Idaho Youth Empowerment Services (YES) Workforce Capacity and Gaps Analysis

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Executive Summary

Objective: The State of Idaho is undergoing a comprehensive children's mental health service system transformation pursuant to the Jeff D. Settlement Agreement. Under the terms of the Agreement, Idaho is responsible for ensuring that youth with serious emotional disturbance (SED) and their families have timely access to an array of community-based mental health services and supports. The new service array is called Youth Empowerment Services (YES). As one component of this effort, Idaho is directed to develop a sustainable workforce capable of delivering YES services to youth with SED. This report provides a foundation for the State's YES workforce development efforts by assessing the current capacity of Idaho's Medicaid youth mental health services workforce. The report provides population estimates of the number of Idaho Medicaid providers who currently deliver mental health services and supports to Idaho youth and their families and assesses the gap between this workforce capacity and the capacity needed to deliver YES services and supports to youth with SED under the terms of the Settlement Agreement.

Method: Population estimates of Medicaid workforce capacity including (1) the number of mental health professionals who serve youth by role (e.g., psychiatrists, master's level clinicians, bachelor's-level staff), (2) the number of mental health professionals with specialized training in wraparound and select evidence-based practices for youth, and (3) the number of youth who received EBPs as part of their treatment, were developed using weighted survey data collected from providers. The Idaho YES Workforce Survey was an online survey of organizations and sole proprietorships that delivered Medicaid-funded mental health services to youth and their families as part of Idaho's Medicaid provider network as of January 30, 2018. The sampling frame included 407 total practices (253 organizations and 154 sole proprietorships) of which, 249 (61%) responded. Weighting class adjustments incorporating information on geographic location, practice type, and practice size were used to develop estimates of population totals. Estimates of youth need for mental health services were based on Idaho Department of Health and Welfare projections and analyses of Medicaid claims data. Workforce capacity gaps analysis was conducted for two different scenarios incorporating different assumptions about the number of youth with SED likely to need YES services and supports.

Results: In 2016, an estimated 3,603 mental health professionals delivered community-based services and supports to 27,411 Idaho youth and their families in Idaho's Medicaid-funded system. The point-in-time workforce capacity and gaps analysis indicated that Idaho's Medicaid youth mental health services workforce needed to be 15.9% to 29.5% larger in order to provide YES services and supports to youth with SED. Significant workforce deficits were observed in training and preparedness to deliver evidence-based practices and new community-based services (e.g., wraparound, respite). In addition, this report documents significant maldistribution of all provider types across Idaho's geographic areas.

Conclusions and Recommendations: Findings from this report are consistent with other analyses of Idaho's behavioral health workforce and with national studies which document significant shortages of mental health professionals for adults and youth in Idaho and across the nation. These data provide a foundation for future workforce development efforts to improve youth access to community-based services under the YES system transformation. Recommendations are provided for improving the capacity of Idaho's current Medicaid youth mental health services workforce, increasing the supply and retention of providers to deliver YES services, and improving data collection for ongoing workforce development efforts.
(July 3, 2018)

1. Introduction

This report presents the findings of the 2018 Youth Mental Health Services Workforce Capacity and Gaps Analysis commissioned by the Idaho Department of Health and Welfare (IDHW), Division of Behavioral Health and completed by Boise State University's School of Social Work to help guide Idaho's Youth Empowerment Services (YES) system transformation. The Department launched the YES transformation initiative in 2014 in response to the Jeff D. Settlement Agreement which was negotiated following the 1980 Jeff D. class action lawsuit. The goals of the Settlement Agreement and the YES transformation are to address deficits in Idaho's mental health service system for youth related to (1) the mixing of adults and juveniles at State Hospital South, and (2) the provision of community-based mental health services to children with serious emotional disturbance. Youth who experience serious emotional disturbance (SED) are those whose daily functioning is severely impaired by a mental disorder as determined by a qualified mental health professional based on established criteria. Under the terms of the Settlement Agreement, Idaho State is directed to ensure that youth with SED and their families have timely access to a full array of community-based mental health services and supports to meet their needs. The YES transformation is designed to provide these services and supports.

The foundation for any effective service system is an adequate supply of a well-trained workforce. As such, the Settlement Agreement directs Idaho State to develop a sustainable workforce to provide the new YES community-based service array. This report provides a foundation for the State's YES workforce development planning and activities by assessing the current capacity of Idaho's Medicaid youth mental health services workforce to meet the needs of Idaho youth with SED. Specifically, this Workforce Capacity and Gaps Analysis meets the Department's stated goals of (1) assessing the current statewide system capacity of the Idaho Medicaid provider network to provide YES services and supports statewide to youth with SED as defined in the Jeff D. Settlement Agreement, and (2) providing recommendations to meet the State's YES workforce goals.

2. Method

The data presented in this report come from three sources: (1) a statewide survey of Idaho's Medicaid mental health provider network conducted by Boise State University School of Social Work in partnership with Rider Consulting and IDHW, (2) Medicaid claims data and reports provided by Idaho Medicaid and IDHW, and (3) published scientific and gray literature on Idaho's mental health workforce and systems as well as literature assessing children's mental health services and workforce in other States and nationwide.

2.1 Idaho Youth Empowerment Services Workforce Survey

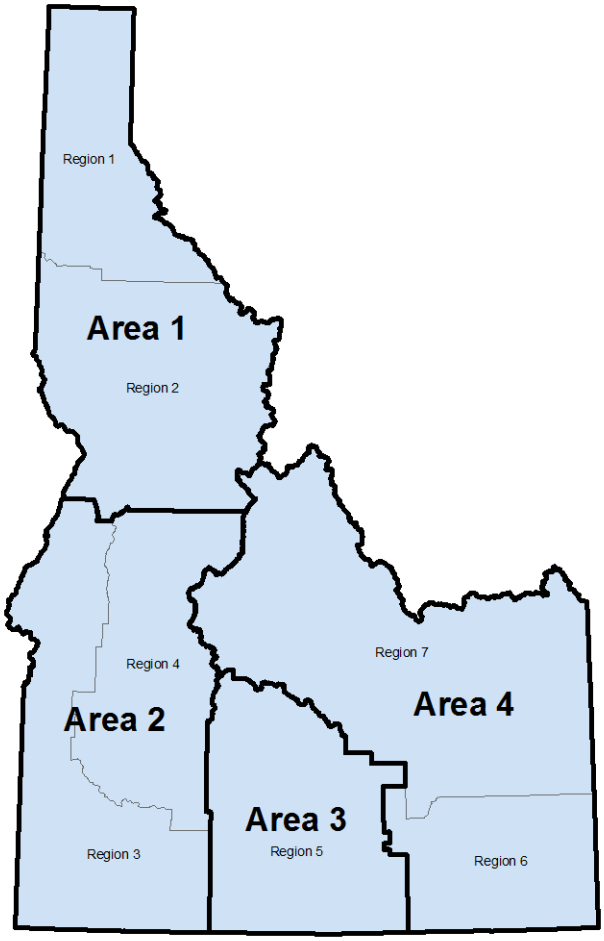
The Idaho YES Workforce Survey was an online survey of Idaho Medicaid mental health providers fielded from January 16, 2018 to February 22, 2018 by Boise State University and Rider Consulting. Full details of the survey methodology and initial analyses of the data are provided in the report *Children's Mental Health Workforce Development Plan: Provider Survey Results* submitted to IDHW on April 19, 2018. In brief, the investigators used a six-step, evidence-based process to survey Idaho Medicaid mental health providers regarding the services and supports they provide to youth and their families and the workforce they employ to deliver those services. The sampling frame for the survey included all organizations and sole proprietorships that delivered Medicaid-funded mental health services as part of Idaho's Medicaid provider network as of January 30, 2018. The original sampling frame provided by the Department included 457 unique businesses (inclusive of organizations and sole proprietorships) based on tax identification numbers. Removal of businesses that had closed or did not have email contact information reduced the sampling frame to 407 total providers (253 organizations and 154 sole proprietorships) which represent the population total for the analyses in this report. The overall response rate to the survey was 61%. A prior report to the Department, *Children's Mental Health Workforce Development Plan: Provider Survey Results*, provides full details and analysis of the unweighted data from the YES Workforce survey.

In this report, we (1) present additional analyses of the YES Workforce survey data in order to provide population estimates of Idaho's Medicaid children's mental health services workforce and capacity, and (2) compare Idaho's Medicaid workforce capacity to youths' need for YES services in order to develop a point-in-time estimate of the YES workforce capacity gap. The analyses in this report use well-established weighting class adjustment methods[1] to compensate for survey nonresponse and to generate population estimates of the total number of youth mental health service providers of various types in Idaho (e.g., psychiatrists, master's level clinicians, bachelor's-level professionals and peer support staff), the total number of youth who received select evidence-based practices (EBPs) in the State, and other workforce and service system characteristics.

Details of the weighting class adjustment procedure and the external data used to generate the weights are provided in the **Technical Appendix.** In brief, the procedure uses information that is external to the survey (e.g., number and size of organizations in each area of the State) to weight the information provided by respondents so that their answers represent their own practices as well as some proportion of similar practices in the same area of the State that did not respond. Weighting class adjustments are a well-established and frequently employed technique in survey research because they protect respondent anonymity and reduce bias in estimating population totals from survey data.[1] In the present study, the use of weighting class adjustments allowed us to estimate population totals of children's mental health providers in Idaho. These population totals provide an assessment of the service system's current workforce capacity and serve as benchmarks for future workforce development activities.

In order to better understand the geographic distribution of Idaho's children's mental health services workforce, we present population workforce estimates in four geographic areas of the state. The four areas are shown in **Figure 1** along with the seven regions used by IDHW to characterize the state. Workforce data are presented at the area level rather than by region because many provider organizations serve multiple regions of the State, particularly in the southwest and southeast areas of the State (Regions 3 and 4 which span Boise and Nampa/ Caldwell; Regions 6 and 7 which span Idaho Falls and Pocatello), and because providers indicated the range of communities they served rather than the address of their practice. The four areas represent geographic sections of the State with distinct providers and population centers.

Figure 1. Idaho Department of Health and Welfare Regions and YES Workforce Survey Areas for Analysis



2.2 Idaho Claims Data and Reports

The second source of data for this report includes Idaho Medicaid claims data and IDHW reports on the number of youth served in different regions of the State and the number of youth who experience SED. As part of the larger YES system transformation, IDHW has analyzed Medicaid claims and Division of Behavioral Health data to better understand the needs of youth who access mental health services in Idaho, the number of youth with SED who are likely to require services under the terms of the Settlement Agreement, and the service system's current capacity

Box 1. Definitions of Serious Emotional Disturbance

US Substance Abuse and Mental Health Services Administration

Pursuant to section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321 "children with serious emotional disturbance" are persons:

a. From birth up to age eighteen (18),

b. who currently or at any time during the past year,

c. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM),

d. that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Idaho Administrative Code (16.07.37)

To be eligible for children's mental health services through a voluntary application to the Department, the applicant must:

a. Be under eighteen (18) years of age,

b. reside within the State of Idaho,

c. have a DSM-IV-TR Axis I diagnosis (a substance use disorder alone, or a developmental disorder alone, does not constitute an eligible Axis I diagnosis, although one more of these conditions may coexist with an eligible Axis I diagnosis), and

d. have a substantial functional impairment as assessed by using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool and Early Child Functional Assessment Scale (PECFAS) with a full eight (CAFAS) or seven (PECFAS) scale score of 80 or higher with "moderate" impairment in at least one of three areas including: Moods/ emotions, Thinking, or Self-harm.

to meet these needs. These reports were shared with the assessor and are incorporated into this report where appropriate.

2.3 Scientific and Gray Literature related to Mental Health Services for Youth and Workforce Development

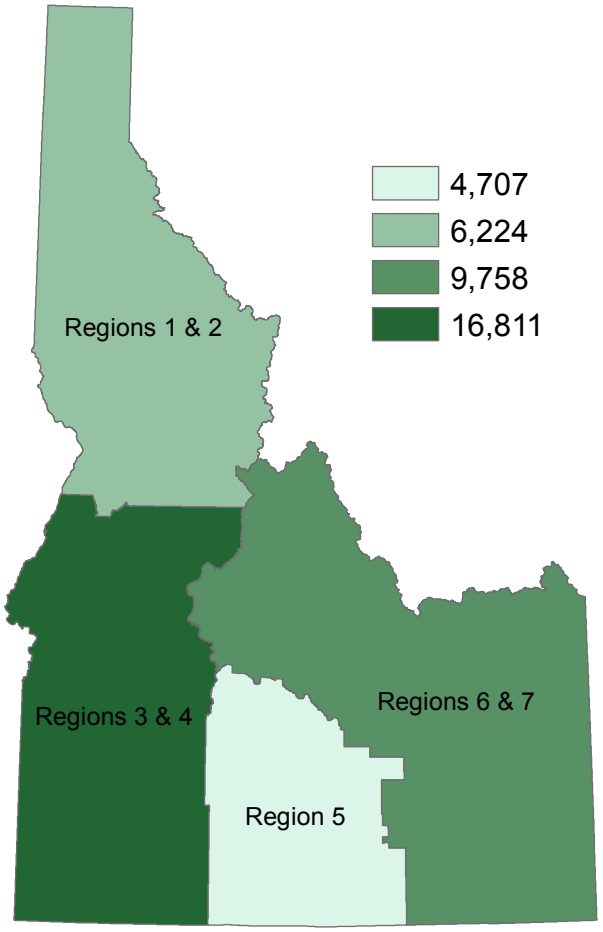
In addition to collecting original primary survey data and examining Idaho claims data and reports, the assessor also conducted a scan and literature review of published scientific reports, State and federal technical reports, and other 'grey' literature on behavioral health workforce and youth mental health services in Idaho and across the United States. This literature includes reports published by the Idaho Department of Labor and the Western Interstate Commission for Higher Education (WICHE) which have both recently analyzed Idaho's overall behavioral health workforce and system with an emphasis on services for adults. These reports provide important context for understanding the capacity of Idaho's children's mental health services workforce to meet the needs of youth with SED.

3. Defining the Target Population

The target population for the YES system transformation includes Idaho residents under the age of eighteen (18) who experience an SED. The Settlement Agreement defines SED in accordance with the definition provided by the US Substance Abuse and Mental Health Services Administration (SAMHSA) pursuant to Public Law 102-321 and as operationalized in Idaho Administrative Code (IDAPA 16.07.37). The SAMHSA and Idaho definitions of SED are presented in **Box 1**. Based on these definitions, the two essential criteria for assessing SED involve determining whether a child experiences (1) a *DSM disorder*, and (2) *substantial functional impairment* secondary to that disorder.

Under the terms of the Settlement Agreement,

Figure 2. Estimated Number of Idaho Youth with Serious Emotional Disturbance by Area (N = 37,500)



each year Idaho State is required to generate an estimate of the number of Idaho youth who experience SED. This estimate forms a basis for assessing the capacity of Idaho's children's mental health workforce in the current Workforce Capacity and Gaps Analysis.

In 2016, IDHW estimated that the number of Idaho youth with SED ranged from 35,000 to 40,000 youth (median = 37,500 youth).[2] This represents 8.1% to 9.2% of Idaho's 2016 youth population of 434,465 (median estimate of 37,500 = 8.6%). The estimate was based on a synthesis of the scientific literature, Medicaid claims data, and an analysis of previous estimates generated for the Jeff D. lawsuit. It is consistent with prior studies documenting the prevalence of SED in population representative samples of youth conducted across the United States.[3-6] **Figure 2** shows the estimated number of Idaho youth with SED in each of the four Idaho areas based on the State's analysis.

In addition to estimating the number of Idaho youth with SED, the IDHW analysis noted that nationally, only about 50% of youth who experience SED participate in mental health services. This finding has been replicated in several population-representative community studies of youth and suggests that the number of youth who are likely to access or need YES services is approximately 50% of the total number of youth with SED. Given that 37,500 Idaho youth were presumed to have experienced SED in 2016, this implies that 18,750 Idaho youth are likely to access YES community-based mental health services and supports (not accounting for population growth). These estimates of the number of Idaho youth with SED (i.e., 37,500 youth) and the number of youth who are likely to utilize or need YES services (i.e., 18,750 youth) form a basis for assessing the capacity of Idaho's mental health workforce in this report.

4. Idaho's Medicaid Youth Mental Health Workforce Capacity

In this section, we present population estimates of Idaho's Medicaid youth mental health services workforce for the State and for the four geographic areas shown in Figure 1. These estimates are based on weighted analyses of the YES Workforce Survey data. It is important to note that these analyses focus specifically on the number of workforce members who served youth and their families. Previous studies of Idaho's behavioral health workforce (e.g., Idaho Bureau of Labor reports) have not distinguished between providers who served youth and those who served adults. Thus, this section provides the first estimates we are aware of regarding Idaho's Medicaid youth mental health services workforce.

The section is broken into three parts addressing (1) the number of mental health professionals by role (e.g., psychiatrists, master's level clinicians, bachelor's-level staff), (2) the number of mental health providers with specialized training in the provision of wraparound and select EBPs, and (3) the number of youth who received EBPs as part of their treatment.

4.1 Idaho Medicaid Youth Mental Health Workforce Capacity by Role

Table 1. Number of Full-time, Part-time, and Full-time Equivalent (FTE) Specialty Mental Health Prescribers Serving Youth in Idaho

Area		Full-time psychiatrists (N)	Part-time psychiatrists (N)	FTE psychiatrists	Full-time ANPs (N)	Part-time ANPs (N)	FTE ANPs	Total FTE specialty prescribers
1	Regions 1 & 2	4	0	3.9	9	3	10.3	14.1
2	Regions 3 & 4	5	2	6.0	13	23	24.3	30.3
3	Region 5	0	1	0.5	1	0	1.0	1.5
4	Regions 6 & 7	12	9	16.4	14	1	14.5	30.8
	State Total	21	12	26.7	37	27	50.1	76.8

4.1.1 Specialty Mental Health Prescribers

Specialty mental health prescribers include child psychiatrists and advanced nurse practitioners with expertise in treating youth with SED and their families. These professionals play an important role in meeting the needs of youth with SED by conducting psychiatric diagnostic evaluations, prescribing medicine and psychosocial treatments to meet youths' needs, engaging in medication management, and directing youths' care. Respondents to the YES Workforce Survey indicated the number of Psychiatrists and Advanced Nurse Practitioner (ANP) prescribers who worked with youth and their families as well as whether these prescribers worked full-time or part-time. **Table 1** shows the number of psychiatrists and advanced nurse practitioners who work with youth and their families in Idaho by Area and statewide based on our weighted analyses of the YES Workforce data.

In order to assess the capacity of Idaho's specialty mental health prescribers to meet the needs of youth with SED, ratios were calculated to quantify the number of full-time equivalent specialty mental health prescribers available to serve youth to the number of youth with SED in each area. Specifically, the ratios indicate the number of specialty mental health prescribers per 1,000 youth with SED. For these analyses, we assumed that part-time prescribers worked 0.5 FTE (20 hours per week). Calculation of these ratios allows us to assess the availability of prescribers to youth relative to the youth population in a given area and to compare the availability of specialty youth prescribers across areas of the State.

The overall ratio of total FTE specialty prescribers per 1,000 youth with SED in Idaho was 2.05 with a range of 0.32 in Area 3 (Region 5) to 3.16 in Area 4 (Regions 6 & 7). **Figure 3** shows the distribution of total specialty prescribers (psychiatrists plus ANPs) available to treat youth per 1,000 youth with SED in each area of the State. **Figure 4** presents the contribution of FTE psychiatrists and ANPs per 1,000 youth with SED by area and across the entire State.

In order to formally compare the availability of specialty prescribers for youth across Idaho, we

Figure 3. Total Specialty Prescribers (Psychiatrists and Advanced Nurse Practitioners) Available to Treat Youth per 1,000 Youth with SED by Area

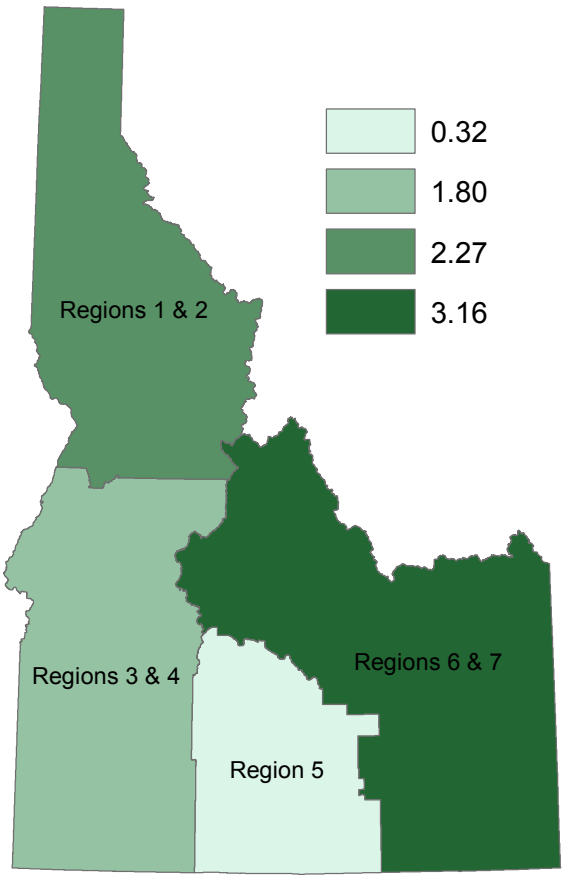
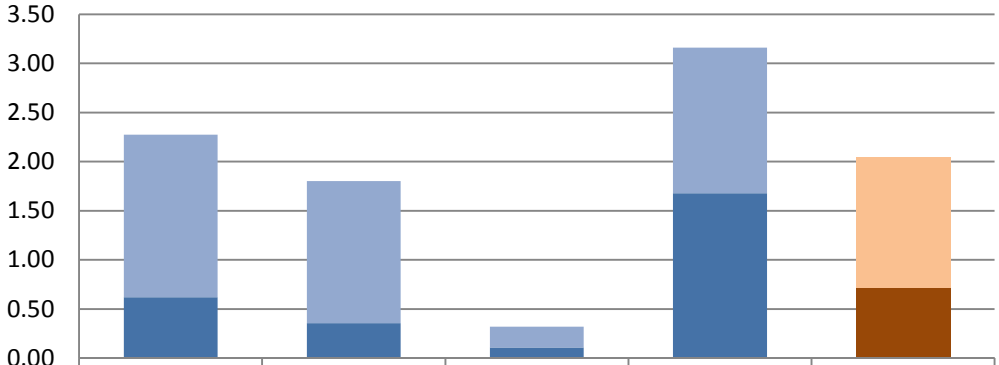


Figure 4. Full-time Equivalent Psychiatrists and Advanced Nurse Practitioners per 1,000 Youth with SED by Area



	Regions 1 & 2	Regions 3 & 4	Region 5	Regions 6 & 7	Idaho Total
FTE Advanced Nurse Practitioners per 1,000 Youth with SED	1.65	1.45	0.21	1.48	1.34
FTE Psychiatrists per 1,000 Youth with SED	0.62	0.36	0.11	1.68	0.71

conducted a chi-square goodness-of-fit test. This test evaluates whether the distribution of specialty prescribers for youth across the four areas of the state is proportionate to youth need in those areas, as measured by the number of youth with SED in each area. This analysis addresses the distribution of available prescribers across the State; it does not address whether or not the absolute number of available prescribers is adequate to meet youth need.

Results of the chi-square analysis indicated that specialty prescribers for youth in Idaho are not distributed proportionate to youth need, p = .004 (see **Table 2**). While there was a relatively close match between the observed and expected number of specialty youth prescribers in Regions 1, 2, 3 and 4; Region 5 emerged as an area of the State with a very low number of specialty prescribers for youth relative to youth. Furthermore, Regions 6 and 7 had a disproportionately high number of FTE prescribers relative to youth need.

4.1.2. Master's-level Mental Health Clinicians

Master's-level mental health clinicians include professionals who have a master's degree and licensure in a behavioral health profession (e.g., social work, counseling, substance use disorder treatment). These individuals are an essential part of the mental health service system for youth as they deliver the most intensive and frequently used services to youth and families including psychotherapy and other psychosocial interventions, such as diagnostic assessments, treatment planning, care coordination, and wraparound. Respondents to the YES Workforce Survey indicated the number of master's-level clinicians working in their practice setting in the following categories: social worker, counselor, mental health professional, and substance use disorder clinician. This information was provided by both organizational respondents and sole proprietorships. In this section, we present analyses of Idaho's master's-level clinical workforce including analyses of the total clinicians available and sub-analyses of mental health clinicians (social workers, counselors, and mental health professionals) and substance use disorder clinicians.

Table 3 shows the number of full-time, part-time, and full-time equivalent mental health clinicians, substance use disorder (SUD) clinicians, and total master's-level clinicians (i.e., mental health plus SUD

Table 2. Analysis of the Distribution of Specialty Mental Health Prescribers for Youth Relative to Youth Need by Idaho Area

	N of Youth with SED	Expected N of FTE specialty prescribers if proportionate to youth need	Observed N of FTE specialty prescribers
Regions 1 & 2	6224	13	14
Regions 3 & 4	16811	34	30
Region 5	4707	10	2
Regions 6 & 7	9758	20	31

Table 3. Number of Full-time, Part-time, and Full-time Equivalent (FTE) Master's-level Mental Health Clinicians Serving Youth in Idaho

		Mental Health Clinicians			Substance Use Disorder Clinicians			Total Master's-level Clinicians		
Area	IDHW Regions	Full-time (N)	Part-time (N)	Total FTE (N)	Full-time (N)	Part-time (N)	Total FTE (N)	Full-time (N)	Part-time (N)	Total FTE (N)
1	Regions 1 & 2	217	62	248.4	39	7	42.4	256	69	290.8
2	Regions 3 & 4	735	175	822.1	77	17	85.7	812	192	907.8
3	Region 5	124	63	155.2	23	6	25.5	146	69	180.7
4	Regions 6 & 7	453	109	507.4	31	8	34.7	484	116	542.2
	State Total	1,529	409	1,733.2	169	38	188.4	1,698	446	1,921.5

clinicians) who work with Idaho youth and their families by area of the State. The total number of mental health clinicians who worked with youth in Idaho in 2016 was estimated to be 1,938 (i.e., full-time plus part-time clinicians), representing 1,733 full-time equivalent (FTE) clinicians. Data provided by Idaho Medicaid indicates that a total of 4,242 mental health clinicians delivered services to all participants in the network during the same time period. Assuming comparable definitions of mental health clinicians, this suggests that 46% of mental health clinicians in the Medicaid network served youth in 2016.

Figure 5. Full-time Equivalent Master's-Level Clinicians per 1,000 Youth with SED

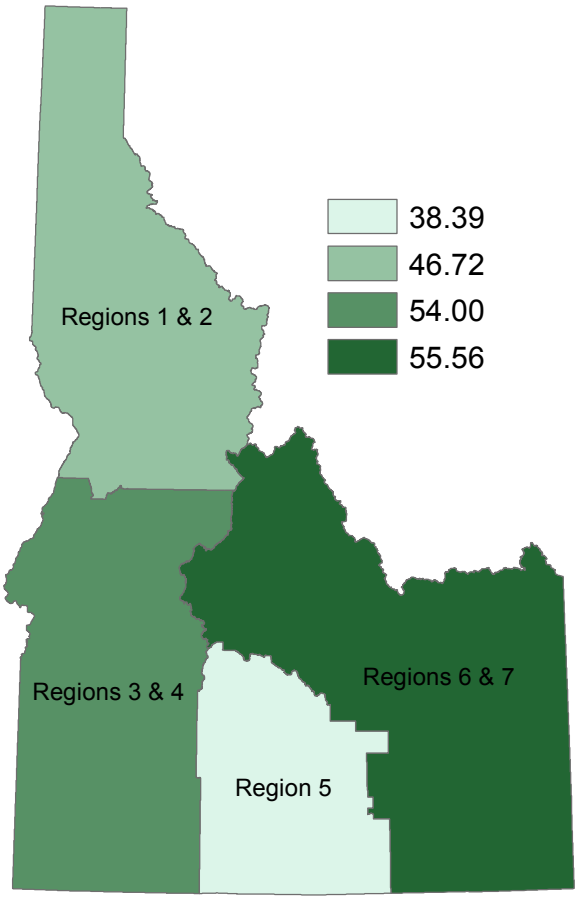


Table 4 presents the ratios of FTE master's- level mental health and substance use disorder clinicians per 1,000 youth with SED across each area of the State. **Figure 5** shows the total number of FTE master's-level clinicians per 1,000 youth with SED in each area of the State.

In order to formally compare the availability of master's-level mental health clinicians for youth with

Table 4. Full-time Equivalent (FTE) Master's Level Clinicians Available to Treat Youth in Idaho per 1,000 Youth with Serious Emotional Disturbance (SED) by Area

Area	IDHW Regions	FTE Mental Health Clinicians per 1,000 Youth with SED	FTE SUD Clinicians per 1,000 Youth with SED
1	Regions 1 & 2	39.92	6.81
2	Regions 3 & 4	48.90	5.10
3	Region 5	32.97	5.42
4	Regions 6 & 7	52.00	3.56
	State Total	46.22	5.02

Table 5. Analysis of the Distribution of Master's-level Mental Health Clinicians for Youth by Area of the State

	Expected N of FTE clinicians if proportionate to youth need	Observed N of FTE clinicians
Regions 1 & 2	288	248
Regions 3 & 4	777	822
Region 5	218	155
Regions 6 & 7	451	507

Table 6. Number of Bachelor's-level Mental Health Staff Serving Youth in Idaho

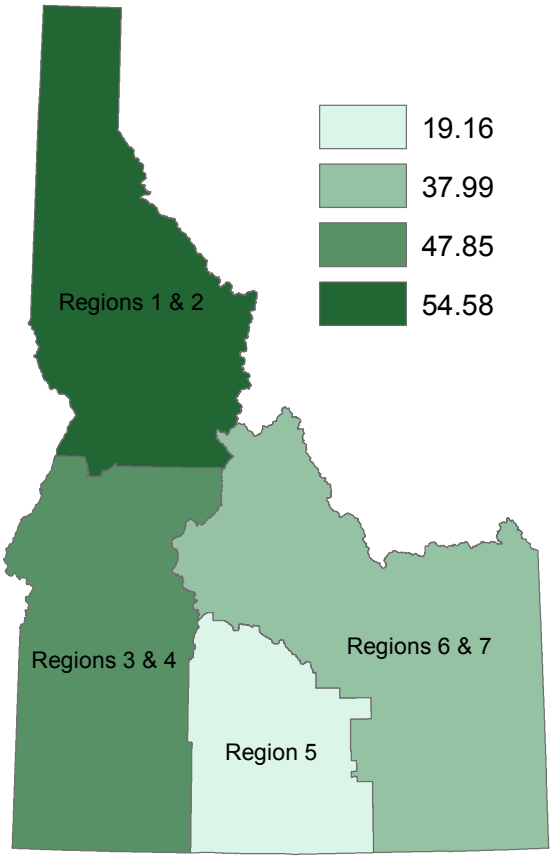
Area	IDHW Regions	N of Full-time Bachelor's-level Staff	N of Part-time Bachelor's-level Staff	FTE Bachelor's-level Staff	FTE Bachelor's-level Staff per 1,000 Youth with SED
1	Regions 1 & 2	272	136	339.7	54.58
2	Regions 3 & 4	647	314	804.3	47.85
3	Region 5	72	36	90.2	19.16
4	Regions 6 & 7	278	185	370.7	37.99
	State Total	1269	671	1604.9	42.80

Table 7. Characteristics of Bachelor's-level Mental Health Staff Serving Youth in Idaho

Area	IDHW Regions	N of Staff Delivering Case Management	N of Staff Delivering CBRS	N of CBRS staff certified to work with children	% of CBRS staff certified to work with children	N of CBRS staff working towards child certification	% of CBRS staff working toward child certification
1	Regions 1 & 2	86	109	71	65%	34	31%
2	Regions 3 & 4	510	316	87	27%	167	53%
3	Region 5	38	89	23	26%	1	1%
4	Regions 6 & 7	334	246	198	81%	38	15%
	State Total	967	759	379	50%	239	32%

SED across Idaho, we conducted a chi-square goodness-of-fit test which evaluated whether the distribution of mental health clinicians across the state was proportionate to youth need, measured as number of youth with SED in each area of the State. Similar to the analyses presented above for prescribers, this analysis does not test the absolute availability of clinicians but rather their distribution across the State. Results of the analyses indicated that mental health clinicians for youth are not distributed proportionate to youth need in Idaho, $p < .001$ (see **Table 5**). Regions 3, 4, 6, and 7 had a higher than expected number of clinicians relative to youth need whereas Regions 1 and 2 had slightly fewer than expected clinicians and Region 5 had the largest deficit in clinicians relative to youth need.

Figure 6. Full-time Equivalent Bachelor's-Level Staff per 1,000 Youth with SED



4.1.3. Bachelor's-level Staff

Bachelor's-level staff and paraprofessionals represent an important part of the mental health services workforce for youth. These individuals have special education, training, credentials, and sometimes licensure which equip them to provide a range of community-based services and supports to

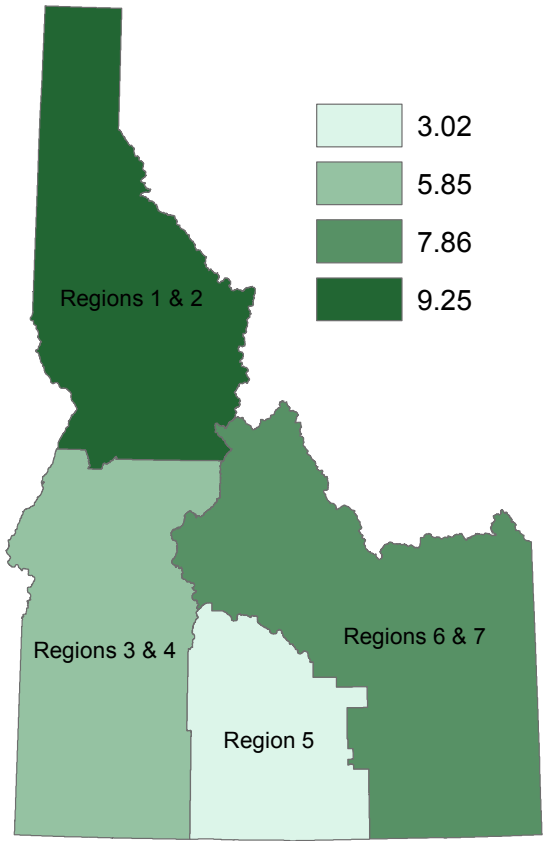
Table 8. Number of Peer-support Staff Delivering Services to Youth with SED and their Families in Idaho

Area	IDHW Regions	N of Full-time peer support staff	N of part-time peer support staff	Total FTE of Peer Support staff	FTE peer support staff per 1,000 youth with SED
1	Regions 1 & 2	30	56	57.6	9.25
2	Regions 3 &4	73	52	98.4	5.85
3	Region 5	11	6	14.2	3.02
4	Regions 6 & 7	61	32	76.7	7.86
	State Total	174	146	246.8	6.58

youth with SED and their families under the supervision of master's-level clinicians and other mental health professionals. Community-based services are a critical part of the new YES service array and having a qualified cadre of bachelor's-level staff to deliver these services is crucial to the effectiveness of the YES transformation.

Respondents to the YES Workforce Survey were asked to indicate the number of bachelor's level and paraprofessional staff who delivered services to youth and their families in the following categories: case manager, community based rehabilitation specialist, community based services provider, crisis case manager, crisis specialist, intake coordinator, mental health technician, psychiatric technician, rehabilitation technician, registered nurse, and respite care provider. These categories of staff were combined to represent the total bachelor's-level staff available to serve youth with SED; however, it is important to note that staff with higher levels of education (e.g., master's level) and/ or licensure can perform these jobs. In a separate section of the survey, respondents were also asked specifically about the number of staff delivering case management and community-based rehabilitation services (CBRS). We present these finer-grained analyses in this section as well.

Figure 7. Full-time Equivalent (FTE) Peer-Support Staff Delivering Services to Youth per 1,000 Youth with SED



The total number of full-time, part-time, and full-time equivalent bachelor's-level mental health staff who worked with youth in Idaho's Medicaid network in 2016 is shown in **Table 6**. **Figure 6** shows the ratio of FTE bachelor's level staff per 1,000 youth with SED across the four areas of Idaho.

Table 7 provides additional detail on the number of staff who provided specific community-based services that are often delivered by bachelor's-level staff—these services include community-based rehabilitation services (CBRS) as well as case management. In addition, Table 7 also shows the percentage of CBRS staff who are certified to work with youth across the entire State and within each area of the State as reported by providers. Overall, 50% of CBRS staff appear to have a special credential for working with youth and there is significant variability across areas of the State in the proportion of CBRS staff who are certified to work with youth. Regions 6 and 7 had the highest percentage of CBRS staff certified to work with youth (81%), followed by Regions 1 and 2 (65%). Regions 3 and 4 (27%) and Region 5 (26%) had much lower proportions of CBRS staff certified to work with youth.

In order to assess the extent to which Idaho's current bachelor's-level mental health staff are distributed across the State proportionate to youth need, we conducted a series of chi-square goodness-of-fit tests. These tests compared the expected number of bachelor's-level staff in each area of the State (if distribution was based on youth need) to the observed number of bachelor's-level staff in each area of the State. Results indicated that bachelor's-level staff were not distributed proportionate to youth need in Idaho (all *p*'s < .001). Regions 6 and 7 had a higher proportion of CBRS workers relative to their expected number if CBRS staff were distributed proportionate to youth need. This suggests that CBRS staff are concentrated in the eastern regions of the State. In contrast, case management staff were disproportionately represented in Areas 2 and 4.

4.1.4. Peer Support Workforce

Peer support staff are persons with lived experience of mental illness or persons who have had a child who experienced a mental illness and who have undergone training and certification to provide mental health services to other persons with mental illness or to youth with SED and their families. These individuals represent an important and growing part of the workforce for youth with SED and their families in Idaho and across the United States as systems shift toward community-based services and supports. Respondents to the YES Workforce Survey indicated whether they employed certified family support partners or peer support specialists and the results of these analyses are presented here. **Figure 7** shows the number of FTE peer-support staff per 1,000 youth with SED in Idaho and **Table 8** presents the number of peer-support staff who worked full-time and part-time.

Analysis of the distribution of peer support staff across the state indicated that these staff were not distributed proportionate to youth need ($p < .001$). The northern and eastern areas of the state had higher than expected counts of peer support staff while Region 5 had an especially low count of peer support staff.

4.2. Idaho Medicaid Youth Mental Health Workforce by Training in Wraparound and EBPs

Evaluating the total number of providers available to treat youth with SED and their families in Idaho is only one part of ensuring that Idaho's mental health service system is effective. It is also crucial to ensure that the content of services is effective. Evidence-based practices (EBPs) are psychosocial interventions

Table 9. Number of Idaho Mental Health Clinicians Trained in Select Evidence-Based Practices for Youth by Area

Area of the State		N of clinicians trained in the model	Trained clinicians per 1,000 youth with SED
Cognitive-Behavioral Therapy (CBT)*			
1	Regions 1 & 2	137	22.0
2	Regions 3 &4	319	19.0
3	Region 5	55	11.7
4	Regions 6 & 7	173	17.7
	State Total	684	18.2
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)*			
1	Regions 1 & 2	85	13.6
2	Regions 3 &4	155	9.2
3	Region 5	24	5.1
4	Regions 6 & 7	98	10.0
	State Total	361	9.6
Home and Community Based Services*			
1	Regions 1 & 2	44	7.0
2	Regions 3 &4	122	7.2
3	Region 5	19	4.0
4	Regions 6 & 7	94	9.7
	State Total	278	7.4
Person-Centered Planning			
1	Regions 1 & 2	41	6.6
2	Regions 3 &4	98	5.8
3	Region 5	14	3.1
4	Regions 6 & 7	63	6.5
	State Total	217	5.8
Parenting with Love and Limits*			
1	Regions 1 & 2	50	8.1
2	Regions 3 &4	82	4.9
3	Region 5	14	2.9
4	Regions 6 & 7	44	4.5
	State Total	190	5.1

*Indicates providers were not distributed proportionate to youth need (chi-square goodness-of-fit test).

shown to improve youth well-being in randomized controlled trials.[7] Ideally, Idaho youth who receive care through the YES service array will receive EBPs that are matched to their specific diagnosis, preferences, and needs. As part of the YES Workforce Survey, organizations and sole proprietors were asked to report on the number of staff in their practice who had training and expertise in delivering select EBPs. The survey included embedded links to 10 EBPs so that respondents could confirm. Currently, there are over 1,200 psychosocial interventions that could be considered EBPs based on their effectiveness as demonstrated in randomized controlled trials.[7, 8] The specific EBPs included in the survey were selected by the Department based on their relevance and importance to Idaho youth.

The EBPs in the survey included: cognitive-behavioral therapy, trauma-focused cognitive behavioral therapy, parent child interaction therapy, eye movement desensitization and reprocessing therapy, Multisystemic therapy, Triple P Positive Parenting Program, Person-Centered Planning, Parenting with Love and Limits, Incredible Years, and Home and Community Based Services. In this section, we present data on the estimated number of Idaho clinicians who serve youth who have expertise in these practices based on weighted analyses of provider-reported data. In addition, we present information on the total number of providers with training in the wraparound service model.

Table 9 presents the number of Idaho mental health providers trained in selected EBPs by region and state totals. For all but two EBPs there was evidence that providers were not distributed across the State proportionate to youth need. Furthermore, the absolute number of trained providers per 1,000 youth with SED was quite low, indicating the need to increase the number of providers trained in these youth EBPs in Idaho.

Figure 8 visually displays the distribution of mental health professionals trained in the 10 EBPs across Idaho's four regions; each map indicates the number of clinicians trained in the EBP per 1,000 youth with SED so that comparisons can be made across areas and across EBPs. From the Figure it is apparent that Regions 1 and 2 tend to have the highest concentrations of providers trained in these EBPs for youth and that Region 5 appears to have a significant shortage of providers trained in these EBPs relative to the youth SED population.

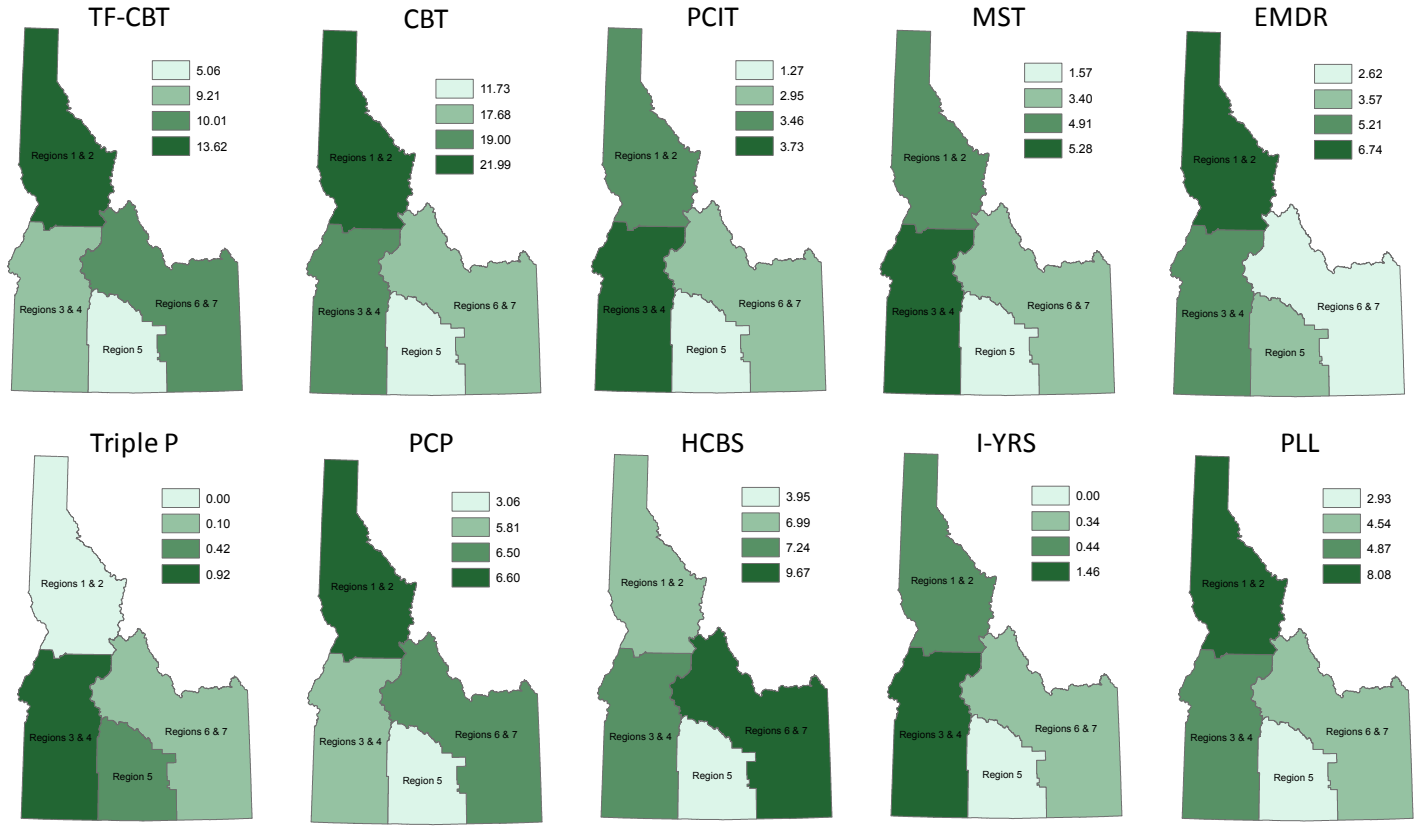
Table 9 (Continued). Number of Idaho Mental Health Clinicians Trained in Select EBPs for Youth by Area

Area of the State		N of clinicians trained in the model	Trained clinicians per 1,000 youth with SED
Eye Movement and Desensitization Therapy (EMDR)*			
1	Regions 1 & 2	42	6.7
2	Regions 3 &4	88	5.2
3	Region 5	17	3.6
4	Regions 6 & 7	26	2.6
	State Total	172	4.6
Multisystemic Therapy (MST)*			
1	Regions 1 & 2	31	4.9
2	Regions 3 &4	89	5.3
3	Region 5	7	1.6
4	Regions 6 & 7	33	3.4
	State Total	160	4.3
Parent-Child Interaction Therapy (PCIT)			
1	Regions 1 & 2	22	3.5
2	Regions 3 &4	63	3.7
3	Region 5	6	1.3
4	Regions 6 & 7	29	3.0
	State Total	119	3.2
Incredible Years*			
1	Regions 1 & 2	3	0.4
2	Regions 3 &4	25	1.5
3	Region 5	0	0.0
4	Regions 6 & 7	3	0.3
	State Total	31	0.8
Triple P (Positive Parenting Program)*			
1	Regions 1 & 2	0	0.0
2	Regions 3 &4	15	0.9
3	Region 5	2	0.4
4	Regions 6 & 7	1	0.1
	State Total	18	0.5

*Indicates providers were not distributed proportionate to youth need (chi-square goodness-of-fit test).

The number of providers who indicated they were providing wraparound services is shown in **Table 10**. The Table also indicates the number of youth who are likely to need Intensive Care Coordination using the Wraparound approach based on a previous report

Figure 8. Number of Idaho Mental Health Providers Trained in Evidence-Based Practices for Youth per 1,000 Youth with Serious Emotional Disturbance (SED) by Area



Note: TF-CBT = trauma-focused cognitive-behavioral therapy; CBT = cognitive-behavioral therapy; PCIT = parent-child interaction therapy; MST = Multisystemic therapy; EMDR = eye movement desensitization and reprocessing therapy; Triple P = Positive Parenting Program; PCP = person-centered care planning; HCBS = home and community based services; I-YRS = Incredible Years; PLL = Parenting with Love and Limits.

submitted to the State.[9] The last column in Table 11 shows the provider to youth ratio of the number of wraparound providers to the number of youth who may need this service. As is shown in the Table, the youth-to-provider ratios are much higher in Regions 1 and 2 than in other areas of the State, suggesting the need to develop wraparound services in the northern part of the State.

Wraparound developers suggest a ratio of 12 youth per provider is necessary to maintain high program fidelity and effectiveness.

4.3. Number of Idaho Youth who Received Select EBPs as Part of their Medicaid-funded Treatment

As part of the YES Workforce Survey, providers indicated the number of youth they treated in the last year using EBPs. These questions asked about the same 10 EBPs listed above and did not include other EBPs that providers may have used. **Table 11** shows

Table 10. Number of Idaho Providers who Deliver Wraparound Services

Area		N of youth with SED likely to need wraparound	N of staff providing wraparound	Youth-to-Provider Wraparound Ratio
1	Regions 1 & 2	227	8	29.1
2	Regions 3 &4	612	167	3.7
3	Region 5	171	80	2.2
4	Regions 6 & 7	355	34	10.6
	State Total	1,365	288	4.7

Note: Youth-to-provider ratio calculated as N of youth likely to need wraparound/ N of wraparound providers.

weighted statewide estimates of the total number of Idaho youth who received EBPs based on provider reports in each area of the State. The Table also shows the percentage of total youth service users (total N = 27,411 youth) who received each EBP based on our weighted analyses. These data show a pattern similar to that observed for EBP training in terms of service coverage and gaps.

5. Idaho Youth Mental Health Workforce Gaps Analysis

The estimates presented above quantify the capacity of Idaho's Medicaid mental health workforce to provide YES services and supports by indicating the number of providers available per 1,000 youth with SED and the distribution of those providers across the State. In this section, we provide additional analyses estimating the projected gap between Idaho's current Medicaid mental health services workforce for youth and the workforce needed to deliver YES services and supports to youth with SED and their families. The estimates presented here are intended to serve as one input into the State's

Table 11. Number and Geographic Distribution of Idaho Youth who Received Select Evidence-Based Practices

Area of the State		N of individual youth served	% of youth who received Medicaid MH services
Cognitive-Behavioral Therapy (CBT)			
1	Regions 1 & 2	1,427	30%
2	Regions 3 &4	2,798	22%
3	Region 5	519	18%
4	Regions 6 & 7	1,458	20%
	State Total Youth Served	6,202	23%
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)			
1	Regions 1 & 2	749	16%
2	Regions 3 &4	1,425	11%
3	Region 5	214	7%
4	Regions 6 & 7	755	11%
	State Total Youth Served	3,143	11%
Home and Community Based Services			
1	Regions 1 & 2	311	7%
2	Regions 3 &4	1,050	8%
3	Region 5	210	7%
4	Regions 6 & 7	498	7%
	State Total Youth Served	2,069	8%
Eye Movement and Desensitization Therapy (EMDR)			
1	Regions 1 & 2	353	7%
2	Regions 3 &4	1,079	9%
3	Region 5	212	7%
4	Regions 6 & 7	423	6%
	State Total Youth Served	2,066	8%
Person-Centered Planning			
1	Regions 1 & 2	501	11%
2	Regions 3 &4	898	7%
3	Region 5	125	4%
4	Regions 6 & 7	400	6%
	State Total Youth Served	1,924	7%

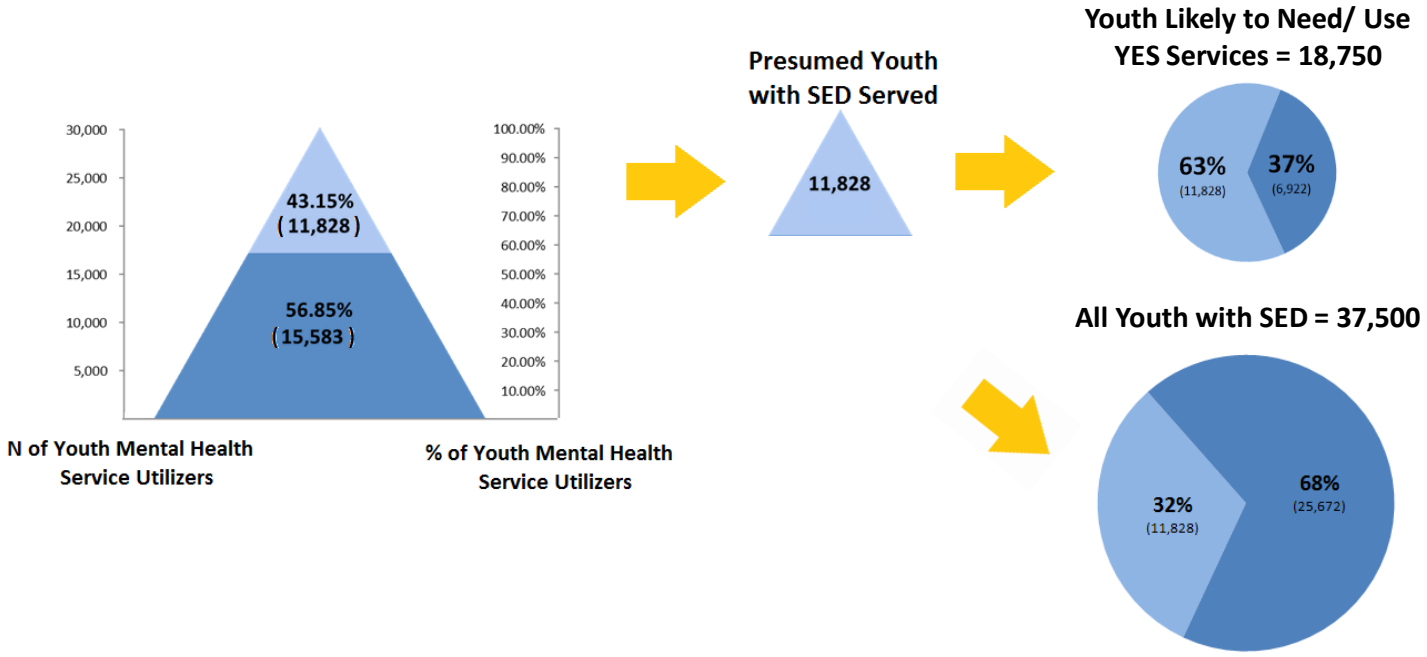
Area of the State		N of individual youth served	% of youth who received Medicaid MH services
Parenting with Love and Limits			
1	Regions 1 & 2	480	10%
2	Regions 3 &4	553	4%
3	Region 5	100	3%
4	Regions 6 & 7	368	5%
	State Total Youth Served	1,501	5%
Multisystemic Therapy (MST)			
1	Regions 1 & 2	281	6%
2	Regions 3 &4	642	5%
3	Region 5	65	2%
4	Regions 6 & 7	303	4%
	State Total Youth Served	1,290	5%
Parent-Child Interaction Therapy (PCIT)			
1	Regions 1 & 2	272	6%
2	Regions 3 &4	556	4%
3	Region 5	50	2%
4	Regions 6 & 7	363	5%
	State Total Youth Served	1,241	5%
Incredible Years			
1	Regions 1 & 2	43	1%
2	Regions 3 &4	106	1%
3	Region 5	0	0%
4	Regions 6 & 7	125	2%
	State Total Youth Served	273	1%
Triple P (Positive Parenting Program)			
1	Regions 1 & 2	0	0%
2	Regions 3 &4	89	1%
3	Region 5	50	2%
4	Regions 6 & 7	100	1%
	State Total Youth Served	239	1%

workforce planning efforts.

5.1. Method for Assessing Gaps

Several methods are available for analyzing the gap between a target population's need for services (i.e., demand) and the available stock of healthcare providers to deliver those services.[10-13] The essential ingredients in any such analysis are (a) an estimate of the available professional workforce (provided above), and (b) an estimate of the target population's need for services (i.e., demand). Some models also incorporate projections regarding changes in the workforce and the demand for services over time; however, in this report, we limit our attention to a point-in-time estimate of the current gap between Idaho's mental health services workforce for youth and the workforce needed to deliver YES services and supports to youth with SED. Furthermore, given that data are not available regarding utilization patterns for new YES services that will be made available as part of the system transformation, we make the simplifying assumption that regardless of the current stock of mental health professionals, the YES transformation will require significant re-training of the existing mental health services workforce and task shifting in order to ensure that the current stock of providers can deliver the new YES services and

Figure 9. Presumed Number of Youth with Serious Emotional Disturbance (SED) Served by Idaho Medicaid in 2016 and Proportion of Total Idaho Youth with SED and Idaho Youth Likely to Use Youth Empowerment Services



supports in accordance with the conditions set out by the Settlement Agreement. These conditions include the use of the Idaho Practice Manual, which outlines the basic principles and procedures to be used in serving youth with SED, and the integration of standardized assessments such as the Child and Adolescent Needs and Strengths (CANS) tool to guide treatment planning.

Below, we present two different estimates of Idaho's YES workforce capacity gap, based on two different assumptions or models of the target population's need for services. For both models, the estimates focus exclusively on the workforce gap related to youth with SED; the workforce gaps will be larger if the entire population of Idaho youth with mental disorders is included in estimating the need for services. That is, workforce capacity gaps presented here focus exclusively on the needs of youth with SED and omit other youths who may need mental health services.

5.2. Workforce Gaps Analysis 1: Anticipated Need Scenario

The first workforce gaps analysis assumes that (1) the existing Idaho mental health workforce for youth is currently meeting the needs of some proportion of youth with SED and their families, and (2) 50% of the total population of youth with SED in Idaho will utilize/ need YES services. Assumption 2 is based on a large and replicated body of scientific evidence showing that 50% of youths with SED (and their families) participate in formal mental health services of any kind from any service sector and 50% of youth with SED do not participate in services. Given this evidence, the first workforce analysis assumes that workforce planning for YES should ensure an adequate supply of staff to meet the needs of all youth with SED who are *likely to use YES services*.

In order to estimate the gap between Idaho's current youth mental health services workforce and that required to meet the needs of all youth with SED who are likely to use YES services, two population estimates are needed. First, an estimate is needed of the proportion of the target population that is currently being served. For this, we relied on an analysis of 2015 Medicaid claims data conducted by Optum Idaho which assessed the number of youth with SED currently served by the Idaho Medicaid system. In the report, the evaluators grouped all youth Medicaid participants who had received any mental health service in 2015 into one of nine diagnostic categories (Schizophrenia and Other Psychotic Disorders; Bipolar and Related Disorders;

Depressive Disorders; Trauma- and Stressor-Related Disorders; Disruptive, Impulse-Control and Conduct Disorders; Anxiety Disorders, and Other Behavioral Health Disorders) and partitioned the youth within each diagnostic category into quartiles based on the number of mental health claims used in 2015. The number of mental health claims was used as a proxy for the severity of functional impairment. Based on this analysis, the evaluators tabulated the total number of Idaho youth with SED who were currently served by the Idaho Medicaid system. Results of the service utilization analysis indicated that 27,367 Idaho youth received some type of mental health service through Idaho Medicaid in 2015. Of these, 11,808 youth (43.15%) were identified as likely to be experiencing SED based on their diagnostic classification and intensity of service utilization. Consequently, 43.15% of youth who participated in Medicaid-funded mental health services in 2015 were presumed youth with SED.

In order to estimate the number of youth with SED who were served by Idaho Medicaid in 2016, we assumed that the proportion of mental health service utilizers who experienced SED in 2015 (i.e., 43.15%) was equal to that of 2016. Data provided by IDHW indicated that there were 27,411 youth who received Medicaid-funded mental health services in 2016. If 43.15% of these youth experienced SED, this implies that Idaho's 2016 behavioral health workforce met the needs of 11,828 youth with SED who were *likely YES service users* (.4315 x 27,411).

The pyramid in **Figure 9** shows the proportion, and number, of presumed youth with SED served by Idaho Medicaid in 2016 based on the analysis presented above. In addition, the Figure projects the presumed number of youth with SED served onto the total population of youth with SED in Idaho (bottom pie) and onto the population of youth with SED who are likely to use/ need YES services (top pie). Based on these projections, in 2016 Idaho's mental health services workforce met the needs of 63% of all youth with SED who are likely to need/ use YES services. This implies that the workforce did not serve 37% of youth with SED who are likely to need/ use YES services. This estimate of 37% was used as one input in estimating the YES workforce service capacity gap.

The second estimate needed to calculate the YES workforce capacity gap is the number of mental health professionals who were necessary to serve the 43.15% of youth mental health service utilizers who were presumed to have SED and to need YES services in 2016. To develop this estimate, we relied on the assumption that the proportion of the workforce that served youth with SED was equivalent to the proportion of total youth service utilizers who experienced SED; that is, if 43.15% of youth service utilizers experienced SED, then 43.15% of mental health professionals who served youth were needed to meet the needs of those youth. This is likely an underestimate of the actual number of mental health staff needed to meet the needs of youth with SED because it assumes that youth with SED and those without SED require equal amounts of time in services delivered across all types of mental health professionals. However, in the absence of finer-grained data on service utilization for each youth, this assumption provides a parsimonious and reasonable basis for developing a projection of the workforce needed to deliver YES services and supports. Based on this assumption, 43.15% of Idaho's youth mental health services workforce was needed to deliver YES services and supports to youth with SED in 2016. **Table 12** shows the estimated number of FTE Idaho providers needed to meet the needs of youth with SED who are likely to need/ use YES services in each professional category in 2016.

Having developed estimates of (1) the presumed number of Medicaid mental health service utilizers who are likely to need/ use YES services, and (2) the mental health services workforce needed to meet their needs, we used this information to estimate the additional workforce needed to meet the needs of all youth with SED who are likely to utilize YES services—these estimates are shown in Column 6 of **Table 12**. As is described above, these estimates assume that the current workforce shown in Column 5 meets the needs of 63% of youth with SED who are likely YES service utilizers and therefore that 37% more staff will be needed to deliver 100% of the YES services and supports to the target population. As is shown in Table 12, this analysis suggests a total of 574 additional mental health professionals, including 276 master's-level clinicians and 256 bachelor's-level staff, will be needed to provide YES services and supports statewide.

Table 12. Estimated Idaho YES Workforce and Projected Need for Increased YES Workforce by Area

Provider Type	Area		N of Total FTE Providers Serving Youth	N of FTE Providers Serving Youth with SED	N of Additional Providers Needed to Fill YES Workforce Gap	
					Anticipated Need Scenario	Extended Population Scenario
Psychiatrists		State Total	27	12	4	8
	1	Regions 1 & 2	4	2	1	1
	2	Regions 3 &4	6	3	1	2
	3	Region 5	1	0	0	0
	4	Regions 6 & 7	16	7	3	5
All specialty Prescribers		State Total	77	33	12	23
	1	Regions 1 & 2	14	6	2	4
	2	Regions 3 &4	30	13	5	9
	3	Region 5	2	1	0	0
	4	Regions 6 & 7	31	13	5	9
Mental Health Clinicians		State Total	1,733	748	276	512
	1	Regions 1 & 2	248	107	40	73
	2	Regions 3 &4	822	355	131	243
	3	Region 5	155	67	25	46
	4	Regions 6 & 7	507	219	81	150
SUD Clinicians		State Total	188	81	30	56
	1	Regions 1 & 2	42	18	7	13
	2	Regions 3 &4	86	37	14	25
	3	Region 5	26	11	4	8
	4	Regions 6 & 7	35	15	6	10
Bachelor's-level staff		State Total	1,605	693	256	474
	1	Regions 1 & 2	340	147	54	100
	2	Regions 3 &4	804	347	128	238
	3	Region 5	90	39	14	27
	4	Regions 6 & 7	371	160	59	110
All Staff (Total)			3,603	1,555	574	1,064

5.3. Workforce Gaps Analysis 2: Extended Population Scenario

The second workforce gaps analysis makes similar assumptions to the analysis presented above with one exception—this analysis assumes that all youth with SED in Idaho will utilize YES services. This analysis incorporates all youth with SED, including those who traditionally have not participated in publicly- or privately-funded mental health services through any sector. As is shown in **Figure 9**, youth with SED who were served by Medicaid in 2016 made up 32% of the total population of all youth with SED in Idaho (total projected population is based on the CSET described above = 37,500 youth). Making the same assumptions about the number of staff required to meet the needs of youth with SED, this projection suggests that the SED workforce shown in Column 5 of **Table 12** would need to be increased by 68.46%. Column 7 of **Table 12** shows the number of additional mental health professionals needed in each category and across each area of the State in order to meet the projected needs of all 37,500 Idaho youth with SED based on these assumptions.

5.4. Caveats and Limitations

The estimates presented in this report must be

interpreted in light of the data's limitations. First, although the YES Workforce Survey achieved a relatively high response rate (60%) and well-established weighting class adjustments were used to generate estimates of population totals, the estimates of workforce capacity presented in this report nonetheless represent a single data-point based on incomplete information. While useful for planning, these estimates should be treated as estimates and not as true population totals. It is also important to note that self-reported data may contain errors; for example, providers may have incorrectly reported on workforce characteristics. Furthermore, other providers outside of the Medicaid system also deliver mental health services to youth and these providers were not included in the YES Workforce Survey.

It is also important to note that these estimates represent a point-in-time analysis. They do not take into account Idaho's large population growth nor do they address changes in the supply of mental health professionals over time. Analyses of licensing data from the Idaho Bureau of Labor indicate that the number of licensed mental health professionals in Idaho has been steadily increasing across all categories of social workers and counselors for the last decade. In sum, these data provide a point-in-time estimate of Idaho's workforce capacity to deliver YES services and supports to youth with SED and highlight needs for workforce development.

6. Summary and Recommendations

The goal of this Workforce Capacity and Gaps Analysis was to assess the current capacity of Idaho's publicly-funded mental health workforce to deliver YES services and supports to Idaho youth with SED and their families under the terms of the Jeff D. Settlement Agreement. Based on a weighted analysis of survey data provided by organizations and sole proprietorships that deliver mental health services in Idaho's Medicaid network, this report provides population estimates of the current number of mental health professionals who work with youth and their families in Idaho, the number of professionals trained in high priority evidence-based practices for youth and newly emerging YES services such as Wraparound, and the geographic distribution of these professionals. The report also provides a point-in-time analysis of the workforce capacity gap based on two separate scenarios incorporating different assumptions about the capacity needed to meet the needs of the target population.

Findings from this analysis indicate that an estimated 3,603 mental health professionals currently deliver mental health services to 27,411 Idaho youth and their families in Idaho's Medicaid-funded mental health system. In order to provide YES services and supports to all youth with SED, Idaho's youth mental health services workforce is projected to require an increase of 15.9% to 29.5% depending on the underlying assumptions used to generate the model. In addition, this report highlights significant gaps in workforce training and preparedness related to evidence-based practices and the new community-based YES service array (e.g., wraparound, respite) as well as maldistribution of mental health providers for youth across Idaho's geographic areas. Findings from this report are consistent with analyses of Idaho's behavioral health workforce conducted by federal agencies and other research groups which indicate that all 44 of Idaho's counties are Health Professional Shortage Areas for mental health professionals[14] and that 31 of Idaho's 44 counties are above the national median on unmet need for mental health professionals.[10]

6.1. Developing Idaho's Current Mental Health Services Workforce for Youth

The YES system transformation will require significant task-shifting for Idaho mental health providers who serve youth as well as re-training to deliver an array of community-based services and supports based on the YES Practice Model. The following recommendations focus on developing Idaho's current mental health workforce for youth to meet these challenges.

Recommendation 1. Support the Idaho mental health provider network in developing competencies to deliver YES services by providing training within a sustainable, value-added approach built around credentialing.

For many years Idaho State has relied on community-based rehabilitation services as the sole community-based service for youth with SED.

Providers developed competence in hiring and training staff to deliver this service and in securing reimbursement. Without proper support, providers may have difficulty transitioning to the new YES service array. One way to support providers in making this transition is to make training accessible across the State and to deliver training within a credentialing framework. A credentialing process allows the State to establish and monitor fidelity to new service models while also offering providers a way to advance their own careers and strategic goals (e.g., through the acquisition of valued credentials and expertise). In order to avoid bottlenecks, training and credentialing processes will need to be made widely available.

Recommendation 2. Make YES training efforts sustainable by partnering with institutions of higher education to develop curriculum materials and certificate programs that meet the State's needs.

Training and credentialing programs for YES services can be made sustainable by working with local universities to develop curriculums that meet the State's need for new YES community-based services. This type of model has worked successfully for targeted workforce development efforts in Idaho including the development of curriculum and certification programs for providers who deliver addiction services. A similar approach could be used for the new Youth Empowerment Service models. Embedding credentialing and training within existing university systems benefits all stakeholders. Students benefit by obtaining an education and credential with real world value once they graduate; rather than having to pay for college *and* pay for credentialing after college, students can optimize their tuition dollars by obtaining actionable credentials through their college degree. Providers benefit by avoiding the high costs of pre-service and in-service training for individuals who provide YES services. The State benefits by avoiding the high costs of ongoing large-scale training efforts which would be required to make ongoing credentialing sustainable.

Recommendation 3. Support providers in delivering new YES services by providing training in practice management and billing and by ensuring that all aspects of YES services are reimbursable.

Analysis of the YES Workforce Survey data indicate that the most common reason mental health professionals leave is because of low compensation; this finding is supported by other studies of behavioral health services across the United States which indicate that financially-strapped providers often go out of business or leave the profession rather than struggling to pay for re-training as new service models are deployed. Developing a robust workforce to deliver YES services will require educating providers on strategies to effectively bill for these new services as well as ensuring that all aspects of provider time, including coordination and non-traditional services, are billable.

Recommendation 4. Provide frequent, low-cost training to providers in EBPs across the State with an emphasis on areas of low penetration.

One clear deficit documented by the YES Workforce Survey is the need for increased training of Idaho providers in EBPs for youth. In their qualitative comments on the survey, providers expressed a complimentary desire for training in EBPs that meet their goals of delivering effective and reimbursable treatment. Several States and large service systems across the country offer models for delivering training to practitioners in EBPs on a large scale. Potential sources of revenue for funding these training efforts include earmarked network re-investment funds, federal grants from SAMHSA and other federal agencies focused on increasing the delivery of EBPs and other community based services for youth, and pursuing research collaborations with institutions of higher education to study the dissemination and implementation of EBPs in Idaho. Several federal research funders including the National Institute of Mental Health and the National Institute of Drug Abuse have prioritized research to better understand how to increase the use of EBPs in community settings. Securing funding for these types of large-scale research projects can increase the penetration rate of EBPs and improve clinician fidelity to these models. Accessing these resources requires dedicated time and effort. The Department should consider developing a half-time or full-time staff position to pursue these types of grants or should

partner with institutions of higher education to access these funds.

Recommendation 5. Reduce the geographic maldistribution of mental health service providers for youth.

This report clearly indicates that mental health providers for youth are not distributed proportionate to youth need across Idaho. Research on healthcare workforce indicates that providers often 'stay where they train' rather than moving to a rural area or returning to a rural and underserved area where they lived prior to training. Several strategies can be used to address this issue. First, the State could support training sites for mental health professionals in underserved areas such as Region 5. Increasing trainees' links to underserved communities may improve recruitment and retention in these areas. Support for training could be provided by sponsoring internships for master's-level social work or counseling students in mental health sites in low access areas or by reimbursing providers in underserved areas for supervising and training graduate students who intern at their sites and deliver YES services. Alternately, the State could provide paid youth mental health internships for graduate students at its own sites in rural and underserved areas. Another option is to provide targeted financial aid to mental health professionals who work with youth in underserved areas following graduation. This can take the form of loan repayment programs, tax incentives, or tuition and stipend programs linked to years of service in targeted areas and with the target population. The State could also provide distance education programs as a standalone or in partnership with institutions of higher education to persons who reside in rural and underserved areas in order to develop the workforce in these areas.

6.2. Increasing the Supply of Mental Health Professionals to Deliver YES Services and Supports

This report documents a need to increase the supply of mental health providers to deliver YES services and supports to Idaho youth with SED with a particular emphasis on areas of the State where workforce shortages are most acute. These data should be used as a baseline and the State should set targeted goals for increasing the supply of specific provider types in specific regions of the State. Following are suggestions for improving the recruitment of professionals into careers that support community-based YES services in Idaho.

Recommendation 6. Leverage federal workforce development funds to increase the supply of mental health providers for youth in Idaho.

Increasing the supply of behavioral health providers is a high priority nationally in the United States and federal monies are available to support States in accomplishing this goal. Idaho should develop a part-time or full-time behavioral health workforce position to pursue these funds which can contribute significant resources to Idaho's workforce efforts. The U.S. Health Resources and Services Administration (HRSA) is one example of a federal agency that supports States' behavioral health workforce efforts. In 2016, HRSA's Behavioral Health Workforce Education and Training program was launched to increase the behavioral health workforce in underserved areas. This program targeted providers at all levels from physicians to bachelor's-level staff and peer providers. Another HRSA program, the Evidence-based Tele-Behavioral Health Network program uses telehealth networks to increase access to behavioral health care clinical supervision and services in rural and frontier communities. Idaho could pilot innovative approaches to healthcare delivery using funds from these programs and then use this data to inform its network development.

Recommendation 7. Create an Idaho State behavioral workforce incentive program that provides stipends, loan repayment, and/ or tax credits to professionals who deliver YES services in targeted areas of the State for a specified period of time.

Several States have enacted legislation creating State-level workforce development incentives to increase the supply of behavioral health professionals within targeted areas and for targted populations. These policies can be similar to federal loan repayment programs which provide health professionals with loan repayment in exchange for working with a targeted population or underserved

area for a specified period of time (e.g., two years). Alternately, some States have used tax incentives for professionals who deliver specific types of services in targted areas. Another option is to develop stipend programs (similar to those used in child welfare settings) in which graduate students in social work, counseling, and other behavioral health-related disciplinces receive tuition remission and/ or stipend funds in exchange for working with a target population or service system for a specified period of years following graduation. These types of financial incentives can target professionals at different levels of training and disciplinary expertise.

Recommendation 8. Incentivize clinical training sites in targeted areas to train graduate student interns and trainees in YES service delivery models.

One strategy for increasing the supply of qualified YES providers is to incentize clinical training sites to educate and supervise trainees and graduate students in the delivery of YES services. This could be accomplished by allowing reimbursement for YES mental health services that are provided by trainees or by contracting with institutions of higher education to administer targeted grant support to YES clinical training sites for graduate and undergratduate students. This recommendation might complement efforts to integrate YES training into university curriculums. Funds for these grants could be used to train clinical site supervisors in YES service delivery models and to compensate them for time supervising graduate students to deliver YES services. Altnerately, IDHW could use its own sites across the State to create paid internship opportunities for graduate students and trainees to develop competence in delivering YES services in targeted areas of the State.

Recommendation 9. Increase the non-profit behavioral health workforce by obtaining federal grants and contracts that directly deliver community-based serivces to youth.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has several programs designed to support States in developing community-based services for youth with SED. These programs have not traditionally been accessed by Idaho State but could be leveraged to increase service delivery to youths with SED in the State. Exmaples of specific SAMHSA programs that support community-based services for youth include the *Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders* program (https://www.samhsa.gov/grants/grant-announcements/sm-18-010) and the *Community Programs for Outreach and Intervention with Youth and Young Adults at Clinical High Risk for Psychosis program* (https://www.samhsa.gov/grants/grant-announcements/sm-18-012). Idaho State should explore funding a full- or part-time position within the Division of Behavioral Health to pursue these funding opportunities.

Recommendation 10. Expand the mental health workforce for youth by increasing funds for family peer support training and supervision and by exploring service integration with schools and other service systems (e.g., juvenile justice).

The peer workforce is an important and growing sector of behavioral health providers for youth and adults. This survey highlights the opportunity to significantly expand family peer support services in Idaho. In addition, integration with other service sectors such as public schools and juvenile justice systems can aid in expanding the behavioral health workforce for youth.

Recommendation 11. Confirm the competitiveness of reimbursement rates for services so that mental health providers for youth can earn competitive salaries relative to other professions.

The YES workforce survey found that uncompetitive compensation was the most common reason professionals left their positions. Ensuring that reimbursement rates for YES services are competitive will help attract and retain qualified professionals at all levels to work with youth.

Recommendation 12. Work with licensing boards to allow telehealth for clinical supervision in remote areas and craft similar guidelines for supervision of YES services at all levels.

Obtaining access to clinical supervision can be a

barrier to developing professional experitse in remote areas of the State. This burden is amplified when practitioners need clincial supervision in specialized service models such as the new services delivered under YES. Creating guidelines that permit clincial supervision to use technology can improve the ability of providers to deliver care in remote and underserved areas. Indeed, if funds were made available to pay for this supervision it would form an incentive for providers to deliver services in areas with professional shortages.

6.3. Enhancing Future YES Workforce Development Efforts

The development of this report revealed several opportunities to improve data collection efforts to guide YES workforce development in the future.

Recommendation 13. Implement a robust, standardized workforce data-collection process that ensures timely, useful data is available for planning.

Obtaining timely, high-quality data on Idaho's mental health services workforce is a major challenge. This report respresents a first step; however, engaging in continuous workforce monitoring and development efforts will require ongoing data. One way of obtaining this data is to implement a workforce data collection system linked to licensing. In New Mexico State, legislators enacted a law requiring health professionals to provide targeted workforce data as part of their mandatory licensing processes. The resultant data is housed and managed by one of New Mexico's large public universities which also makes reports and data available to State workforce planning groups. Idaho could implement a similar system in parnterhip with boards that licsense mental health professionals. Bachelor's-level staff could be surveyed upon graduation from credentialing or curriculum programs at universities (or other institutions).

Recommendation 14. Develop sustainable methods of assessing youth need/ demand for mental health professionals that serve youth.

The workforce capacity and gaps analysis presented in this report represents only one method of assessing the need for and supply of mental health professionals to deliver YES services and supports. The State could develop other procedures for assessing youth need and workforce capacity. Other methodologies for assessing youths' need for services include: (a) developing estimates of need based on claims data (e.g., the average amount of services currently used by youth with various SED profiles), or (b) developing expected clinical profiles and service usage for each level of care within the YES system.

Recommendation 15. Develop an estimate of projected changes in the supply and demand for YES services to further aid workforce planning.

The present report provides a point-in-time assessment of Idaho's current mental health workforce capacity to deliver YES community-based services and supports to youth with SED. In order to aid workforce planning it would be valuable for the State to conduct a 'stock and flow analysis' of projected changes in demand for YES services and the supply of professionals to deliver these services over time. These projections, which take into account population growth and changes in the labor pool over time, are important for identifying specific areas of need for growth.

Recommendation 16. Partner with other Idaho State agencies, such as the Idaho Bureau of Labor to inform workforce development.

The Idaho Bureau of Labor should be included in the YES workforce development committee and integrated into efforts to develop the YES workforce. IBOL has special expertise in workforce development and has recently completed analyses of Idaho's behavioral health workforce in preparation for applications for HRSA grants. These efforts should be coordinated with the YES workforce development initiative.

7. Conclusion

This Workforce Capacity and Gaps Analysis provides population estimates of the number of Idaho providers who currently deliver mental health services and supports to Idaho youth with SED and their families and assesses the gap between the

system's current workforce and the workforce needed to deliver YES services and supports under the terms of the Jeff D. Settlement Agreement. The report finds that Idaho needs to increase its mental health services workforce for youth by approximately 16% in order to deliver YES services and supports to youth with SED. Recommendations are provided for developing Idaho's current mental health workforce, increasing the supply of well-trained professionals, and for developing data that is useful for future workforce planning efforts.

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Technical Appendix

Weighting class adjustments were developed for the YES Workforce Survey using data available in the sampling frame including: (1) the number of organizations versus sole proprietorships operating as practice entities in Idaho (based on Tax Identification Numbers), (2) the number of organizations and sole proprietorships operating in each of four areas of the State (shown in Figure 1), and (3) the number of large versus small organizations in each area of the State based on roster information provided by Idaho Medicaid. These data were combined to form 'classes' based on the type of practice, the location of the practice, and the size of the practice (if an organization). Within each class, the total population of survey units was known and this population served as the denominator in calculating the within-class response rate. Data from the survey were then used to determine the number of respondents in each class (e.g., sole proprietorship vs. organization, size of organization, and location based on respondents' reports) and to calculate the probability of survey response within each class (i.e., number of respondents within class divided by the population within each class = response probability). The inverse of the within-class response probabilities represent weights which are applied to each survey respondent. The weighting procedure was verified by ensuring that the sum of the weights equaled the total population sample size, in this case N = 407 total practices representing the total number of organizations and sole proprietorships.