Final Report

of the

Youth Empowerment Services (YES)
Quality Review (SFY 2022)

Provided by:

Union Point Group, LLC

for the

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Division of Behavioral Health *and* Division of Medicaid

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Acknowledgements

This protocol has been developed and refined these last two years by a series of important voices. These include family and youth advocates, the Plaintiffs and State Attorney General's Office, Youth Empowerment Services (YES) service providers and administrators.

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Questions this Quality Review Answers

The Jeff D Settlement requires that Idaho adopt and implement a meaningful annual Quality Review (QR) process. The purpose of Idaho's annual QR is fourfold. Namely, to:

- objectively assess and improve clinical practice and program effectiveness systemwide;
- identify program strengths and needs;
- develop actionable clinical data / information;
- identify targeted areas for system improvement.

Each year, that purpose is applied to a central, clinical question. The central question addressed by this year's QR is: How well are youth with intensive treatment needs initially connected to timely, appropriate care?

How well are youth with intensive treatment needs initially connected to timely, appropriate care?

The central question of this year's QR originates from the findings of last year's QR. In last year's QR, we found that youth with intensive treatment needs experienced:

- Delays in the initial access to care;
- Infrequent treatment sessions;
- Care coordination that did not successfully engage partners at school or in the community;
- Disparities in both care and outcomes for persons who identified as culturally diverse.

Recommendations that were made last year to address these concerns are listed in Appendix B. In collaboration with the Plaintiffs, the Idaho Department of Health and Welfare (IDHW) identified a need for a closer look at the process of connecting youth with intensive treatment needs to appropriate services.

IDHW and the Plaintiffs identified four related questions for further study:

(1) What barriers do youth and their caregivers experience when trying to access and participate in intensive community-based treatment services.

(2) To what extent are providers serving youth with intensive treatment needs with care that is timely, appropriate, collaborative and ultimately effective?

(3) What capacity do providers currently have for intensive community-based treatment?

(4) What state-level barriers and supports impact the expansion of intensive community-based treatment?

This report presents the results from the QR process. The QR data are used to answer these four questions, in turn, and generate recommendations for system improvement. A succinct overview of the QR methodology and sampling is provided on the next page. A more detailed description of the sampling and information gathering methods is provided in Appendix A. Key findings and recommendations are provided following the results of the data analyses.

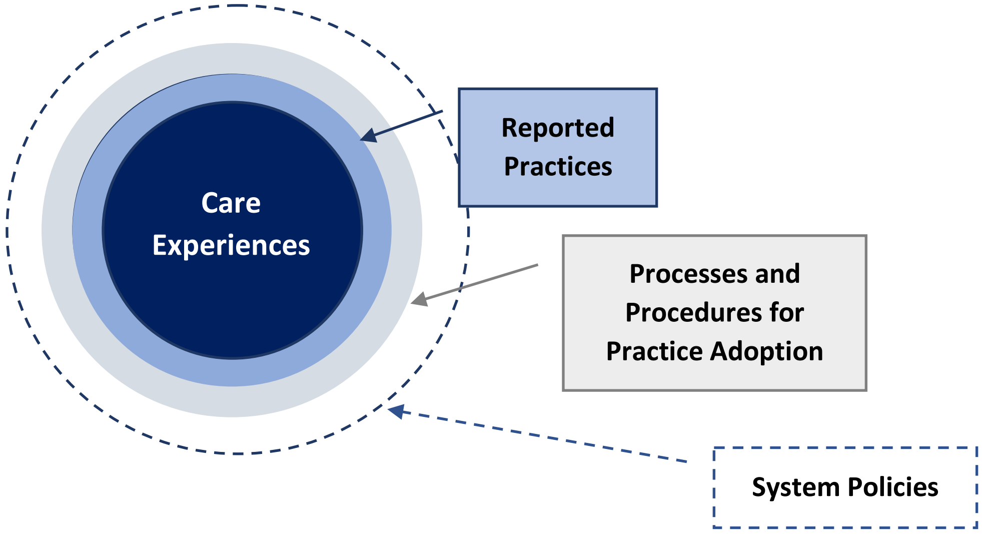
Methodology in Brief

A QR process is designed to understand variation in practice. From a practical standpoint, we also want to identify the drivers of these variations in practice. This is because we want to use the findings of the QR. We want to identify a brief set of system actions likely to result in more youth having better experiences and outcomes of care.

The QR we used this year focused on understanding the initial process of accessing appropriate care for twelve youth designated as needing Level 2 or Level 3 intensive community services, per the CANS assessment. We interviewed 12 caregivers and 7 youth. In the interviews we asked about the care received, and the emotions evoked during that care process. This way we can understand how care experiences affected motivation for treatment and treatment outcomes. We also conducted two youth focus groups, with 4 participants.

Then we reviewed all clinical documentation provided to us. This included assessments, plans of care, encounter notes, crisis plans, transition plans and any other practice documentation. We rated care in terms of its timeliness, appropriateness and the collaboration providers documented. We contacted all of the youth's primary clinicians: seven responded, and we completed structured interviews with each of them. We asked clinicians about their decisions during treatment and policies and procedures which may have affected those decisions.

***Figure 1.* Assessing the Ecology of Idaho's Youth Empowerment Services**



Then we surveyed 158 agency representatives and individual practitioners regarding the continuum of care they currently provide, and expansion intentions within the next six months. This year we also asked about what supports are important to expand the services they offer, and how well IDHW supports efforts to expand care.

Results in Full:

Quality Review 2021-2022

Question #1. What barriers do youth and their caregivers experience when trying to access and participate in intensive community-based treatment services?

A series of barriers to service access and participation was identified for youth eligible for intensive community based treatment. These include:

- Waitlists and delays in initial appointments;
- Lack of availability of additional, meaningful treatment services;
- Difficulty accessing care coordinators to help locate and connect to needed services.

Barriers to accessing appropriate services were identified in file reviews, caregiver and youth interviews, and youth focus groups. Clinician interviews and the provider survey help describe the system context of these barriers. We also note an important contrast in our data. Youth whose treatment was effective, per the 120-day CANS reassessment, were less likely to experience these barriers. It is reasonable to believe that addressing these barriers for all youth may improve the effectiveness of treatment for youth with more serious behavioral health concerns. Evidence for each barrier is described in detail.

Waitlists and delays in service access.

Caregiver and youth interviews. The primary theme caregivers noted was difficulty in finding a provider who accepted Medicaid and had the training and skills to address the youth's specific needs and strengths. Reported wait times for an appointment ranged from 'a couple of weeks' to 'six months.' Parents who were interviewed volunteered that the process was 'stressful,' 'frustrating' and 'overwhelming.' Parents noted that even when an appropriate provider was found, that provider might not continue with Medicaid, or might not consistently show up for appointments. This barrier was described by one caregiver who told us, "She went to one counselor, got along really good, then the counselor stopped taking Medicaid…." Another stated, “[It was] was not bad one we got through the wait list [which took six weeks]. [Now] they are no longer taking Medicaid.”

Half of the youth interviewed mentioned that either they did not know how long it took to get access to services, or that they were not involved in the access process (it was handled by their caregiver). However, about half of the interviewed youth specifically mentioned having a long wait for service. One stated, “It took a while. We did some stuff and took a long time waiting to get in. We did a lot of paperwork and answered a lot of questions.” Others stated, “It was a very long process,” and that it took, “A month or two.” Many youth appear to be aware of these delays in getting access to care.

Youth in our focus groups also identified a potentially very serious issue regarding access. These youth indicated long wait times to get access to an adult to talk to when in crisis. Two youth indicated that they had experienced long wait times when calling the suicide hotline for help. One youth said they experienced long wait times both for the text-based help as well as help via the telephone line. The other indicated that they wished that the person associated with the hotline could provide the information communicated in the call with the therapist who they were seeing, so that the concerns raised could be addressed in treatment.

One caregiver clearly linked the wait to their child’s willingness to get help. "I think [the agency] provided really good services. The problem was the access to them took so long, and we'd gone through so many people and places that didn't offer those services. By then, [the youth] couldn't care less."

File reviews. Per file review, one-third of youth did not receive an initial treatment session within 10 business days of referral. However, this is almost certainly an underestimate. Coders noted during these reviews that the process of receiving a referral is not documented in a standardized manner. The lack of standardization extends to documenting when a referral was received, from where it was received, and the reason for referral. These three pieces of information would allow for a consistent accounting of how well the system is able to provide timely service access for youth with non-urgent needs.

Lack of availability of additional, meaningful treatment services.

Across almost all caregivers, being able to choose the appropriate care for a youth was described as an unsatisfying process. Several caregivers indicated that they were never made available of the range of helpful services their child could receive. "If there was a list [of eligible services to choose from] I never saw it," said one. Another stated, "We weren't given information on other services. No other choices were given." "All we were offered was talk therapy with [her therapist] and we were only with her for a couple of months. We were not offered any other services," indicated another parent.

All but one clinician indicated that their agency had a written description of available services that could be provided to families. Half of the interviewed clinicians indicated that this description was provided to families and youth. Each of these clinicians indicated that the families considered, but were ultimately uninterested in additional services that were offered. One clinician stated, “They weren't interested in additional services offered; they had some ideas of their own.” Another stated, “they were not really interested but they usually want to do their own research, but not really interested [in other services].” There did not appear to be any effort to engage with families regarding their own search for services. Families have indicated that they are deeply concerned about accessing appropriate services to need what may be complex challenges experienced by their child. This points to the importance of having a person on their care team whose role it is to hear youth and caregiver concerns and help them access appropriate, coordinated care.

Difficulty accessing care coordinators to help locate and connect to needed services.

Per file reviews, none of the youth in this sample had a Child and Family Team meeting in the first 90 days of care. Yet successfully engaging a treatment provider often required outside help in the form of personal connections, or the use of care coordinator or case manager. As one caregiver stated:

> The best thing that has happened has been the TCC's [Targeted Care Coordinators] and the Case Managers, some have been fantastic. They have done a superb job. Find yourself a good Case Manager. [Trying to access appropriate services] has caused me more physical grief than I care to disclose. It has not been a good experience.

When asked about the use of care coordinators, one of the therapists interviewed indicated that a care coordinator was involved in the treatment of these youth. One therapist indicated that their agency had a care coordinator available internally. Another therapist indicated that they made an outside referral for care coordination, but that, "[there was] no follow through from dad. Unfortunately no follow through with contacts [provided]." There is no indication that youth or families are routinely introduced to a potential care coordinator, or that the benefits of this service are presented in a compelling way to families.

Provider survey data corroborates that intensive outpatient services have become less available, as well as adjunct treatment services identified as desirable by families. As noted in the provider survey results, agencies are having difficulty recruiting staff who are qualified and will work the hours desired by agencies. Per the provider survey, there has been a 13% drop in agency locations providing targeted care coordination, and an 8% drop in agency sites providing case management. Adjunct treatment services, such as Skills Building / Community-Based Rehabilitation Services and Behavior Modification and Consultation also appear to have become less available (at 8% and 26% fewer sites, respectively). Together, these data indicate that desired adjunct treatment services are becoming harder to access. In the same time frame, supports to facilitate access (Targeted Care Coordination and Case Management) have also become harder to obtain.

Question #2. To what extent are providers serving youth with intensive treatment needs with care that is timely, appropriate, collaborative and ultimately effective?

This QR found that the care youth received was often delayed, not well matched to the intensity of their needs, and somewhat collaborative. This determination was made based on data from file reviews, structured interviews with caregivers and youth, youth focus groups and structured interviews with therapists.

In the file review we looked at fourteen indicators of high quality practice. The definitions for these indicators are provided in Table 1 (below). The practice standards were met only about one-third of the time. We also asked about the helpfulness of each care process that youth experienced, from the initial process of access to the process of transition from care (process definitions are provided in Table 2). Practices used at each care process were described as helpful just over half of the time (in 55% of cases). Data from structured interviews and focus groups are used to better understand the specific experiences of caregivers, youth, and therapists which drove these findings.

We measured the effectiveness of care by comparing ratings on the Initial CANS assessment with the youth's first Reassessment CANS. Half of the youth in the QR had an improvement in their CANS rating sufficient to reduce their recommended level of care by at least one level. This is a practically meaningful indicator of effectiveness, as it indicates that the care was effective enough to warrant step-down to a less intensive level of treatment.

The youth who demonstrated improvements in their CANS ratings were provided with care that was more timely, appropriate and collaborative than youth who did not improve per the CANS. These results indicate that ongoing attention to improving the initial quality of care can substantially improve the effectiveness of care, and reduce the intensity of treatments needed to serve similar youth.

In the following section we will walk through how we measured these four characteristics of treatment, and then walk through the data for each characteristic: timeliness, collaboration, appropriateness, and effectiveness.

Throughout the following section we refer to two sources of quantitative information. The first source is the file review. In the file review we evaluated the care provided based on fourteen indicators of care quality.

Table 1. Practice Indicators and Definitions by Care Process

Care Process	Practice Indicator Definition
Access	
Timely	First treatment service within 10 business days of contact
Barriers Addressed	Documented effort to address barriers to access
Assessment	
Timely	Completed within 30 days of first contact
Collaborative	Integrates multiple perspectives on needs and strengths
Planning	
Assessment-informed	CANS assessment is completed before Treatment Plan
Timely	Completed within 10 days of first service
Collaborative	Goals are written in the youth and family's words
Treatment Dose	
Initial	Three of more treatment contacts within 30 days of first contact
Ongoing Dose	More than 45 minutes of direct service per week
Psychiatric Supports	
Timely	Consultation within 30 days of first treatment contact
Skills Focus	
Homework	Greater than 50% of sessions assign skills practice outside session
Progress Checks	Greater than 50% of sessions include progress review or celebration
Supporters Enlisted	
Caregiver Present	Caregiver attends at least 50% of sessions
Reassessment	
Timely	Completed within 120 days of initial CANS assessment

The indicators are categorized by the sequence in care in which they typically occur, beginning with access to care and continuing through reassessment. The percentage of files reviewed in which a given practice indicator meets the standard defined in Table 1 is reported in tables throughout this section.

The second source of quantitative information we reference comes from interviews with caregivers of youth in treatment. In these interviews, we asked respondents to describe their experiences at each care process. The care processes are defined in Table 2.

Table 2. Definitions of Care Processes Discussed in Caregiver and Youth Interviews

Care Process	Care Process Definition
Access	the process of initially connecting to a provider to receive needed services.
Assessment	practices used to complete the initial comprehensive diagnostic and functional assessment.
Goal Setting	the process of setting self-directed goals in the initial treatment plan.
Selecting Care	how care was described and chosen to meet the youth's goals.
Therapist Alliance	the experience of working with the therapist to meet goals.
Progress Review	formally checking in and adjusting care based on progress.
Crisis Care	planning and response services received by all individuals who experienced a mental health crisis.
Transition	preparing to leave, and leaving, a particular care provider.

For each care process, in addition to asking about what occurred, we asked caregivers to tell us whether the practices used in the care process were helpful or not. This creates a simple binary indicator of the helpfulness of the care process: Yes, it was helpful, or No, it was not helpful. The total number of ‘Yes, it was helpful’ responses is divided by the number of respondents interviewed. The percentage of ‘Yes, it was helpful’ responses is reported in tables throughout this section.

Narrative information from interviews and focus groups allowed us to identify the specific practices used in these care processes. Interview and focus group data also provided us with examples of the specific practices which are experienced as collaborative and appropriate, and which are not. We used these data to better understand the numerical data provided by the file review and the helpfulness ratings.

Timeliness. We addressed time to initial appointment in the previous question. For this question we focus on the timeliness of the initial functional assessment (the CANS), treatment plan, and psychiatric consultation. Our primary data source for gauging performance is the file review. The definition of these indicators is provided in Table 1. The extent to which these practices were timely is noted in Table 3 below.

Table 3. Rate at which Timeliness Practice Standards are Met

Process and Indicator	All Youth
Assessment	
Timely	58%
Planning	
Timely	58%
Psychiatric Supports	
Timely	50%

Two points are of note regarding the timeliness of these practices. The first is that only about half of the youth in this sample experienced these practices in a timely manner. The likelihood that a youth will experience these practices in a timely manner appears to be completely dependent on the service provider to whom they are connected.

Second, there is some tension between these indicators. In the draft version of IDHW's Behavioral Best Practice Standards, there are no clearly identified completion timeliness requirements for the initial CANS assessment. Because of this we use the developer-supplied timeliness standard. This standard indicates that the CANS ratings are valid for 30 days, barring any major changes in the youth's context. From this we extrapolate that the CANS should be completed within 30 days of the first contact with the youth and family. However, the MCO requires the treatment plan to be completed within 10 days of the first service contact.

This creates a disconnect between when the information from the CANS regarding the level of need and specific treatment needs may be available, and when treatment plans are developed. In this sample, only one third of youth had an initial CANS completed before the Treatment Plan was signed.

Appropriateness. Three indicators of appropriateness are considered here. They are: treatment dose, the use of progress check-ins to shift treatment as needed, and the working relationship with the therapist. We consider each in order.

Treatment dose. File review data indicate that in the first 90 days of care, youth experienced an average of 20 minutes of treatment per week and less than two (1.7) treatment sessions per month. This translates to one 45-minute treatment session every other week. These dose levels are even lower than those found in last year's QR (which averaged 30 minutes of treatment per week). No youth in this year's sample averaged more than half an hour of treatment per week. These levels are grossly inadequate for youth with serious, impairing mental health concerns. As noted in the previous year's QR, evidence-based treatments for youth with intensive mental health challenges consistently require multiple hours of treatment contact per week. This is required to help youth learn, test, and routinely use new ways of preventing crises and reacting to intense emotions.

Caregivers described a series of challenges in trying to get the appropriate dose of treatment for their child. These included high turnover among treatment professionals, lack of fit with the counselor, and difficulty managing transportation. Regarding turnover, one parent recounted, "CBRS kept quitting….CBRS was a wonderful dream and we gave it a shot. 15 workers later it was over." In terms of fit, a caregiver reported that as the lack of fit becomes apparent, "We usually end up walking away and trying a different counselor." Another parent noted that being able to experience treatment at-home helped address a transportation problem, "[The] therapist comes to the house which is helpful since [the behavior of the youth] in the car is hard."

The majority of the clinicians interviewed indicated that interventions needed to be provided more frequently than once a week. Several clinicians indicated that youth needed services in addition to outpatient therapy in order to be successful. Clinicians' accounts of the frequency with which they remembered providing care tended to overestimate the dose of care provided, relative to the treatment encounters we recorded via the file reviews.

When provided information from the file review regarding the dose of treatment actually provided, half of interviewed clinicians indicated that the dose was inadequate, and that they would have preferred to provide a higher dose of care. Reasons for not being able to provide that dose included families not making appointments, the therapist going on medical leave, and the youth's 'lack of motivation.' Clinicians also echoed some of the themes of caregivers. In terms of fit, two therapists described identifying needs of the youth that were outside of their scope of practice or experience. They noted that this was addressed by referring the youth to another professional.

Regarding transportation, one therapist stated, “With some clients having difficulties making it to appointments, transportation is an issue. Medicaid transportation is unreliable. I'm forced to do telehealth with clients who don't really want to do telehealth because there are no other options.” One therapist also had a recommendation for making the appointments more impactful: “get rid of the 45 minute [session limit] and go with the 1 hour the kids deserve. It's wild what a difference that 10 minute difference can make.”

Progress check-ins. The needs of youth change based on events in their environments, and their response to treatment. Progress check-ins help make sure that treatment is responsive to the youth’s current situation. They take two forms that we assess here. First are check-ins that can occur in each treatment session in order to gauge how well treatment is working and how it can be tailored. Second are periodic, formal reviews of progress. These typically include a re-assessment of symptoms and functioning, and a review of progress in reaching treatment plan goals.

In this sample, only one-third of youth had documented check-ins on progress in 50% or more of their treatment sessions. Progress check-ins were defined as documentation of check in on the use of a skill or technique discussed in the previous treatment session, or celebration of progress in using such a skill or technique.

A parent described these check-ins, “The review of the goals happened weekly. We would ask lots of questions, have check-ins, so it was more than just a snapshot of a moment, [there were] long term observations, culminating in specific questions.” Another caregiver remarked on their frequency, ““We had pretty consistent check-ins throughout. Both from our perspective and the counselor [sic] perspective.”

When asked about their experience of formal check-ins regarding treatment progress, caregivers described both useful and effective reviews, as well as experiences that were frustrating or inadequate. One parent stated, “[The initial goals] were too optimistic. There was discussions between me and them. They asked how they should approach things.” This process of being able to adjust as treatment went on was also described as important by another caregiver, “They changed as we went on, certain things for her to focus on, for her well being.” One parent described it as being a process that focused on mutual accountability, “...every person had goals, we had to sign things and talked about them and adjusted them a lot.”

However, several parents also described an absent or inadequate process. One stated, “With [our] first therapist, it was good, there were a few times when my son met his goals. The most recent therapist - he hasn't reached any goals.” Another stated that, “I don't remember doing this.” One parent was even clearer about how this lack of communication can be problematic, “I wasn't involved in that at all. I was not even aware of what the goals were. The therapist never reviewed anything with me. All of a sudden [the youth] wasn't going [to therapy] anymore, I never heard anything.”

The process of formally reviewing treatment progress varied tremendously across clinicians. Almost half of the clinicians described a formal review of progress towards goals and its implications for treatment. Others described doing informal reviews of progress, or reviews involving some caregivers and not others, or did not describe a review process at all.

One stated, "I do try to do it informally. A formal review might be in the old system, but I don't know if there is one done in the new system." Another therapist described a more structured process, "After intake, I schedule time to pull out the chart, go over it, what goals are beneficial, what needs to change. We usually run screeners at that time, and the CANS, to talk about goals if they needed to change."

Working relationship with the therapist. The working relationship with the therapist, sometimes called the therapeutic alliance, refers to the process of engaging together to meet agreed upon therapeutic goals. It includes the ability to disagree and then find a way to move forward. We describe findings from three sets of information: caregiver appraisals of the helpfulness of the therapist, caregiver and youth narratives of care experiences, and youth responses to focus group prompts about their care experience. We consider each in turn.

In interviews with caregivers, we asked them how helpful each clinical process was in their child's treatment. We asked about each of the key clinical processes in care: assessment, setting goals, choosing care, working with the therapist to reach goals, reviewing progress towards reaching goals, and transitioning from care. We did this so that we could identify which practices improved the working relationship, and which practices may be hurting the working relationship. For each care process we asked the participants to a) describe their experience of care and b) indicate whether or not the practices used were helpful to them or not.

Table 3. Helpfulness of care processes

	All Respondents
Assessment	90%
Goal Setting	50%
Selecting Care	11%
Therapist Alliance	70%
Progress Review	56%
Transition	57%

In Table 3 (above), we can see that the practices used in many treatment processes are not experienced as helpful. For instance, almost none of our respondents indicated that the process of selecting care was helpful. About half of respondents indicated that the practices used in setting goals, reviewing progress and transitioning from care were helpful. Setting goals, selecting care, and then reviewing progress toward those goals are at the heart of what makes change possible in treatment. We expect that changes to these practices would improve the working relationship between the caregiver, youth and therapist, and improve the effectiveness of treatment.

Caregiver and youth narratives from the interviews and focus groups provide more insight into which specific practices are experienced as helpful during the treatment process. Two types of behaviors were highlighted by caregivers and youth whom we interviewed. The first was the therapist working to fully engage and understand the youth. The second was the therapist having a set of useful skills to address the youth's concerns, and help them find new ways of coping and interacting.

Regarding the first, a caregiver reported that the treatment relationship started off on the right foot because of the efforts by the therapist to fully engage the youth, "The therapist went out of her way to get youth to come in. She tried, she called and texted, trying to engage her." Another youth reported feeling very close to his therapist, "like an Aunt," with another youth stating that he liked his therapist because, "..[S]he got to know me as much as I got to know her."

Skills training provided by the therapist was described as very helpful:

> She was awesome, she was really nice, she gave feedback in a positive way. She had these like things fidget in her office that was good she was good at telling me stuff she was really patient, good at giving helpful feedback. [The] feedback was useful.

Youth also described instances in which the treatment provided was less helpful. One youth noted that their interactions with their first therapist were unhelpful because she "played therapy board games" with her that did not feel age appropriate. One youth stated that that it was sometimes difficult to connect with the therapist "because of technology."

Another youth described concerns about the pace of therapy, “I don't feel like it's getting the job done. Maybe he's taking the slow route. I tell him but he says that we'll eventually go there.”

Collaboration.

We use two sets of quantitative information to identify the extent to which care is practiced and experienced as collaborative: file review data and interview ratings of the helpfulness of different care processes. We supplement these sets of information with additional information from the interviews and focus groups conducted. The file review data focus on documented efforts by the therapist to engage in a dialogue and create mutual understanding about the youth and family, including what action steps to take based on that understanding. The table below (Table 4) identifies the percentage of youth for whom these collaborative practices were documented in their chart.

Collaborative practices start with identifying any barriers to access, and supports that could address those barriers (Barriers Addressed). During the assessment process, indicators of collaboration include introducing the assessment tools to the family, reviewing written drafts of the assessment or assessment tool ratings, and coming to a consensus or noting areas of difference on the assessment (Collaborative Assessment). In treatment planning this includes using the language and priorities of the youth and / or caregiver in goal-setting (Collaborative Planning). During treatment, collaboration involves both checking in to see how well the clinician’s action recommendations work when used outside of the therapy encounter (Progress Checks), as well as the extent to which caregivers or other important adults are enlisted in the youth’s treatment (Caregiver Present).

Table 4. Practice Standards Related to Collaboration

Process and Indicator	Youth with Documented Collaboration
Access	
Barriers Addressed	8%
Assessment	
Collaborative	18%
Planning	
Collaborative	8%
Skills Focus	
Progress Checks	33%
Supporters Enlisted	
Caregiver Present	25%

Per Table 4, we can see that documented collaboration is the exception, rather than the rule. This extends across all of the file review-based indicators of collaboration.

The data from interviews with caregivers paints a somewhat more positive picture. Seventy percent of caregivers indicated that they had a helpful experience working with the therapist. Ninety percent of caregivers indicated that the assessment process was helpful. This may indicate that therapists are engaging in more collaborative actions than they are documenting in their encounter notes. Alternately, it may be that caregivers found these processes helpful, even when they were not collaborative in the ways measured in the file review.

The data on progress checks and treatment planning are more consistent across the file review and interviews. In terms of progress checks, the file review shows that this happened in about one-third of the sessions; just over half of all caregivers found this helpful. Eleven percent of caregivers found the process of selecting care to be helpful; in eight percent of the charts there was a documented, collaborative treatment planning process. We find the evidence for a collaborative treatment process to be mixed. The data indicate that caregivers perceived the relationship with the therapist as helpful, but that several specific collaborative practices were not routinely used or documented.

Effectiveness.

In this review we looked at the first 90 days of care. We did this because the initial effectiveness of treatment is the strongest single predictor, per the scientific literature, of the ultimate effectiveness of treatment. Experiencing success in treatment makes a person more likely to stay motivated and keep trying new ways of thinking and acting.

Table 5. Practice Standards Met by Treatment Effectiveness

Process and Indicator	All Youth	Effective Care	Ineffective Care
Access			
Timely	67%	67%	67%
Barriers Addressed	8%	17%	0%
Assessment			
Timely	58%	67%	50%
Collaborative	18%	17%	20%
Planning			
Assessment Informed	33%	17%	50%
Timely	58%	67%	50%
Collaborative	8%	17%	0%
Treatment Dose			
Initial	0%	0%	0%
Ongoing Dose	0%	0%	0%
Psychiatric Supports			
Timely	50%	67%	33%
Skills Focus			
Homework	0%	0%	0%
Progress Checks	33%	50%	17%
Supporters Enlisted			
Caregiver Present	25%	33%	17%
Reassessment			
Timely	92%	100%	83%
Weighted Average[1]	**32%**	**37%**	**28%**

In our sample, half of the youth experienced clinically significant improvement in their behavioral health needs across the first three months of care. Half of the youth did not. However, these treatment effects were not random.

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[1] Weighted average refers to the average weighted by the respective denominators of each indicator. Individuals for whom an indicator could not be calculated were excluded from the denominator.

Our QR data replicate what we have found previously: the effectiveness of care is a predictable outcome of collaborative, clinically appropriate treatment practices. The more indicators of high-quality practice that we observed in a youth's care, the more likely it was that they got better in the first three months of care. Care that met more of the practice standards (in Table 5) was more likely to lead to improvements in the CANS-derived Level of Care over the first 90 days of treatment. On average, youth with better treatment outcomes experienced appropriate care on 10% more of the practice indicators than youth with poorer treatment outcomes (37% of practice standards were met vs 28% of practice standards). This may indicate that even a modest improvement in the care provided can predict better outcomes for children and youth.

Table 6. Caregiver perceptions of the helpfulness of each care process, by care effectiveness

	All Respondents	**Effective Care**	**Ineffective Care**
Access	40%	60%	20%
Assessment	90%	83%	100%
Goal-Setting	50%	67%	33%
Selecting Care	11%	25%	0%
Therapist Alliance	70%	83%	50%
Progress Review	56%	50%	60%
Crisis Care	67%	67%	67%
Transition	57%	67%	50%
Weighted Average	**55%**	**68%**	**44%**

In Table 6, we see that these results also hold true when we look at the experience of care. Caregivers of youth with effective care were substantially more likely to report that their experiences of accessing care, setting treatment goals, selecting care and working with the therapist were helpful. Across all care processes, youth with effective care were almost 25% more likely to have experienced care that their caregiver rated as helpful.

Summary.

Access. Navigating access to services, particularly specialized services, is a vexing challenge for families of youth in YES. Clinicians treating the youth in this QR appear to be relying on their own personal knowledge of available care options in order to suggest additional appropriate services for youth. This does not result in consistent, appropriate connections to much-needed, often specialized services. Therapists do not have the time to serve as care coordinators for youth with complex needs, nor should they have to. In order to reduce the burden for both families and therapists, care coordination should be more accessible and its use clearly prescribed. Without creating automated prompts for when youth must have care coordination, and an easy to use, reliable process for connecting youth to intensive care coordination, youth and families will continue to experience substantial frustration when trying to connect to the services to which they are entitled.

Appropriateness. The YES System of Care is currently undergoing substantial change. The expansion of the Medicaid-eligible population, re-organization of the Department of Behavioral Health, and re-bid of the Idaho Behavioral Health Program (IBHP) contract are each sufficiently disruptive organizational events to pull focus from the quality of clinical care. At the same time, the effort and time it took to make the initial connection to appropriate services is the most consistent, persistent pain point we heard across all of our interviews with caregivers and youth. Access and Selecting Care were the two care processes rated as the least helpful by caregivers. No youth received a dose of care in the first thirty days that was consistent with full engagement. Documented collaboration between providers and families across early care processes was observed in less that 20% of cases.

Youth generally experienced care that did not meet quality standards. Yet there is a reason to be particularly focused on quality indicators from the first thirty days in care. Youth who are underengaged are more prone to dropout and poor treatment outcomes. Without addressing the first thirty days in care, the YES System of Care may not get another opportunity to meaningfully help youth when they need it the most.

Question #3. What capacity do providers currently have for intensive community-based treatment?

Capacity for community-based treatment. Chart 1 (below) identifies agencies' self-reported service array. Response percentages are based on survey responses from 38 child-serving agencies who participated in the Summer 2022 survey. Service descriptions are lightly edited versions of the descriptions appearing in the Managed Care Organization's (MCO) Provider Handbook.

Chart 1. Agency Respondents' Current and Planned Services

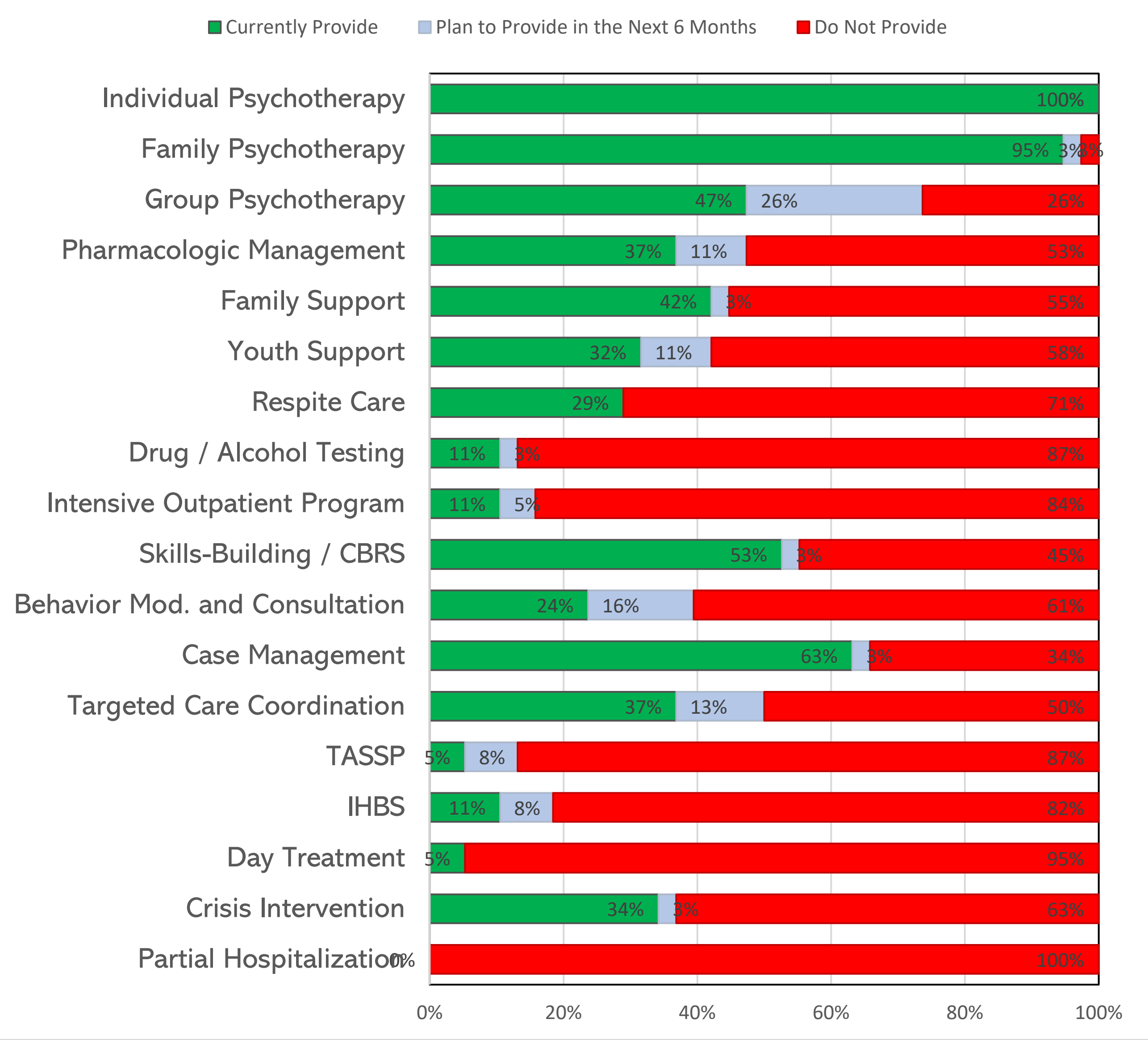
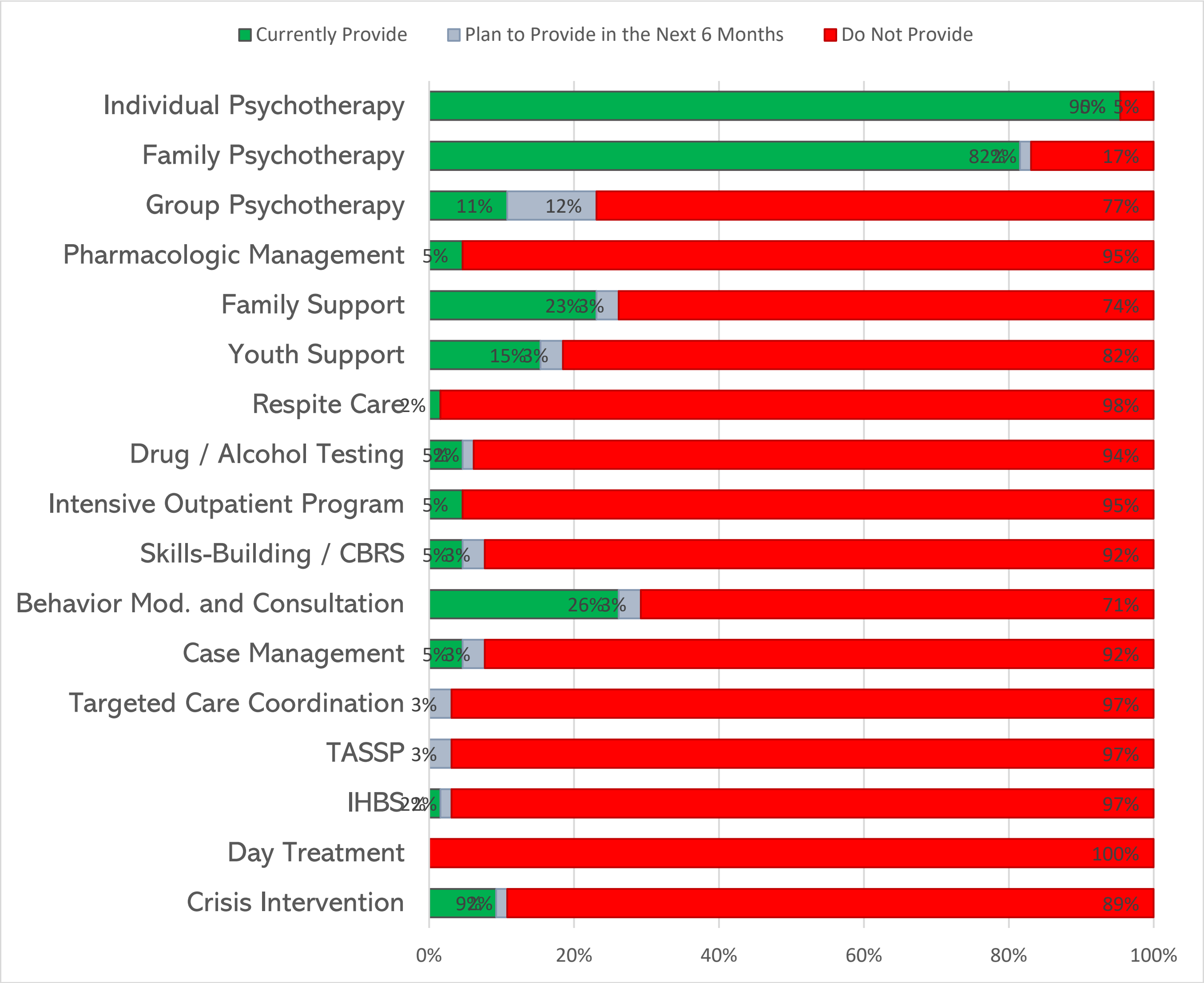


Chart 2 (below) identifies individual practitioners' self-reported service array. Response percentages are based on survey responses from 65 child-serving practitioners who participated in the Summer 2022 survey.

Chart 2. Individual Practitioners’ Current and Planned Services



Summarizing the Current Service Array

Idaho's YES population includes a high proportion of youth who need intensive services provided in their community. Analyses from last year's QR sampling data indicate that 40% of youth completing an Initial CANS may have intensive treatment needs. The service arrays we see in Charts 1 and 2 are disproportionately focused on services which are appropriate for youth with mild to moderate behavioral health concerns. Only about 5% of individual practitioners provide services targeted towards youth with severe or complex behavioral health needs.

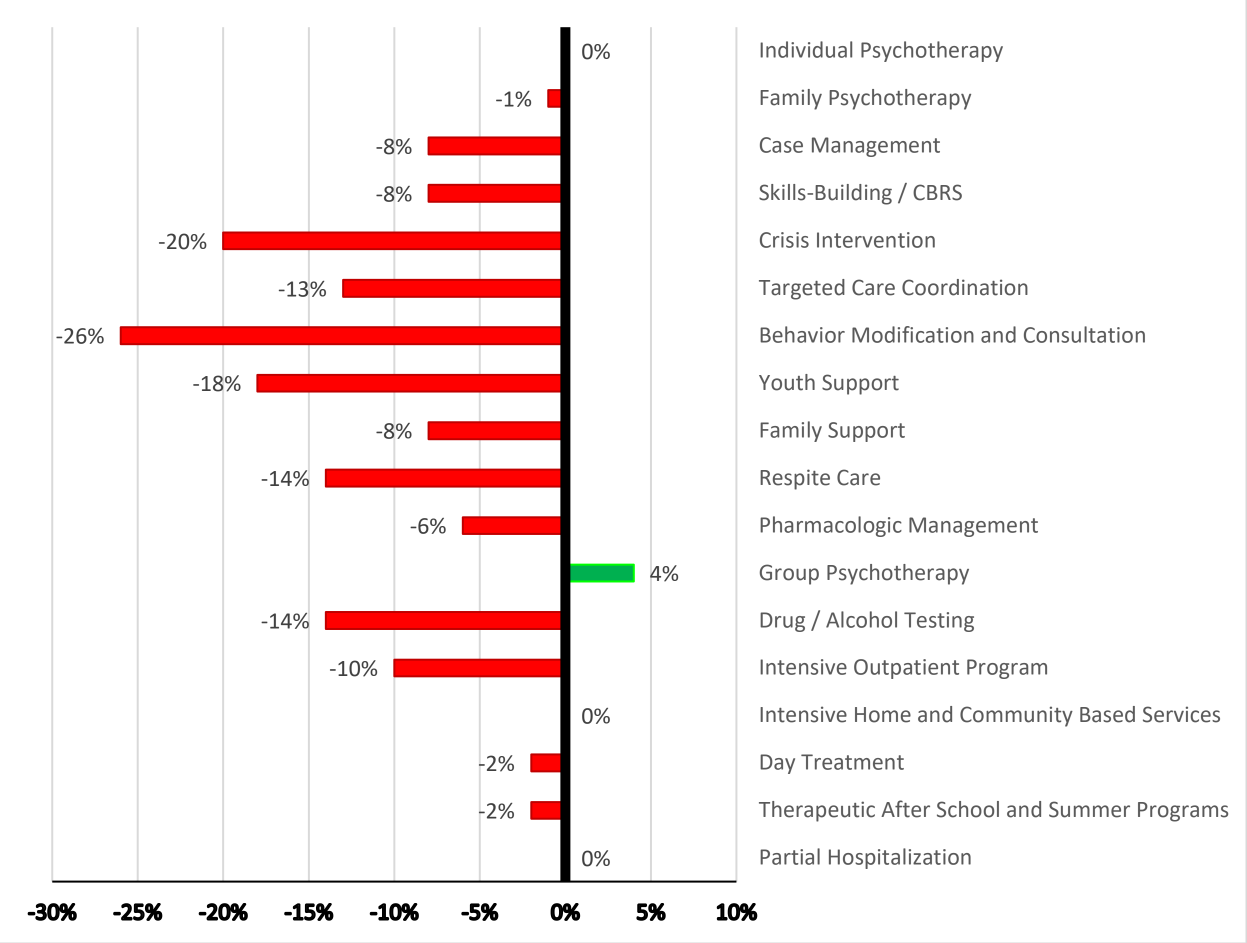
Across multiple service types, provider agencies are also unlikely to provide the intensive treatment options best suited for youth with severe or complex needs. Only about 10% of agencies indicate that they provide Intensive Outpatient Programs, Intensive Home and Community-Based Services, or Drug and Alcohol Testing. Only about 5% indicate that they provide Day Treatment or Therapeutic After School and Summer Programs.

Recent data in the Annual Availability Assessment that the State of Idaho submitted to the Centers for Medicare and Medicaid Services (CMS) indicated that there are currently ~ 50 beneficiaries with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED) for every Medicaid enrolled practitioner licensed to independently treat mental illness. The ratio of Medicaid beneficiaries with SMI/SED to Medicaid-enrolled providers offering intensive outpatient services is more than 2500-to-1. These 50-to-1 and 2500-to-1 ratios contrast sharply with the fact that at least 12% and as many as 40% of youth entering the YES program likely require intensive community treatment. Youth served in the YES program also need access to psychiatric prescribers, as many experience serious mental health concerns for which psychotropic medication is the first line treatment. The ratio of medication prescribers to beneficiaries with SMI/SED is greater than 1000-to-1. These data from the Annual Availability Assessment converge with the data from the QR survey. The lack of providers able to provide a full array of services is creating particularly acute care shortages for youth with the greatest community treatment needs.

Projected versus Actual Growth in Service Capacity

In the 2021 QR Pilot we asked respondents about their intentions to add a new service type in the next six months. Across services, about 9% of providers indicated that they planned to add a specific service in the next 6 months. However, when this year's respondents were asked about services they currently provide, they were 8% less likely than last year's respondents to currently be providing a given service (Chart 3). Across eighteen different types of services, providers were only more likely to provide one type of service (Group Therapy) in 2022 than they were in 2021. Three services were offered at the same rate. Fourteen services were less likely to be offered in 2022 than in 2021. Though there were some sampling and response rate difference between the two years' surveys, the consistent trend across nearly all services indicates that this bears further understanding.

Chart 3. Net Change in Care Types that Agencies Currently Provide (2021-2022)



Question #4. What state-level barriers and supports impact the expansion of intensive community-based treatment?

Unpacking the Results. In this year's survey, we asked providers if they had stopped providing one or more services in the past year. Twenty-seven percent of agency respondents indicated that they had stopped providing at least one service in the past year. Sixteen percent of individual practitioners indicated that they had stopped providing at least one service in the past year.

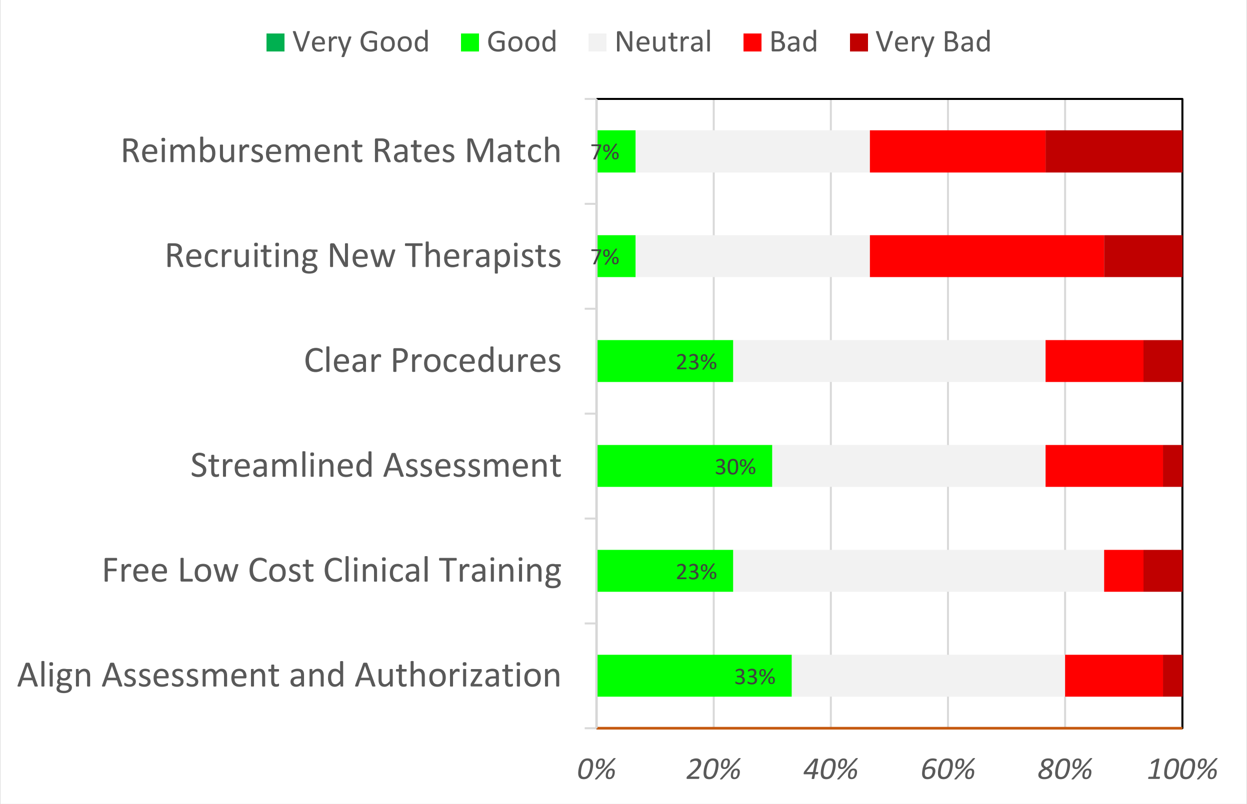
We also asked if providers had initiated a new service in the past year. Twenty-three percent of agency respondents indicated that they had initiated a new service in the past year; only 4% of individual practitioners indicated that they had initiated a new service in the past year. For both agency respondents and individual practitioners, the results indicate a net reduction in the continuum of services being offered to YES recipients. These within and cross-year results indicate that it is more likely that the public behavioral health continuum of care in Idaho is contracting than that it is expanding.

Understanding Why Services are Expanded or Reduced. We then investigated the reasons for service expansion and reduction among this year's respondents. In the previous year's QR, individual practitioners and agency representatives identified a series of barriers to expanding the continuum of care they offered. These included:

- A lack of clear procedures for service initiation;
- Reimbursement rates which did not keep up with the costs of doing business;
- Difficulty recruiting therapists willing to work in the public sector;
- Dearth of affordable, high-quality training needed to provide effective services;
- Confusing and mis-aligned assessment and service authorization procedures;
- Onerous and duplicative assessment processes.

We used these responses to construct a scale asking how well or poorly IDHW addressed these barriers and provided incentives for service expansion (Chart 4).

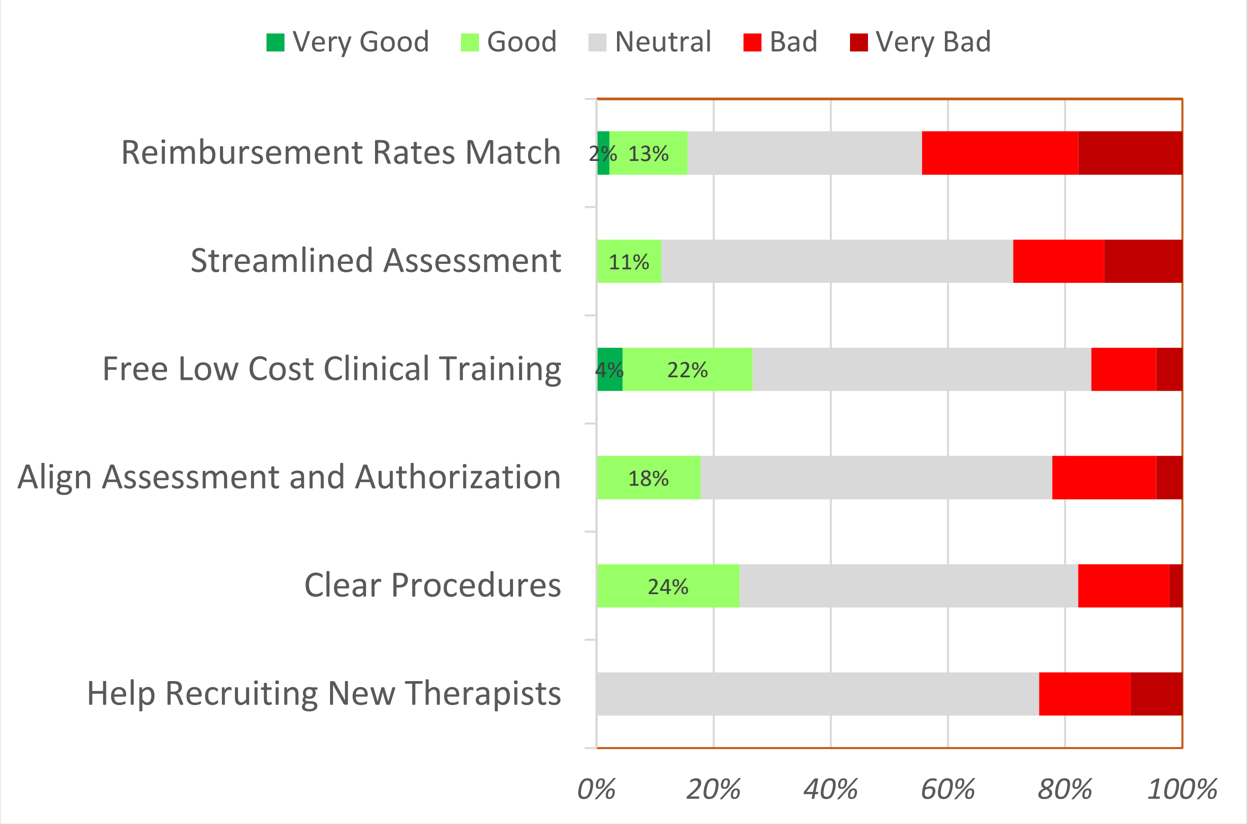
Chart 4. Agency Respondents' Satisfaction with Supports for Service Expansion



We asked agency representatives to rate, on a scale ranging from "Very Good" to Very Bad" how well IDHW currently provides these supports for service expansion. These supports are listed from most important ("Reimbursement Rates Match Costs") to least important ("Align Assessment and Authorization Procedures"), as rated by providers. Consistent with industry standards, we calculate satisfaction as the percentage of respondents indicating that the State of Idaho does a Good or Very Good job at providing these supports.

The percentage of respondents satisfied with the State's supports for expanding the continuum of care ranged across items from 7% to 33%, averaging 21% across all supports. Of greatest note, the most important supports for service expansion ("Reimbursement Rates Match Costs", "Help Recruiting New Therapists") had the lowest rates of satisfaction.

Chart 5. Individual Practitioners' Satisfaction with Supports for Service Expansion



For service expansion, Individual Practitioners and agency representatives had the same top priority: that reimbursement rates are adjusted to match the costs of delivering care. However, Individual Practitioners were more focused on improving processes directly related to care delivery (assessment, clinical training, aligning assessment findings and service authorization) than were Agency respondents. Across support types, satisfaction with supports ranged from 0% to 27%. Practitioners were satisfied with supports, on average, 16% of the time.

These rates of satisfaction have a very practical implication. Persons who are satisfied with the State's supports for expansion represent the fraction of providers who are likely to engage with the State to expand services in the near future. Per these findings, we estimate that only about one-sixth of individual practitioners and one-fifth of agencies are currently receptive to State efforts to expand their services. These results indicate that the State must take a substantially more proactive stance to improving high priority supports for expanding the continuum of care. Otherwise, the continuum of care is likely to further shrink.

Identified Drivers of Change among Persons Actively Expanding or Cutting Back Care

In our survey, we further identified three groups of providers with recent, grounded experience of expanding or reducing their care offerings. Providers who:

- Added a new service in the past year;
- Tried to add a new service, and then stopped;
- Eliminated an offered service.

Nine respondents (out of seventy-five; 12%) indicated that they had added a service in the past year. Thirteen of seventy-five respondents (17%) indicated they began work on expanding at least one service, and then stopped that effort. Fifteen of seventy-four respondents (20%) had eliminated at least one service they offered in the past year. We asked these providers about what were the most important drivers of their decisions.

Service Expanders

Agencies and individual practitioners who expanded services indicated that the ease of working with IDHW and the MCO was a key driver in their ability to expand the service. Also mentioned were “feasible” reimbursement rates and “low cost training.”

Respondents who Tried to Expand Services, and Stopped

Eight individuals provided a description of the barriers that caused them to pause or stop expanding their services. Half of the individuals identified multiple barriers to expanding their services. Five of the eight individuals mentioned that funding for beginning (and continuing) a new service was inadequate. As one provider stated, "[It's] too much work for the reimbursement amount. ...Idaho pays meager reimbursement rates compared to states with populations that match our locale."

Three of the eight respondents indicated that the process of starting a new service was too burdensome or unclear to risk continuing to move forward with initiating a new service. One provider stated, "[Our agency] can't get credentialed to start the program. [The MCO] and the state do not know how to get us started for the new TBS program."

Two persons identified problems finding new staff. One person identified a lack of cost-effective training as a barrier to expanding services.

Providers who Stopped Providing One or More Services

Six agency providers indicated that a lack of staff forced them to cut back their services. They indicated both that current practitioners had left, and that there was not a set of willing and capable providers to replace or supplement staff who had left. Two respondents indicated that staff who do stay on are only willing to work limited hours, restricting their ability to provide the service.

Four respondents indicated that ongoing costs and inadequate reimbursement drove the decision to stop providing a service. One stated, “Poor reimbursement / dealing with [the MCO],” drove their decision. Three agency respondents indicated that training costs, and time lost to training also factored in the decision to cut back service.

Three individual practitioners indicated that paperwork and regulations made it too difficult to continue to provide service. One noted, “I'm tired of Medicaid's never ending list of requirements without removing any. They continue to pile on the paperwork making it impossible to do my job.” Another stated that, “Overly complicated and rule bound requirements for treatment” had prompted them to stop providing service.

One Missing Support

Providers were also asked to identify the one most important missing support for service expansion. The most frequently identified missing support was a reduction in the complexity of the process for initiating and continuing to provide services (identified in seven responses).

The second most frequently missing support was a lack of acceptable reimbursement rates (six responses). Within this response, several providers indicated that the scope of services covered for reimbursement is currently inadequate. Respondents specifically stated the need to, “increase rate reimbursement,” “broaden [the] scope of service,” and “increase the number of allotted [service] hours per client.

Other missing supports included the need for help recruiting practitioners (two responses) and to provide training (one response).

Summary of Drivers of Service Expansion and Contraction

The comments provided by agency respondents and individual practitioners were largely consistent with the themes identified in last year’s QR Pilot. The vast majority of comments revolved around the need for:

- reimbursement rates consistent with service costs;
- less onerous paperwork and more understandable policies and procedures;
- specialized training that is accessible and low cost;
- assistance in developing and recruiting from a sufficient pool of practitioners.

Two observations were of note in this year’s responses. First, only one response indicated that the COVID pandemic had affected their decision to reduce or expand their service offerings. Though the pandemic was clearly a driver of myriad changes in behavioral health care policy and practice nationally and in Idaho, this did not appear to be on the forefront of most providers’ minds in this year’s survey. It may be that the pandemic has surfaced or exacerbated the limitations agencies and individual practitioners have been dealing with for many years, and providers’ narratives simply reflected those longstanding limitations.

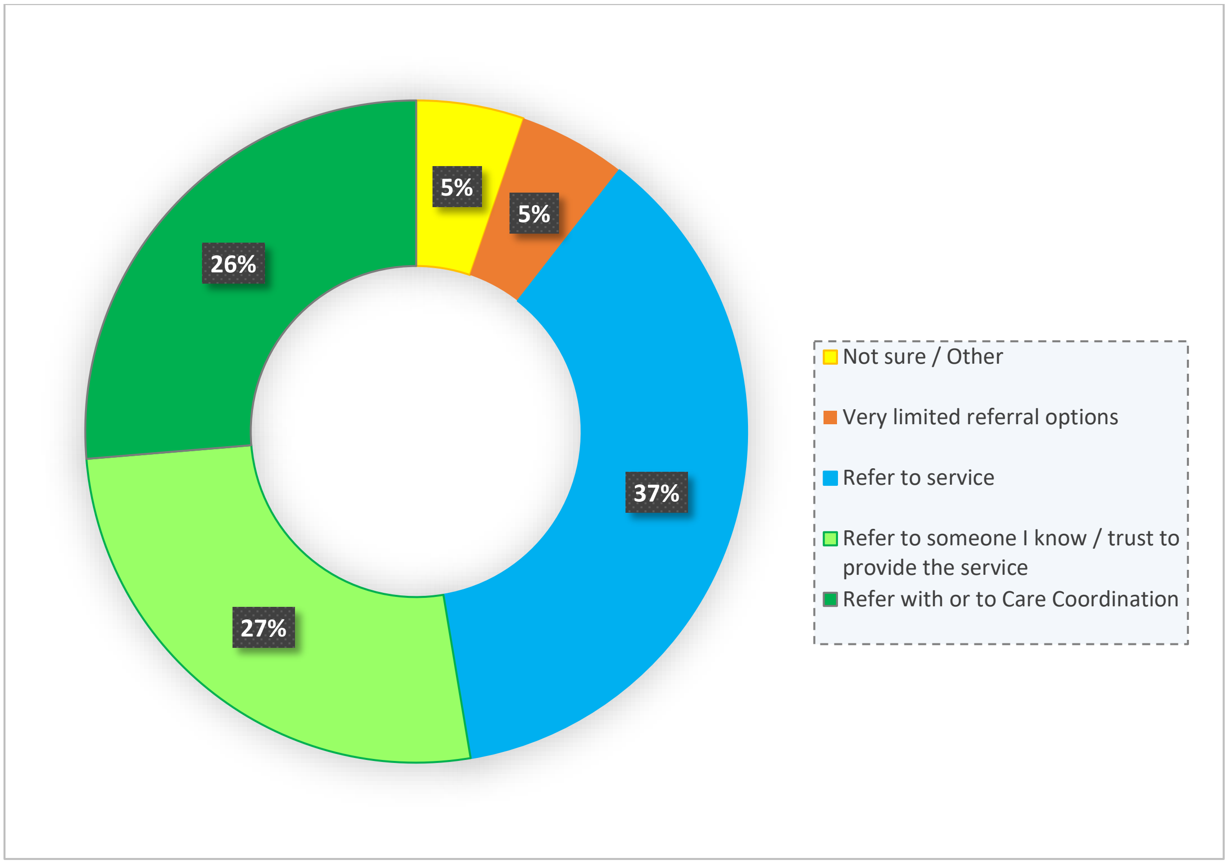
Second, one new variation on a theme did emerge in this year’s responses. Several times, respondents alluded to or explicitly described the importance of having access to knowledgeable, personalized help in working to initiate services or address regulations.

Agency and individual providers appear to be operating under substantial fiscal pressure and have limited staff resources to initiate new services. Should the State of Idaho decide that expanding the continuum of care is a high priority, creating accessible, individualized, in-person help for providers. Providers noted the need for help in understanding the process and completing the paperwork necessary to move forward with service expansion. One provider summarized it as, "A person that had time to zoom or visit so I could talk through the requirements and make sure what we have in place is still compliant and appropriate."

Service Continuum Implications for Care

Agency Respondents. Agency respondents indicated that about four in ten youth served in their agency will need additional behavioral health services not provided by that agency (Arithmetic Mean = 37%, Median = 40%). When asked what happens when a youth has these needs, respondents provided a variety of answers. These were classified by theme. Their frequencies are represented in the chart below (Chart 6). Of note, only one quarter of respondents included a mention of the use of care coordination or care coordinators to facilitate effective linkages to outside services. Providers appear to rely heavily on the providers they have personal knowledge of in order to make referrals. New providers, or providers with limited networks of connections, may be at an important disadvantage in trying to find help for youth with complex needs. Two providers explicitly stated that they have very limited referral networks or local treatment options when youth have more complex needs.

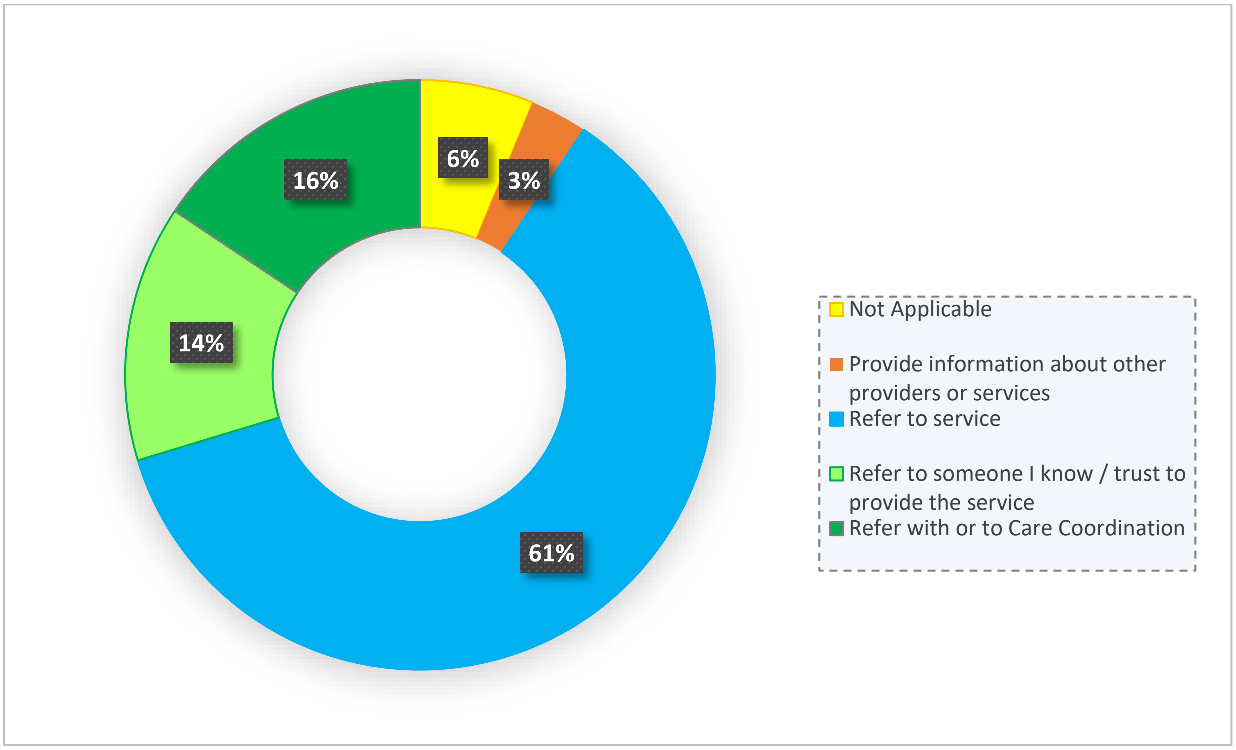
Chart 6. Agency Respondents' Processes for Connecting Youth Needing Other Services



Individual Practitioners. Individual Practitioners indicated that about one in five youth served in their agency will need additional behavioral health services not provided by that agency (Arithmetic Mean = 22%, Median = 15%). One quarter of providers indicated that none of the children or youth they see have needs requiring outside services. One sixth of providers indicated that 50% or more of the youth they see require outside services. When asked what happens when a youth has these needs, respondents provided a variety of answers. These were classified by theme. Their frequencies are represented in the chart below. Approximately one in six respondents included a mention of the use of care coordination or care coordinators to facilitate effective linkages to outside services. Surprisingly, individual practitioners with higher percentages of youth with complex needs were not more likely to indicate that they used care coordination services.

Individual practitioners appear to rely on their personal referral networks even more heavily than do agency providers. As care coordination services become more available, it will be important to provide targeted outreach to individual practitioners who indicate that they routinely service youth with complex needs. Connecting these providers with care coordination services is likely critical to their ability to consistently link children and youth with complex care needs to the appropriate supports.

Chart 7. Individual Practitioners' Processes for Connecting Youth Needing Other Services



Summary.

In short, there are a readily identifiable set of barriers to providing behavioral healthcare in Idaho's public sector, particularly to youth with intensive treatment needs. Youth with intensive treatment needs routinely require care outside of the initial setting in which they are provided care. That care is not consistently accessed through a coordinated care linkage process. Rather, it is frequently dependent on individual providers' own connections to specialized care providers. The care network for youth with intensive treatment needs is inadequately developed, and the processes for connecting people to resources across the network are also inadequately developed.

Diverse providers consistently identify similar barriers. The identified barriers have remained stable across two years of survey administration. Many of the same barriers and supports were identified by both individual practitioners and provider agencies. Similar barriers and supports were identified across ratings of implementation needs and free-response prompts. These barriers are:

- unsustainable reimbursement rates;
- administrative burdens to standing up and continuing to provide a service;
- lack of qualified and willing workforce;
- high costs and productivity losses associated with training staff to work with new populations.

IDHW has not addressed these barriers satisfactorily. Providers have opportunities to pursue work with higher reimbursement rates, substantially fewer authorization and documentation requirements, and better hours. They are choosing those opportunities. IDHW must make providing care, particularly intensive community treatment, attractive to providers. Otherwise IDHW will continue to see a shrinking provider pool and will not be able to meet its obligations for care under the terms of the Jeff D Settlement Agreement.

Key Findings and Recommendations

This summary provides:

- high-level findings from the QR, and subsequent recommendations,
- how the recommendations were established, and
- incremental action steps to address the recommendations.

The summary walks through select file review, interview, focus group, and survey data contributing to each recommendation. Sub-recommendations provide specific actions that can be taken to move closer to achieving the goal set out in the recommendation.

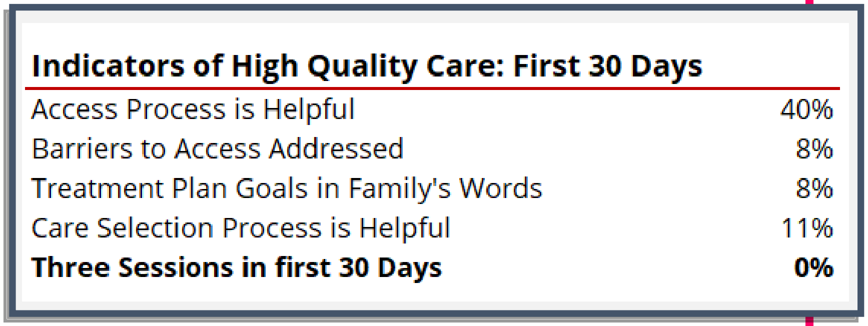
Two key findings stand out in this review:

1) The first is that the network of providers appear to be responding to the cumulative impact of low margins, high administrative burden, and multiple oversight bodies. Their response is to pull back from the Medicaid network, either leaving altogether or reducing the breadth of service types and service hours provided. This finding is first, in that the quality of care is immaterial if care cannot even be accessed.

2) The second key finding is that the care network is not routinely providing timely, appropriate, effective care for youth with serious and complex behavioral health needs. Though caregivers and youth appreciate the efforts of dedicated providers, these efforts often come after lengthy attempts to access services, and multiple experiences with inadequate care. Even when care is effective, many of the care processes leading up to treatment are experienced as unengaging or unhelpful. A set of practice- and system-level recommendations are offered below to help improve this state of affairs.

Recommendation #1. Focus the system on providing engaging, high-quality care during the first 30 days of treatment.

Evidence Summary. The research literature indicates that experiencing three treatment sessions in the first month of care predicts better treatment outcomes. No youth in our sample experienced three treatment sessions in the first month of care. A series of system and practice barriers need to be addressed to change this, and set youth up for treatment success.



Indicators of High Quality Care: First 30 Days	
Access Process is Helpful	40%
Barriers to Access Addressed	8%
Treatment Plan Goals in Family's Words	8%
Care Selection Process is Helpful	11%
Three Sessions in first 30 Days	**0%**

Participants identified that service waitlists, provider service hours, lack of face-to-face appointments, and inconsistent availability of medical transportation were system barriers to timely care. Reported wait times for an appointment ranged from 'a couple of weeks' to 'six months.' As one caregiver noted, “The problem was the access to them took so long, and we'd gone through so many people and places that didn't offer those services. By then, [the youth] couldn't care less."

Our file reviews and interviews also identified a series of practice barriers to full engagement. These included a sense that the provider was not the right fit for the family, lack of true engagement in the initial processes of care (assessment and treatment planning), and the absence of meaningful treatment choices.

Actions to Consider

- Standardize the documentation and tracking of the referral process. Include referral source, date of referral, assigned clinician or case manager, and date of first outreach post-referral. Monitoring these metrics will allow IDHW to better understand the sources of referrals, and the time from referral to the first treatment session.
- Standardize and require assessment for barriers to accessing treatment as part of the intake process. Routinely assess the extent to which this occurs at intake.
- Monitor the use of, and satisfaction with, non-emergency medical transportation and any other system-provided supports to address access barriers. Address identified barriers to the timely use of these supports.
- Provide specialized assistance to therapists working with youth with co-occurring disorders and complex needs. Make available and promote consultation billing codes. Recruit expert clinical consultants and make them available statewide to therapists working with these youth.

Recommendation #2. Systematize access to care coordination for youth with highly complex needs.

Evidence Summary. There does not appear to be a systematic process in place to insure that youth with the most complex needs are prioritized for and offered care coordination. All of the youth in this QR presented with intensive or complex treatment needs (identified as Level 2 or Level 3 per the CANS algorithm). None of these youth had a care coordinator at the time of their interview. None had a Child and Family Team (CFT) meeting during their first 90 days of care. As one caregiver stated, “"[The] Targeted Care Coordinator, [and] Case coordinator [were] really handy…[we] lost those services. Without these services, no one is maintaining the case. It's terrible."

> “Find yourself a good Case Manager. This has caused me more physical grief than I care to disclose. [Accessing care without a Case Manager] has not been a good experience.”
>
> -Parent of Youth in YES Quality Review

Provider survey data indicate 13% fewer providers are offering Targeted Care Coordination in 2022 than in 2021. Data from the SFY 2022 Q3 QMIA Quarterly Report indicates that that “there is a trend toward fewer children accessing Case Management” (p. 13). Similarly, use of Targeted Care Coordination appears to have decreased in 2022 relative to 2021 (p. 31). This is likely to have a disproportionate impact on youth who have cross-system involvement or conditions that require coordination across multiple treatment providers. One parent described the impact of having to advocate, alone, for services: "We got on a waitlist for a neuropsych [assessment] for the autism - it was hard to fight and far to travel for a failed exam. We still didn't walk away with an autism diagnosis. You shouldn't have to go to three people, and not have the proper diagnosis to get proper care, proper testing. I called out of state to trying to get information. All of the testing overwhelmed my son, and the behaviors got worse. I had to pull him out of school.” Seeking YES services should promote each youth’s success in the community, not undercut it.

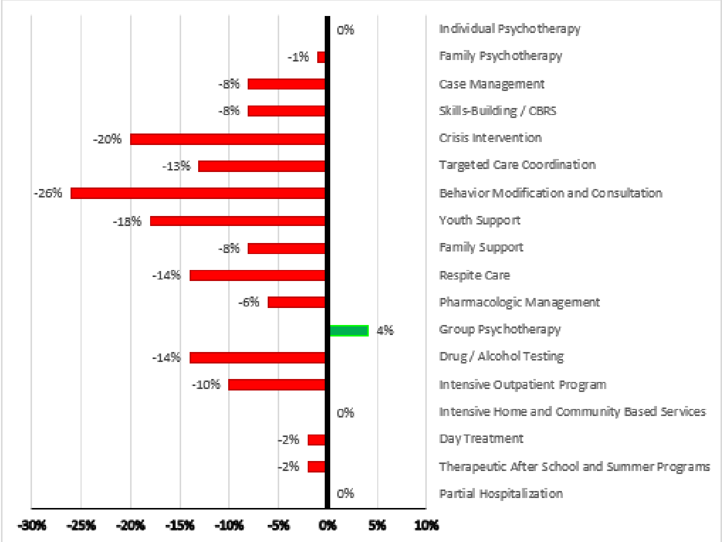
Actions to Consider.

- Create, and publish online, a CANS-based algorithm for determining the need for care coordination;
- Provide online an updateable directory of programs currently offering care coordination services, and current availability of care coordinators;
- Track the percentage of youth who have a CFT meeting led by a care coordinator within the first 30 days of care;
- Provide requirements, in contract, for the timeliness and rate at which eligible youth are provided care coordination.

Recommendation #3. Increase the number of specialized providers by making it more rewarding to serve youth with complex needs.

Evidence Summary. Youth with high intensity treatment needs often had to encounter multiple providers in order to find appropriate treatment. Caregivers of the youth in our sample described the process of finding providers with the relational and technical skills necessary to help as 'stressful,' 'frustrating' and 'overwhelming.' Parents noted that even when an appropriate provider was found, that provider might not continue with Medicaid. Similarly, the Provider survey found that only 11% of providers offer services such as Intensive Home and Community-Based Services or the Intensive Outpatient Program. Providers have difficulty identifying the benefits of working with these youth via Medicaid and the Managed Care Organization. Conversely, they are able to identify multiple administrative barriers to providing effective care.

Chart 1. Net Change in Care Types that Agencies Currently Provide (2021-2022)



Supporting these clinicians in their work is important in making it effective and attractive. A comprehensive, customer-focused review of how providers are recruited, on-boarded and flourish over time is overdue. The Idaho Department of Health and Welfare needs to identify a set of fiscal, workforce competency development, and provider-facing customer service supports and standards that it will employ to grow its network of providers.

Actions to Consider.

- Aggressively pursue system development models, such as Certified Community Behavioral Health Clinics, which simultaneously address multiple concerns including reimbursement rates, staff training, and intensity of care offered;
- Use existing CANS and diagnostic data to identify types and rates of co-occurring and treatment-resistant conditions, in order to prioritize trainings and treatments offered via the Center of Excellence;
- Address policy and administrative barriers to care, including conflicting clinical timelines, redundant assessment and care planning processes, and confusing credentialing and compliance requirements. Establish numerical customer service, provider retention, and network expansion benchmarks to guide system actions.

Appendix A:

Full Methodology

Method

Measures

File Review. This review protocol assesses the quality of the interaction between helping professionals and children, youth and families. The items in this review assess a series of decisions and processes which lead to the achievement of an individual's functional improvement, symptom reduction and strength development goals. This review is not specifically focused on a chart's technical quality for billing purposes, or its reflection of disease models of assessment and treatment.

The QR designed for the State of Idaho's YES is specifically designed to identify practices associated with high-quality, effective care coordination and behavioral health treatment. The content and sequence of the items in the QR reflects the sequence of care coordination and treatment tasks expected to occur in a typical case. This organization parallels the layout of the Practice Manual adopted by the state of Idaho for YES service recipients, which focuses on understanding performance at key, sequential decision points in care. This organization allows us to identify when certain interactions lead to negative, neutral, or positive treatment trajectories. The file review has a set of modules, each of which are described below.

Common Elements of Care. The purpose of this module is to assess how collaborative practitioners are in interacting with families and youth across key processes in care. Common elements of care include initial engagement (28-items), assessment (14 items), care planning (18 items), crisis prevention and response (23 items), reassessment (30 items), and transition planning (11 items). These processes are not always completed by one type of practitioner. Many types of practitioners may engage in one or several of these processes. This module assesses the quality of interactions between the practitioner and youth at these processes.

Treatment Characteristics. The purpose of this module is to describe the quality and content of interactions between the youth, caregiver and person(s) providing active treatments. The Treatment Characteristics module provides a session-by-session description of therapeutic interventions. The 13 items in the module focus on interactions leading to the development of new skills and behaviors, and are coded for each treatment encounter. This includes actions taken directly by the therapist, and how the therapist works to enlist other people in the youth's environment to support their changes.

Inter-rater reliability is assessed each year on a test file, created from a composite of note taking and record-keeping styles observed in the field. This year's raters initially demonstrated a reliability of 0.78 on the test vignette. With targeted feedback, their reliability increased to 0.87 on a second set of vignette materials. This exceeds any published reliability standard which we have encountered.

Family Interviews. The Family Interviews consisted of interviews of youth included in the QR, and their caregivers. The youth interviews are appropriate for youth ages 14 years and older, based on our experience regarding the developmental appropriateness of asking youth about their experiences with care, and their relationship with their therapist. The questions in the Family Interview ask about the person's experience of care across each major care process: access to care, assessment, treatment planning, crisis planning, treatment, care coordination, crisis events, and transition from care. The questions cover both the practices experienced by the individual, as well as their emotions during that process of care.

Focus Groups. Youth focus groups were conducted in this QR. Focus groups, much like the QR itself, are designed to elicit the boundaries of current practice. Participants in focus groups often hear from each other about a wide range of practice experiences. This may empower youth to talk about how their experiences have been similar to or different from these other care experiences. Such dialogue can surface a wider range of experiences than are elicited during one-on-one conversations or via file review. Facilitators are trained to prompt participants for both their experiences in care and the emotions associated with those experiences. This allows us to better understand the emotional impacts of different practices.

Youth in the focus groups were recruited from the list of eligible youth generated for the file reviews, in order to insure comparability of need and treatment context.

Clinician Interviews. We used structured interviews to learn more about how clinicians approached care. The design of the prompts was constructed to understand how treatment decisions were made, and what influenced those decisions. Throughout the protocol, interviewers asked about treatment choices made, why they were made, and what would have led to a different course of action.

The protocol consists of eleven modules, with a total of eighty-five prompts. Modules are completed in sequence, in the same order that these actions are likely to take during a course of care. The modules are: referral (4 prompts), initial assessment (10 prompts), diagnosis (7 prompts), goal setting and treatment planning (6 prompts), treatment selection (13 prompts), therapy / treatment process (9 prompts), care coordination (6 prompts), treatment review (2 prompts), crisis prevention and response (11 prompts), transition (14 prompts), and system policy and performance (3 prompts).

Interviews were scheduled for an hour; each took at least an hour to complete.

Provider Survey. A statewide survey of providers was used to gauge how well the YES system of care provides the continuum of care needed by children and youth. The use of a core set of questions across survey administrations allows us to identify how the continuum of care is developing in response to policy changes. Last year we asked about the practices currently provided by agencies and practitioners. This year we asked the same set of questions, in order to understand whether there have been any changes in the care available to YES members.

A second section of the survey focused on the drivers of care expansion (or contraction). We used the responses from open ended items in last year's Provider Survey to generate an initial list of implementation supports. Then we asked providers to rate the importance of those supports, and how well the IDHW provides those supports. This year's provider survey also asked whether the agency or practitioner had, in the past year:

- Begun offering one or more new services;
- Worked to implement a new service, but then paused or stopped implementation;
- Stopped providing one or more services.

Then we asked these respondents open-ended items about the drivers of their decisions to expand, pause expanding, or end services. Responses to these items were grouped by themes. These themes point to specific policies and procedures that affect the growth of the YES continuum of care.

Sampling

File Review

A key goal of a file review is to observe and understand the causes of variation in practices used. We initially chose six agencies whose Child and Adolescent Needs and Strengths (CANS) results maximized the opportunity to see practice differences in the behavioral health care provided to children and youth with high intensity or complex care needs (Table 1). High intensity or complex care needs are defined as being designated for Level 2 or Level 3 tier services per the individual's Initial CANS assessment. Youth in the responding agencies who met the timeframe and initial level of care criteria for participation were contacted for inclusion in the QR.

Timeframe. The timeframe requirement was the presence of an Initial CANS completed between 01/01/2021 and 01/01/2022. This timeframe does not overlap with the previous QR. The time frame keeps the sample up to date, representing recent or current access and initial treatment practices.

Level of Care. Individuals' Initial CANS must indicate a composite treatment need equal to the State's designation of Level 2 or Level 3. Finally, there must be at least one additional completed CANS (Reassessment or Discharge) within 150 days of entry to care. The number of youth, by Agency and Region, meeting these requirements is listed in the table below (Table 1).

Table 1. Top six agencies for participation

Agency	Performance	Region	Sample Size
Agency A	More Change	4	16
Agency B	More Change	4	15
Agency C	More Change	5	10
Agency D	Less Change	4	10
Agency E	Less Change	4	22
Agency F	Less Change	5	21

Sampling Goal and Methodology for the Quality Review

The goal of sampling for the QR is two-fold. First, to represent the experience and outcomes of youth served by the public behavioral health system in Idaho. Second, to maximize the chance of detecting meaningful differences in practices employed by clinicians. By 'meaningful differences,' we mean differences likely to change treatment outcomes. Sampling from Regions 4, 5 and 7 offered the benefit of some variation in population density, while representing the bulk of Idaho's youth treatment population (Table 2).

Table 2. Census and service population breakouts by Region

Region	R1	R2	R3	R4	R5	R6	R7	Total
Assessed L2/3 Youth	199	54	220	377	218	147	310	1525
Census Percent of Total Youth	12%	5%	18%	27%	12%	11%	15%	100%
Assessment Percent of Total Youth	13%	4%	14%	25%	14%	10%	20%	100%

The selected Regions also provided access to organizations serving enough youth to screen for more and less effective practice. They broadly represent the rates of service engagement experienced across the state with the exception of Region 2 (Table 3). By service engagement we mean youth who had a completed Initial CANS and then had a completed 90-day Reassessment CANS within 150 days of entry to care. Though rudimentary, this metric allows us to see which agencies appear to be engaging youth in a manner consistent with the Department's published standards of practice.

Table 3. Youth Treatment Engagement Rates

Region	R1	R2	R3	R4	R5	R6	R7	Total
Assessed L2/3 Youth	199	54	220	377	218	147	310	1525
QR Eligible L2/3 Youth	105	19	126	220	136	74	162	842
Engagement Rate	53%	35%	57%	58%	62%	50%	52%	55%

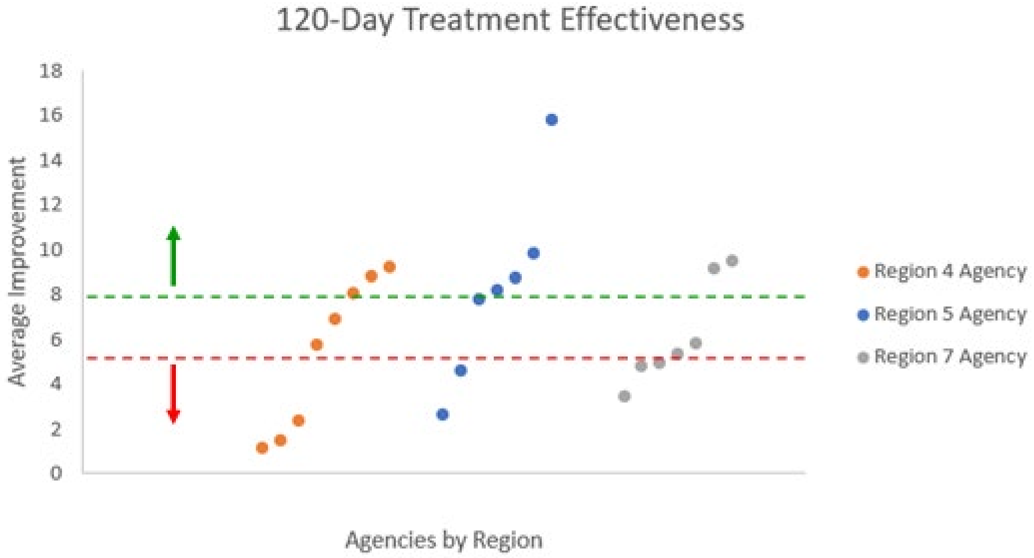
Choosing Agencies to Maximize Practice Variation

We worked to identify six organizations with potentially meaningful differences in clinical practices used with youth qualifying for intensive community care. Our assumption is that differences in clinical outcomes in these organizations stem from differences in clinical practices. To that end, we worked to identify organizations with at least a 0.5 Standard Deviation (SD) difference in initial treatment outcomes.

We did this comparing agencies' Initial and 120-Day CANS scores for these youth. Specifically, we compared scores on four domains: Strengths, Life Domain Functioning, Risk Behaviors, and Behavioral and Emotional Needs. Following the recommendation of the measure developer, we transformed the domain scores into 30-point scaled scores. We then added these scales together for a total score ranging from 0 to 120. The change in composite scores was compared across each of the four agencies.

The chart below shows that in each of the three regions, agencies are similarly distributed in terms of how well they improve outcomes at 120-days. The implication for the QR is that in each of the three regions we should be able to recruit participants from agencies above the green line (denoting relative effectiveness) and below the red line (denoting relatively less effectiveness). Of note, in all three regions, Liberty-performed assessments showed very high levels of treatment improvement. Given the relative lack of contact Liberty assessors have with families, this appears to be an anomaly worth investigating.

Chart 1. 120-Day Treatment Effectiveness by Region and Agency



Agency Selection

In looking across agencies at agency performance, we identified that Regions 4 and 5 had multiple high performing agencies; Region 7 had only one. In order to maximize our chances of being able to recruit from high-performing agencies, we made the decision to contact six agencies from Regions 4 and 5. These consisted of three high-performing agencies, and three under-performing agencies. As soon as an agency accepted the invitation to participate, we provided them with a list of eligible youth. As agencies provided contact information for those youth, we reached out to those youth and their caregivers. Ultimately, four agencies responded and were included in the QR.

Two agencies did not respond, despite multiple and varied efforts to engage them. This included six efforts to engage each of these agencies over the course of nearly two months. These were both high-performing agencies, and were both located in the same region. This resulted in a sample primarily drawn from one populous region, and primarily from agencies identified as under-performing.

In order to identify whether we would be able to identify effective practices as well as ineffective practices with this sample, we examined the outcomes of individuals ultimately included in the review. Examining the changes from the Initial CANS assessment to the Reassessment, we found that half of the sample (n=6) showed evidence of functional improvement over the course of the first 120 days of treatment. In this case we defined functional improvement as having at least a one level reduction in the CANS-derived recommended Level of Care. This gives us some confidence that we have been able to identify youth who experienced a variety of effective and ineffective treatment practices.

Response Rates by Informant

Response rates varied across informant types. We interviewed caregivers and completed file reviews for twelve youth. Six youth were age fourteen years or older at the time of the interview. All six age-eligible youth were interviewed. We were able to contact nine of their therapists, and secure interviews with six of them (effective response rate of 67%). Two youth had no therapist of record, and only received Respite services. One agency ceased providing Medicaid-funded services in between our sampling start date and the time interviews were conducted. These two agencies accounted for the bulk of the missing therapist interviews.

Provider Survey

An invitation email with a survey description and link was provided to all individual practitioners, and all agency representatives in the MCO's statewide behavioral health provider network. The provider list was obtained directly from the MCO. De-duplication was accomplished via a multi-step process. We initially removed exact duplicate email addresses. We also removed email addresses which did not have an identified Region.

We sampled all resulting individual practitioners. In order to reduce the burden on agencies, we sampled one agency representative per location address in a given region. Regions with fewer agency providers (more individual practitioners) are more likely to have a higher percentage of unduplicated contacts. We retained 550 unduplicated agency contacts or individual practitioners. Each were contacted by e-mail for participation in the survey. Three of these individuals opted out of the survey. They indicated that they did not provide behavioral health services to youth in the previous year.

Of the 547 remaining respondents, 121 did not open the survey (22%). Fifty-eight of the e-mails bounced back, indicating an invalid or inactive e-mail address (11%). The remaining 368 respondents (67%) opened the survey. One hundred and eighty of these respondents clicked through the survey. One hundred and fifty-eight respondents provided partial (55; 35%) or complete (103; 65%) responses.

Survey invitations were first sent out on June 29th, 2022. Automated reminders were sent out weekly to persons who had not opened or had not completed the survey. The survey was closed on July 22nd, 2022.

Appendix B:

Quality Review Recommendations (SFY 2021)

Recommendation #1. Work with diverse youth, advocates and service providers to create helpfulness, timeliness, dose, and duration standards for care.

Actions to Consider.

- Engage diverse stakeholders to create care standards. Only with their full participation will more inclusive, appropriate standards for performance be crafted. Work with them to identify needed supports for full participation. These may include participation options outside of traditional business hours, ready availability of interpreters, translation of workgroup documents into multiple languages. Provide all necessary supports for diverse voices' full participation.
- Check with key stakeholders between scheduled meetings, in order to insure that voices are being heard and represented. Persons who do not have a history of system-level advocacy may be unsure of how to best participate, and leery of consequences for what they may say or do.
- Elicit care standards both in terms of numerical benchmarks for care practices, and the desired experience of care.
- Consult with experts with a history of working successfully with both advocates and system employees in order to create standards that are written in clear, non-technical language and are easily assessed and tracked.

Recommendation #2. Publicly report on care helpfulness, timeliness, dose, and duration standards for existing and new care.

Actions to Consider.

Care reporting needs to:

- Be based on care standards that explicitly achieve the YES Principles of Care and Practice Model, per families, advocates and providers;
- Show people the link (using data) between care practices and youth and family experiences;
- Use data which are regularly updated so that decisions can be made based on current performance;
- Be easily accessed by the public.

Recommendation #3. Develop higher intensity, evidence-based community treatment services.

Actions to Consider.

- Identify the types of clinical and functional needs experienced by youth qualified for Level 2 and Level 3 services;
- Analyze current treatment intensity of youth by clinical subtype and quantify the types of intensive services needed to be developed;
- Work with Idaho's Medicaid and their Managed Care Organization to reduce duplication of clinical processes by different providers during the same episode of care;
- Create statewide standards for crisis prevention, detection, and care review;
- Monitor crisis care and develop incentives for effective crisis care.

Recommendation #4. Identify root causes of current, serious concerns about Wraparound care before scaling it further.

Actions to Consider.

- Identify ongoing feedback mechanisms for families and youth to describe and rate the helpfulness of care received;
- Clarify initial training and ongoing coaching requirements of Wraparound care coordinators: create position requirements and track care coordinator fufillment of these requirements;
- Clarify care coordination quality standards, in terms of treatment procured and stakeholders engaged;
- Identify system and practice interventions needed to improve cross-sector stakeholder and natural support engagement in Wraparound;
- Formalize mechanisms for cross-sector care review and joint action for youth with the most complex needs;
- Prioritize roll-out of Wraparound training and coaching at agencies with a demonstrated ability to provide intensive outpatient treatment.

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