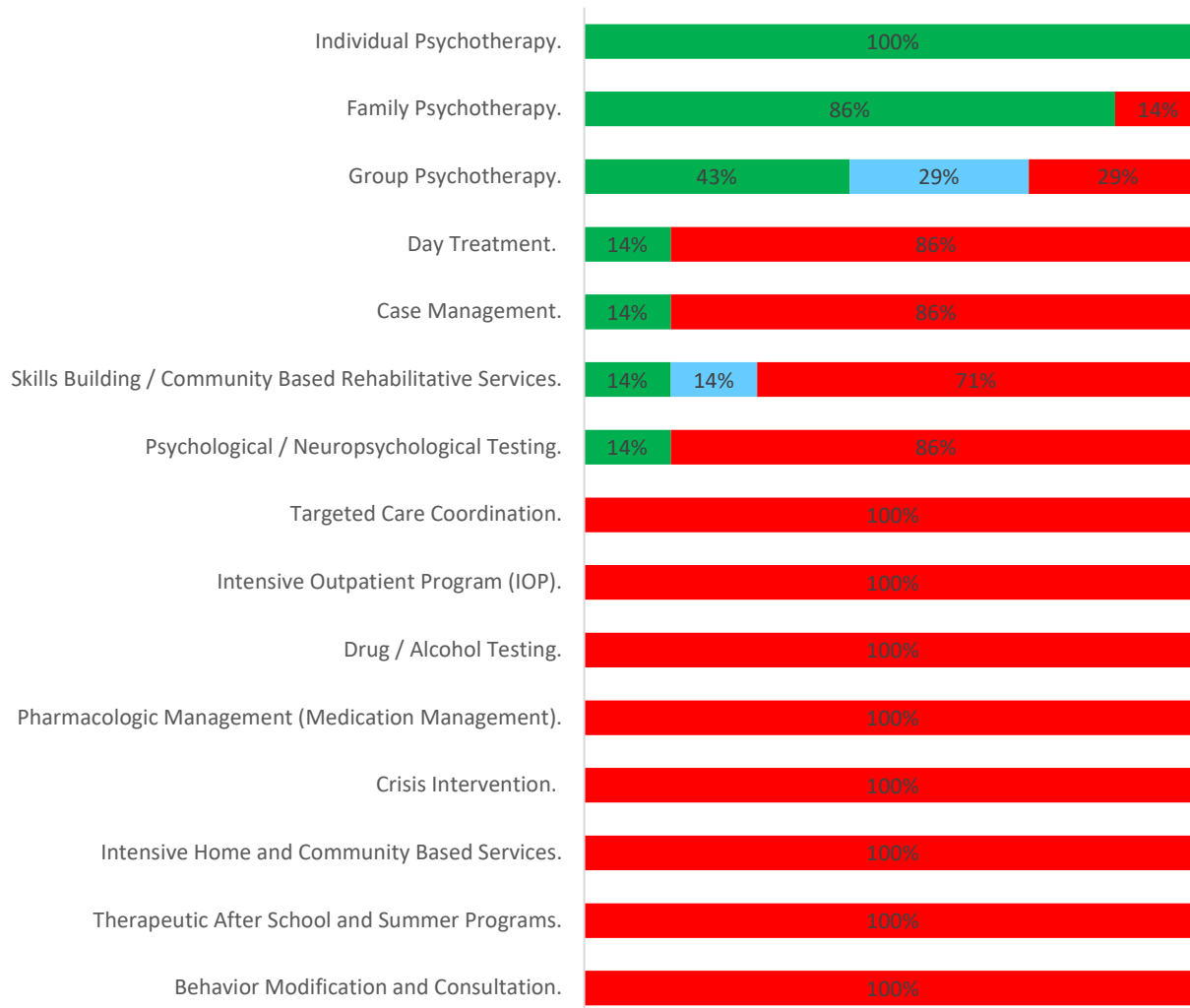This Table identifies individual practitioners' self-reported service offerings. The response choice 'Plan to Offer' refers to services which agencies indicate that they are planning to offer within the next six months.

As might be expected, few services outside of individual and family psychotherapy are provided by individual practitioners. Planned increases in group psychotherapy and the provision of skills-building / CBRS services are of note, though the survey's small sample size makes it difficult to estimate the system impact of such plans.

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Agency Supports for YES Practices

Provider data was collected on the practices and procedures agencies reported as using, consistent with YES practices and principles. Practices assessed included: screening, assessment, treatment planning, progress review and care updating, crisis care, transition planning, and complaints facilitation. Processes assessed for each of these sets of practices included having:

written protocols for how care is to be conducted collaboratively;

regularly scheduled trainings related to that protocol;

reports on the youth and family experience of each care process;

a process for using data to improve these care procedures and practices.

These processes were chosen as they are building blocks for standardizing and then improving care. Complaints facilitation is not discussed in depth here, nor compared to other systems' data on complaints facilitation because it was specific to Idaho's model of practice implementation. The data obtained indicate that agencies report having implemented a written protocol (100%), ongoing training (88%), reporting (75%), and data-based improvement processes (88%) for complaints facilitation at the same high rate as they do for care processes such as accessing care.

Providers were also asked one open-ended question, "What steps could the Idaho Department of Health and Welfare take to better support you and your agency in growing your treatment capabilities?" Response themes and examples are provided after the summary of the supports in place for YES implementation.

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Agency Supports for YES Practices

Idaho Providers: YES Implementation

QUALITY CAPABILITIES		Care Processes				
	↓	Access (Screen)	Engage (Assess)	Approp. (Plan)	Effectiveness (Treat)	Link (Transition)
SUMMARY CAPABILITY						
Practice Protocol						
Targeted Training						
Aligned Reporting						
Improving Value						

IMPLEMENTATION PROGRESS KEY: Robust | Active | Planned | Considering | Absent

Idaho's Agency providers report having active or even robust standardization, implementation, training, and continuous processes for every care process, from access to care to transition from care. They report a remarkably consistent, high level of resources in place for ensuring that YES practice and principles are carried out. Their ratings are substantially higher than from providers and administrators in other state systems which we have surveyed, including both states working thorugh Settlement agreements and states not currently beholden to such agreements. The next page provides one such example.

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Agency Supports for YES Practices

Comparison State: System Change Implementation

QUALITY CAPABILITIES		Care Processes				
		Access (Screen)	Engage (Assess)	Approp. (Plan)	Effectiveness (Treat)	Link (Transition)
SUMMARY CAPABILITY		Planned	Planned	Considering	Considering	Planned
Practice Protocol		Planned	Active	Planned	Planned	Planned
Targeted Training				Considering	Considering	Considering
Aligned Reporting			Active	Considering	Considering	Planned
Improving Value				Considering	Considering	Planned

IMPLEMENTATION PROGRESS KEY: | Robust | Active | Planned | Considering | Absent |

This comparison state was at a similar point in addressing their Settlement agreement when this survey was conducted. We can clearly see that their Summary Capability (the top row, summarizing resources available for practice implementation and improvement at each step in the care process) was both lower and more variable than Idaho providers report. We were able to find only one other network that identified having such a consistently high level of resources level of resources and processes in place for insuring their quality of care. Their pattern is provided on the next page.

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Agency Supports for YES Practices

Statewide Collaborative: EBP Implementation						
QUALITY CAPABILITIES ↓		Care Processes				
		Access (Screen)	Engage (Assess)	Approp. (Plan)	Effectiveness (Treat)	Link (Transition)
SUMMARY CAPABILITY	Robust	Robust	Robust	Robust	Robust	Robust
Practice Protocol	Robust	Planned	Robust	Robust	Robust	Planned
Targeted Training	Robust	Robust	Robust	Robust	Robust	Robust
Aligned Reporting	Robust	Planned	Robust	Robust	Robust	Robust
Improving Value	Robust	Robust	Robust	Robust	Robust	Planned

IMPLEMENTATION PROGRESS KEY:	Robust	Active	Planned	Considering	Absent

This pattern was obtained from surveying a long-standing practice collaborative of more than twenty agencies. This practice collaborative implements a single evidence-based practice, and has access to extensive expert resources, a dedicated funding stream for implementation and improvement, and a community of practice dedicated to coordinating implementation efforts across the state in which it is located. Even with this history, dedicated practice community, and administrative resources, it shows a pattern of implementation progress that is not as advanced as that reported by Idaho's providers.

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Open ended-Responses: **Three Identified Themes**

I. Reduce Administrative Barriers to Care

Reduce the amount of paperwork needed

Reduce barriers to care and duplication of charting requirements. ICANS should be more user friendly.

We want to provide more respite, but we hear that Liberty is hard to get into to get the assessment done. I think it would be great if we could assess these needs ourselves.
Stop CANS every 90 days
More training on how to deal with the redundancy of YES and other services
Unsure. We don't serve very many youth with YES as it seems to be more work
than the family wants

II. Increase the Incentives for Providing Care

Offer incentives for people to enter the treatment field
Provide a higher reimbursable rate so we can attract more clinicians.
Give us a raise, rates have stayed about the same for 10 years.
Ease of access to billing / claim customer service (Optum)
We would offer more services if it was cost effective, current reimbursement does not
allow for that.

Themes continue on next page…

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Open ended-Responses: **Three Identified Themes**

III. Engage in Clear, Inclusive Process for System Development

Transparency and inclusive systems development

TCC services are still very unclear.

Communication

Listen to provider needs, barriers, and options for community services.

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Summary: **Agency Supports for YES Practices**

These examples demonstrate that Idaho providers report having the practice implementation capabilities exceeding those of a well-developed evidence-based practice collaborative. The practice and outcome data from this Quality Review indicate that families and youth routinely experience serious problems in care access, care selection, crisis care, and transition planning. Treatment data indicate that treatment dose, use of skill-building interventions, and engagement of treatment supporters all lag behind empirically established best practices. The data on the existing continuum of care also points to a serious gap in the availability of intensive community treatment. Together, these are hallmarks that the care described in the YES practice manual and YES principles is still in an early phase of development. There is a misfit between the care desired by youth and families served in this system, and care received.

Furthermore, the outcome data that we analyzed as part of this Quality Review indicate that there are very modest improvements in strengths, and similarly modest decreases in risk and impairment. For example, youth served for 90 days in outpatient (non-Wraparound) care average a roughly one-point change in rating on one item (out of 14 items) in the Functioning domain.

Providers likely indicate that they meet YES practice standards and enact YES principles because there are few to no numerical standards yet applied to these practices and principles. For example, in the YES practice manual four levels of care are described as available to youth and their families. Yet the YES practice manual does not include timelines for key care processes in each of those levels of care, the minimum expected dose of care at each level, nor the optimal duration of care. By contrast, other states' Practice Manuals have clearly described timeliness, dose, and length of stay standards. In Appendix A we provide examples of such standards from two states with lawsuits similar to the lawsuit leading to the Jeff D Settlement agreement.

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Appendix A : Numerical Practice Standards

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Overview and Sources: Numerical Practice Standards

These manuals provide both empirically based practice standards as well as extensive examples of structured documentation. Providing clear, publicly available guidance to agencies and practitioners helps create trust and buy-in and reduces anxiety and ambiguity regarding key decisions in care.

Both resources are also explicit about the training and coaching requirements for providing different types of care, and for people with different roles in the care process. The WISe manual provides the clearest explanation of training and ongoing development requirements, beginning on p. 93 of the WISe manual.

The numerical practice standards are provided in two practice manuals which are freely available. They are:

Hawai'i Teal Book:

https://health.hawaii.gov/camhd/files/2018/06/Teal-Book-2018.pdf

WISe Practice Manual:

https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf

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Standards for **Access**

Hawai'i   Washington

General Performance Standards	Intensive Services Standards	Wraparound
Eligibility criteria provided on p. I-9. 'Routine services must be initiated within 30 days of need identification' (p. I-15). Referral packet must be provided within 3 days of need identification (p. I-16).	Includes age, parental participation, and clinical criteria specific to the intervention's theory of change. Contact must be made within 72 hours of referral for this service.	Potentially qualifying populations described on p.13; Screening must occur within 14 days of referral (p. 14). Standardized numerical clinical criteria for entry are published in the Manual (p. 75). Decision flow chart on p. 21.

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Standards for **Initial Assessment**

Hawai'i   Washington

General Performance Standards	Intensive Services Standards	Wraparound
Required within 21 days of referral and authorization (p. II-21). Feedback session with family required within 2 weeks of completion (p. II-21). Template provided (Appendix 4).	Follows General Performance Standards.	Within 30 days of entry (p. 25).

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Standards for **Treatment Planning**

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Hawai'i   **Washington**

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General Performance Standards	Intensive Services Standards	Wraparound
Initial plan within 10 days of intake; Quarterly Review (I-14).	Follows General Performance Standards.	Within 1-2 weeks of CANS completion (p. 27); form example on p. 76.

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Standards for **Crisis Prevention and Response Planning**

	Hawai'i		**Washington**
General Performance Standards	Intensive Services Standards	Wraparound	
Safety Plan required within ten days of admission (p. II-54). Template provided (Appendix 7).	Follows General Performance Standards.	Update must occur within 14 days of crisis resolution (p. 33); form example included in Manual (p. 85). Mobile crisis services are required of each plan provider, available 24/7/365 (p. 33).	

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Standards for **Reassessment**

Hawai'i		Washington
General Performance Standards	Intensive Services Standards	Wraparound
Requires monthly reviews: "Review interventions, needs, goals and progress with the youth and family monthly utilizing data regarding the major treatment targets. These data should be collected regularly via self-monitoring, parent monitoring, client/parent ratings, or brief standardized measures" (p. II-50). Annual Evaluation and template provided (Appendix 5).	Continuing stay clinical criteria are reviewed every 30 days for continuing authorization (p. II-66).	Tasks assigned and updated every 30 days (p. 29); formal Reassessment every 90 days (p. 30).

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Standards for **Dose of Care**

Hawai'i   ## Washington

General Performance Standards	Intensive Services Standards	Wraparound
Manual specifies that, "The usual course of treatment is six (6) to twenty-four (24) sessions or six (6) months. This service should be provided in conjunction with at least occasional family therapy sessions and may include a brief "check-in" with the parent or guardian as part of the individual session" (p. II-50).	Standard that, "The majority of the service (80% or more) is provided face-to-face with the youth and their family" (p. II-67). Up to sixty hours of care authorized per 30 days (p. II-66).	CFT every 30 days, at a minimum (PM p. 26); caseload sizes explicit (p. 10). Initial dose of care must be clearly described (per p. 24). Dose is not specified, but instead, "Direct services will be available in the amount, duration, and scope necessary to address the medically necessary identified needs" (p. 31).

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Standards for **Care Duration**

Hawai'i		**Washington**
General Performance Standards	Intensive Services Standards	Wraparound
Empirical standards derived from local data.	Empirical standard for length of stay, "Average length of FFT treatment is three (3) months with most youth reaching a point of diminishing progress by the fourth (4) month" (p. II-66).	Not provided explicitly in the Manual, but analyzed to set policy: https://www.hca.wa.gov/assets/program/wise-length-of-stay-and-cans-outcomes.pdf

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Standards for **Transitioning**

	Hawai'i		Washington
	General Performance Standards	Intensive Services Standards	Wraparound
	Discharge criteria are a mixture of numerical and clinical standards, and are explicit in the manual (p. II-52). Discharge summary required within 10 days of exit from care (p. I-15).	Discharge criteria are a mixture of administrative and clinical standards, and are explicit in the manual (p. II-67).

"FFT therapists must provide CC [Care Coordinator] with a thirty (30) day written notice of intent to discontinue services" [p. II-69]. | "When the team agrees it is appropriate" (p. 34). Documented in care plan. |

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