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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

JEFF D. et. al,

Plaintiffs,

v.

BRAD LITTLE, et. al,

Defendants.

Case No. 4:80-CV-04091-BLW

NOTICE OF FILING ANNUAL REPORT

COMES NOW Counsel for Defendants BRAD LITTLE, *et. al*., Kathryn T. Garrett and Kimberli A. Stretch, Deputy Attorneys General for the State of Idaho, and hereby provide the attached Annual Court Report. The Settlement Agreement approved by this court

on June 18, 2015 (Docket 741) requires the defendants to provide an annual report to the Court and Plaintiff's counsel. Paragraph 68 of the Agreement provides:

> Defendants will provide a draft of the report to Plaintiffs' counsel at least thirty (30) days in advance of filing their annual report with the District Court. Plaintiffs' counsel will provide any feedback within fifteen (15) days of receiving the draft unless the Plaintiffs' counsel request a reasonable an extension of time of up to fifteen (15) days. If the Parties are unable to reach consensus on the final contents ofthe status report, Defendants may proceed with filing their report, and Plaintiffs' counsel will have the option to prepare a response that will be filed with the District Court and attached as an addendum to a publicly available version of the status report.

As previously stipulated and reported to the court, the parties anticipated filing a consensus report by mid-2023. Due to events beyond the Department of Health and Welfare's control, the Department has determined it needs to submit the annual court report now without further collaboration. Aside from the stipulation to continue work on the report, the parties have complied with Paragraph 68 as follows:

1. Counsel for Defendants provided Plaintiffs' counsel with a draft report on January 25, 2023;
2. On February 9, 2023, Plaintiffs' counsel sought, and Defendants' counsel approved, an extension until February 24, 2023, to review the report;
3. On February 22, Plaintiffs' counsel provided comments and feedback on the report to Defendants' counsel, along with a request that Defendants' counsel substantially re-write the report.
4. Defendants' counsel notified Plaintiffs' counsel that revisions were ongoing and would be provided to Plaintiffs' counsel by March 29, 2023.

5. On March 29, 2023, Defendants' counsel notified Plaintiffs' counsel that the report was undergoing final reviews and would be provided to Plaintiffs' counsel on April 3, 2023.
6. Defendants' counsel provided an updated and revised copy of the report to Plaintiffs' counsel on April 3, 2023, and asked Plaintiffs' counsel to confirm whether counsel anticipated filing a joint report by April 10, 2023.
7. On April 6, Plaintiffs' counsel sought, and Defendants' counsel agreed to extend the time for response until April 28, 2023.
8. On April 21, Plaintiff's counsel proposed that the parties delay filing the court report until after planned meetings could occur at which the report, in addition to other issues, could be discussed.
9. On April 25, Defendants' counsel agreed to stipulate to delay the filing of the court report. That stipulation was filed with this court on April 27, 2023.

Due to forthcoming changes in personnel providing legal counsel to the Department, the above-referenced meetings will be delayed, which necessitates the filing of the attached report. The attached report is thus, not a consensus report. Pursuant to the Settlement Agreement, Plaintiffs' counsel will have the option to prepare a response that may be filed with the District Court and attached as an addendum to a publicly available version of the status report.

Dated: April 26, 2023.

/s/
KATHRYN T. GARRETT
Deputy Attorney General,
State of Idaho

Dated: April 26, 2023.

KIMBERLI STRETCH
Deputy Attorney General,
State of Idaho

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 26th day of April 2023 I caused the following parties or counsel to be served by email, as more fully reflected below:

Howard A. Belodoff hbelodoff@hotmail.com	X Electronic Service by Email
Patrick Gardner patrick@adolescentmentalhealth.org	X Electronic Service by Email

KIMBERLI A. STRETCH
Deputy Attorney General

ATTACHMENT A

FIFTH YOUTH EMPOWERMENT SERVICES IMPLEMENTATION PROGRESS REPORT

May 26, 2023

Submitted under the
Settlement Agreement in
Jeff D. et al. vs Brad Little et. al.
U.S. District Court, Case No. 4:80-CV-04091-BLW

YOUTH EMPOWERMENT SERVICES
FIFTH IMPLEMENTATION PROGRESS REPORT

I. INTRODUCTION AND RECAP

On June 12, 2015, the State of Idaho finalized a Settlement Agreement with plaintiffs regarding the *Jeff D. et al. vs. Brad Little*, Case No. 4:80-CV-04091-BLW class action lawsuit.[1] (Docket No. 741). In the Settlement Agreement (Agreement), the State of Idaho (state) committed to developing acommunity-based mental health system of care that is sustainable, accessible, comprehensive, and coordinated for children and youth with serious emotional disturbance (SED) and functional impairment. The objective of the Agreement was to develop and successfully implement a service array that meets the needs of children, youth, and families. The state worked with youth and other stakeholders to help brand the effort and chose the name "Youth Empowerment Services" (YES) for the new system of care.

The Agreement required the defendants — the State of Idaho, including the Idaho Department of Health and Welfare (IDHW) Divisions of Behavioral Health (DBH), Medicaid, and Family and Community Services (FACS); the State Department of Education (SDE); and the Idaho Department of Juvenile Corrections (IDJC) — to develop an implementation plan and provide an annual progress report to this Court and class counsel on the progress the state has made operationalizing the implementation plan. The Defendants (YES Partners) submitted the Idaho Implementation Plan to the Court on April 29, 2016, which was subsequently approved. The Implementation Plan was organized around seven (7) objectives and the proposed strategies to accomplish the commitments of the Agreement.

The parties agreed to an Implementation Plan in 2016 that was approved by this Court. (Docket No. 754) Implementation of that plan proceeded but was incomplete at the end of 2019. At that time, the parties engaged in a collaborative process to address problems related to implementation and agreed to engage with expert consultants to develop a new Implementation Assurance Plan (IAP) to address several barriers to full implementation. After much collaboration and negotiation, the parties submitted the IAP to this Court for approval in early 2022. This Court approved the IAP in an order requiring timely compliance with the IAP on January 24, 2022. (Docket Nos. 770, 771).

[1] Brad Little became the Governor of Idaho on January 7, 2019, replacing Butch Otter as the previously named Defendant in this matter.

As with the Implementation Plan, the IAP that was approved in January 2022 follows the requirements of Paragraph 61 of the Agreement, which requires the implementation plan to:

a. Identify and sequence tasks necessary to fulfill the Commitments and achieve the Outcomes provided in this Agreement;
b. Develop and use quality assurance and improvement procedures to measure, assess, manage and report on the implementation process;
c. Set clear and accountable timelines for compliance, including interim progress until compliance is achieved;
d. Identify responsible agencies and divisions for achieving tasks identified;
e. Outline processes for the Implementation Work Group (IWG) to monitor progress, provide feedback, and resolve problems in meeting Defendants' obligations under this Agreement and carrying out the Implementation Plan;
f. Identify the staffing and financial resources necessary to fulfill the Commitments and achieve the Outcomes required by this Agreement; and
g. Describe the communication and outreach activities that Defendants will undertake in order to inform Class Members, their families, stakeholders and the community about services and procedures provided under this Agreement.

IDHW continues to undergo many changes that will ultimately advance the work toward full implementation of the YES SoC. These changes include the expansion of the Idaho Behavioral Health Plan and a transition for DBH: in its role as the state's Behavioral Health Authority, DBH is transitioning from a provider of direct voluntary services to a new model that will include a Center of Excellence.[2] The Idaho Behavioral Health Plan (IBHP) will be a single Medicaid and non-Medicaid provider network that will serve as the state's contracted delivery system for mental and behavioral health services throughout the state. In its role as the Center of Excellence (CoE), DBH will guide, train, coach, and oversee the delivery of best practices by the Idaho Behavioral Health Plan.

The State of Idaho Department of Administration, Division of Purchasing (DOP) issued an invitation to negotiate (ITN) to potential vendors for the new IBHP contract in late December 2021 and the procurement process proceeded through much of 2022. DOP issued a Notice of Intent to Award in December 2022 to one (1) vendor, which caused the other two (2) vendors who had applied to be awarded the contract to exercise their appeal rights. DOP quickly processed those appeals and issued a Notice of Award to one (1) of those two (2) vendors who appealed. This caused the other two (2) vendors to issue new appears that DOP is processing. The state is anticipating quick resolution of these latest procurement appeals with the goal of executing the

[2] DBH will continue to provide direct services to patients at state hospitals on an involuntary and voluntary basis.

IBHP contract shortly so that full implementation of the IBHP can occur by the end of 2023 to early 2024.

This report details the ways the YES partners are working together to implement YES, meet the requirements in the Agreement and the IAP, to transform mental health services for children and youth into a comprehensive integrated system of care. The report includes a summary of achievements and continuing work; addresses IAP deadlines, progress, and continuing work; includes relevant information from Quality Management Improvement and Accountability Reports, and identifies implementation challenges, achievements, and collaborative efforts.

II. ACHIEVEMENTS AND CONTINUING WORK

Idaho's YES system partners are committed to developing statewide capacity to provide services and supports that meet the needs of children, youth and families in scope, intensity, and duration. While much of the work in improving access and services falls within the requirements of the Implementation Assurance Plan that are described in more detail below, the state would like to highlight additional efforts outside of the plan that will ultimately help the state fulfill the settlement agreement commitments, outcomes, and exit criteria. Idaho has continued to make impressive advances since January of 2022. Some of these achievements are summarized below.

A. Notice of Intent to Award the New IBHP Contract

Following the state's completion of the Invitation to Negotiate (ITN) for a new Idaho Behavioral Health Plan (IBHP) contract, the state's Department of Purchasing (DOP) underwent a rigorous and lengthy contract negotiation process throughout 2022, which culminated with a Notice of Intent to offer the contract to one of the bidders. The bidders who were not awarded the contract appealed the decision and the Director of the Department of Administration has directed DOP to rescind the original letters of intent and to issue new letters of intent to award a contract. Current estimates of when the new IBHP will go live and begin to serve the youth of Idaho who have Serious Emotional Disturbance (SED) is seven (7) to nine (9) months after the contract is awarded. The new IBHP contract will be an expansion of the current IBHP. Currently the contracted IBHP network provides outpatient, Medicaid-funded services for adults and children. The new IBHP contract will include services funded by the Division of Medicaid and by the Division of Behavioral Health (which are funded through state general funds and federal block grants) and will include both inpatient and outpatient behavioral health services for children and adults. Until the expanded IBHP contract goes live, DOP will extend the contract with the current IBHP provider so as to ensure continuity of outpatient, Medicaid-funded services; inpatient and non-Medicaid behavioral health services will continue to be managed by the Divisions of Behavioral Health and Medicaid.

B. Joint Bureau: IBHP Collaborative Governance Bureau

IDHW has begun creating an IBHP Collaborative Governance Bureau that will be instrumental in the success of the new IBHP. This bureau is a cooperative unit providing governance of the IBHP. The Bureau Chief will report to both the Division of Behavioral Health Deputy Administrator and the Division of Medicaid Deputy Administrator for Benefits. The vision for this bureau is to create an environment where both divisions remain engaged and can leverage the expertise of their division's programs to best serve the citizens of Idaho through management of the IBHP and monitoring of the contract. The Bureau Chief will serve as the Single Point of Contact for all IBHP work, and will lead and participate in the DBH and Medicaid cross-divisional management team. This bureau will be fully established prior to the Service Start Date of the IBHP contract.

This Bureau will provide three (3) main functions:

1. Shared governance of the IBHP to present a unified voice of IDHW in communication with the Managed Care Organization (MCO) selected as the IBHP contractor.
2. Oversight of quality, performance, and innovation in coordination with DBH.
3. Oversight of MCO contract requirements in coordination with Medicaid.

C. Hired YES Project Manager

In April 2022, IDHW hired a YES Enterprise Project Manager to plan, implement, and manage enterprise-level system design projects necessary for the completion of the YES System of Care (SoC). She is tasked with utilizing project management principles to help YES work teams facilitate, create, and track the design and redesign of business processes; define data models; design how the different services, processes, events, and data will work together; define the technologies that will be used such as applications, components, toolsets, etc.; and define how the system will be maintained after the YES project has ended. the new Project Manager has been a tremendous boon to the Department's YES team, and is helping the DBH and Medicaid teams engage collaboratively across divisions, and stay on task as they move towards full implementation of the YES SoC.

D. New Psychiatric Residential Treatment Facilities in Idaho

Idaho currently has no Psychiatric Residential Treatment Facilities (PRTF) in the state and youth needing this level of care must be sent to PRTFs outside of the state. PRTFs are subacute, hospital-like settings typically directed by a psychiatrist, with support from licensed counselors and social workers and 24/7 supervision by nursing staff. PRTFs are appropriate for youth with severe psychiatric symptoms, who need a high level of care and supervision, but are not actively homicidal or suicidal, and therefore, do not meet criteria for acute psychiatric hospitalization. IDHW, in partnership with IDJC, has awarded three (3) Psychiatric Residential Treatment Facility (PRTF) Expansion Subgrants. These grantees will each receive a portion of

the fifteen million dollars ($15,000,000) set aside by Governor Little and the Idaho Legislature to stand-up this level of care in our state. This set aside was requested of the Governor by the Idaho Behavioral Health Council,[3] in response to the needs of minors in Idaho with SED. This new resource will allow youth to remain in Idaho nearer to their families. Negotiations with the three (3) grantees have been ongoing for the past several months and IDHW announced on March 27, 2023, that the three (3) grantees are the Idaho Youth Ranch in southwest Idaho, Northwest Children's Home in north Idaho, and Jackson House in east Idaho.[4] When operational, these facilities will provide up to eighty (80) PRTF beds in the state. The Idaho Youth Ranch intends to open its facility with sixty-four (64) beds in the summer of 2023.[5]

E. 988 Project and Mobile Crisis Response Team

The Agreement requires Defendant agencies to implement Crisis Response Services that are available 24-hours a day, seven days a week through telephonic contact with a mental health professional to determine the most appropriate response to a crisis situation. Agreement, Appendix A. In addition, the Agreement calls for implementation of Crisis Intervention Services, defined as face-to-face services to safely identify and assess immediate strengths and needs to ensure that appropriate services are provided to de-escalate a crisis and prevent future crises. *Id*.

IDHW has taken steps to expand access to crisis services with the implementation of mobile crisis teams and the national 988 Suicide & Crisis Lifeline. In addition, the Invitation to Negotiate the IBHP includes several provisions related to the IBHP's crisis response, including specific requirements for YES program members.

988 is a 24/7 behavioral health crisis line that provides crisis intervention and de-escalation to anyone who calls. In 2022, the Idaho Legislature approved IDHW's request to utilize over four million dollars ($4,400,000.00) to support preparations for the nationwide 988 rollout in July 2022. IDHW partnered with the Idaho Crisis and Suicide Hotline (ICSH) to establish and expand mobile crisis teams and access to crisis services available to Idahoans.

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[3] The Idaho Behavioral Health Council is a partnership created and endorsed by all three branches of Idaho state government in 2020. *See* Senate Resolution No. 126 (2020); Executive Order No. 2020-04-A; *In re: Idaho Behavioral Health Council* Supreme Court Order and Proclamation (2020). The Council provides a forum for collaboration between state and local governments and community members to improve Idaho's behavioral health system. It is co-chaired by the IDHW Director and the Idaho Supreme Court's Director of the Administrative Office of the Courts.

[4] https://healthandwelfare.idaho.gov/news/idaho-expands-mental-healthcare-children-and-youth-complex-needs

[5] See Russell, Betsy, *Idaho Steps Up: Youth Ranch building treatment center, after raising $27M*, Idaho Press Tribune, July 16, 2022, < https://www.idahopress.com/news/local/idaho-steps-up-youth-ranch-building-treatment-center-after-raising-27m/article_7451123f-eea7-52d4-8d0d-56c334768b11.html> (visited January 23, 2023). For more information on the Idaho Youth Ranch's Plans for its facilities in Canyon County, Idaho, see the Youth Ranch's Bring Idaho Kids Home site.

Crisis is self-identified by callers to 988 or local IDHW crisis lines, and services are provided to all ages, including children and youth. Calls are received from clients in crisis, from loved ones of clients experiencing crisis, community providers, law enforcement and other first responders, and community members. When clinically indicated, 988 will refer calls to Mobile Crisis Units for a phone or face-to-face response in the community. Response, intervention, and evaluation entails providing therapeutic phone conversations and de-escalation, clinical consultation, and face-to-face visits with clients and loved ones in the community, hospitals, incarceration settings, with law enforcement as needed for safety, and first responders or other service partners. Screening, triage, and assessment for behavioral health crisis services and service coordination, includes evaluation of presenting problems, imminent danger including risk and protective factors, family systems, mental status, diagnosis, and the formulation of a safety monitoring plan and/or treatment plans. Plans for safety and treatment include rapid and appropriate decision-making and acuity triage along with resource referrals and safe placement. IDHW currently staffs Mobile Crisis Units in all regions throughout the state by providing an in-person response during business hours, 8:00 a.m. to 5:00 p.m. Monday through Friday, and from 8:00 a.m. to 12:00 a.m. in Region 4 (Ada, Elmore, and Valley counties). Mobile response decisions are triaged according to crisis acuity and staff capacity depending on the volume of crisis calls and response requests. The Mobile Crisis Units may physically respond in the community, with and without law enforcement or may provide phone consult to law enforcement, first responders, other community partners, and family and friends of individuals in crisis. The units are available to provide support and de-escalation, safety planning, guidance around imminent danger risks, and planned/future mobile responses. The new IBHP contractor will assume the Mobile Crisis Units when the new contract is finalized.

In addition to phone and in-person crisis response, ICSH and IDHW provide service coordination, warm referral for clients to appropriate behavioral health services and follow-up as necessary. Mobile Crisis Units also provide outreach to locate and identify individuals experiencing behavioral health crisis, who without appropriate services are subject to significant risk.

Values of the Mobile Crisis Unit include a person-centered, strengths-based approach rooted in empathy, cultural responsiveness, and unconditional positive regard for clients, their loved ones, community partners, and colleagues. These same values have been stated as expectations for the new IBHP contractor's required crisis response. DBH's Center of Excellence has a team dedicated to Crisis Response that will be responsible for training crisis responders. DBH has historically partnered with law enforcement, first responders, and others through the Crisis Intervention Training Collaborative (CITC) program**.** Those efforts will continue following implementation of the new IBHP.

Resources for families related to mental health crises have been updated on the YES website.

F. Youth Behavioral Health Community Crisis Centers

Goals of the Agreement include developing a system that keeps "Class Members safe,

in their own homes, and in school; to minimize hospitalizations and out-of-home placement; to avoid delinquency and commitment to the juvenile justice system in order to receive mental health services." Agreement ¶ 15. IDHW and IDJC have engaged in a collaborative effort to develop Youth Behavioral Health Community Crisis Centers (YBHCCCs) that will assist with the realization of this goal, as well as the requirement that defendant agencies provide crisis services to Class Members. *See* Agreement ¶¶ 18, 28-30, 36, and Agreement Appendix C.

The 2022 Idaho Legislature approved a supplemental grant of $4.2 million to allow the IDJC in collaboration with IDHW to partner with law enforcement, city and county providers, nonprofit organizations, and courts through a grantor/grantee partnership to establish YBHCCCs across the state for youth safety, stabilization, and immediate case management. These youth crisis centers will provide short-term placement options for youth experiencing a behavioral health crisis that prevents them from remaining safely in their home. Youth crisis centers have been shown to reduce criminal charges, hospitalization, domestic violence, child abuse and the need for residential treatment.

YBHCCCs are a place for youth to go if they are experiencing a behavioral health crisis, (suicidal thoughts, actively self-harming, etc.), to get help. Youth can stay for up to twenty-three (23) hours and fifty-nine (59) minutes (most episodes of care are resolved in less time) and will receive a place to rest, food, and services from mental health professionals to deescalate the crisis, develop a plan of care and provide referrals to resources in the community. Each YBHCCC will provide round-the-clock operation, medical screening, rapid stabilization, assessment, crisis intervention services, and community-based referrals.

IDJC has identified four (4) awardees for these grants in areas throughout the state in Judicial Districts 3, 4, 5, and 7.[6] The grantees are readying operations and will be subject to a rigorous Readiness Review conducted by IDJC and IDHW before offering services to Idaho youth. The Readiness Reviews must be conducted no later than thirty (30) days prior to the close of the IDJC project period, which is scheduled for June 30, 2023. The Centers will be allowed to open upon successful completion of the Readiness Reviews. Once operational, IDHW will assume responsibility and oversight of the Crisis Centers, as Idaho's Behavioral Health Authority, consistent with Idaho Code title 39, chapter 91. The Children's Mental Health program within DBH's new Strategy, Innovation, and Community Development Bureau has been working closely with IDJC and the grantees.

Implementation of the YBHCCCs is a phased approach: to pass the Readiness Review each center must provide capacity for no less than four (4) and no more than six (6) youth. IDJC/IDHW Grant Application Guidance, 2022 Youth Behavioral Health

[6] For additional information about the Youth Behavioral Community Crisis Centers, visit: http://www.idjc.idaho.gov/com. *See also*, IDHW Newsroom Articles, *Four Organizations Chosen to Operate Youth Crisis Centers in Idaho*, December 20, 2022. Available at: https://healthandwelfare.idaho.gov/news/four-organizations-chosen-operate-youth-crisis-centers-idaho (visited March 27, 2023). Judicial districts are roughly the equivalent of IDHW's geographical regions.

Community Crisis Center Grants, p. 10 (hereinafter YBHCCC Grant Guidance). The centers will be authorized to increase capacity as IDHW determines the centers have adequate staff and safety measures in place.

The function of the centers is consistent with the goals, commitments, and outcomes of the Agreement:

> Youth crisis centers have four (4) primary functions: [1] divert youth experiencing crisis away from unnecessary emergency department visits, hospitalizations, [2] reduce the need for incarceration of youth because of behavioral health crisis, [3] prevent escalation of family conflict and violence in their home, and [4] to provide access to professionals to de-escalate youth in crisis while setting up community-based treatment and support options for youth and family.

YBHCC Grant Guidance at p. 4; *see also* IDJC Grant Manual, Youth Behavioral Health Community Crisis Centers, 2022 – 2023, p. 2.

G. Youth Assessment Centers

In spring 2022, the Idaho Legislature appropriated $6.5 million to IDJC to establish Safe Teen Assessment Centers in Idaho. This effort is another project recommended by the Idaho Behavioral Health Council based on the Council's Strategic Plan. IDJC partnered with the National Assessment Center (NAC) Association to undertake training Idaho to the best-practices framework and assisting with the development of a competitive grant application for these funds. The NAC is a national organization that "guides a partnership of assessment centers that advance best-practice through advocacy, education, technical assistance and community engagement."[7] In June 2022, IDJC made eight (8) individual Safe Teen Assessment Center awards to grantees in each judicial district across Idaho, with two (2) in District Five (5) with projects initiating on July 1, 2022 and an expectation that all eight (8) centers will be operational by June 30, 2023.IDJC, Youth Assessment Centers In Idaho Report at p.2.[8]

Assessment Centers provide screening, assessment, and connections to community-based resources for youth in their community. Youth presenting to Assessment Centers may be dealing with family conflict, insufficient housing or food insecurity, behavioral health issues, and more. Assessment Centers utilize validated screening to determine immediate need and identify need for further assessment. Once the assessment is complete, centers partner with youth and family to refer youth to

[7] https://www.nacassociation.org/

[8] This report is available at: http://www.idjc.idaho.gov/wp-content/uploads/2023/03/Youth-Assessment-Centers.REPORT.NARRATIVE.pdf (visited March 27, 2023). Note that IDJC organizes the state by judicial districts, whereas IDHW organizes the state by regions. The geographical distinctions are generally equivalent. For additional information and updates about the Youth Assessment Center grants, visit: http://www.idjc.idaho.gov/community-operations/cops-project-manager/youth-assessment-centers/.

community-based resources to address the needs identified.

While Youth Assessment Centers and Youth Crisis Centers share similarities, they serve different functions in their communities: Assessment Centers serve as a prevention resource to address youth needs earlier on while Crisis Centers help to stabilize youth in the midst of a behavioral health crisis. Both Assessment Centers and Crisis Centers will add to the array of services available to youth and their families in Idaho.

The implementation of the Assessment Centers is ongoing. As of December 31, 2022, IDJC reports that seventy-nine (79) youth had been served by the three centers that were operational at that time. All eight centers are expected to be operational in summer 2023.

Assessment Centers are intended to be available to all youth who need them; not just those who are *Jeff D.* Class Members. Defendants anticipate the Assessment Centers will lead to greater identification of youth with unmet mental health needs and, accordingly, access to YES services for youth who need them. The Assessment Centers will be identified in the Access Pathways Map as a resource to enable identification, screening, assessment, and referrals of Class Members. *See* Agreement ¶¶ 29 - 34; 42; Agreement Appendix A; IAP Objective C.

H. Quick Reaction Team Established

IDHW, class counsel, and parents collaborated on the issue of how IDHW should respond to a parent's request for out-of-home care for a child with mental health concerns for several years, without reaching agreement. Parents and counsel have argued that children should not come into the care and custody of IDHW under the Child Protective Act when parents request out of home care for their children with SED. In 2021, parents and *Jeff D.* Class Counsel lobbied for legislation to address this situation without consulting IDHW. The Legislature passed "HB 233" (as it is still commonly referred) which created a new provision of the Children's Mental Health Services Act, Idaho Code section 16-2426A. The statute prevents parents from being substantiated for abuse, neglect, or abandonment under IDHW's administrative rules when a parent or guardian requests "inpatient hospital treatment or an out-of-home placement for the child, if the child's recent mental health condition demonstrates that the child is likely to cause harm to himself or to suffer substantial mental or physical deterioration, and/or is likely to cause harm to others, and if the risk cannot be eliminated before returning the child to the child's family." Idaho Code § 16-2426A(1).

In addition, the statute requires the development of an interagency clinical team to review cases of children who are at the hospital or another similar treatment facility; to connect the child and family to appropriate services, treatment, and support; and to stabilize the child's SED to prevent removal by IDHW under the Child Protective Act. Idaho Code § 16-2426(2). The IDHW Divisions of Medicaid, Behavioral Health, and Family and Community Services (FACS) entered into an Intra-Agency Agreement establishing a Quick Reaction Team (QRT) to comply with that provision. The goal of

the QRT is to provide effective solutions for appropriate level of care placement. The team provides planning, resources, and solutions for families of child clients whose mental health needs compromise the safety of the family. The team is authorized to utilize IDHW resources in an expedited manner to create treatment options for the client, family, and treatment facility. The QRT meets weekly and additionally as needed to process emergency and non-emergency referrals.

IDHW held focus groups with families and hospitals and solicited information from local law enforcement agencies; information learned from these groups was utilized to develop the QRT model. IDHW and IDJC are currently developing an inter-agency agreement that will allow IDJC to initiate and/or participate in QRT meetings for children in IDJC custody.

IDHW leadership including the Deputy Director, and Deputy Administrators from the Divisions of Medicaid, FACS, and DBH have continued to conduct outreach with local hospitals to address challenges related to discharge and supportive community services. On November 17, 2022, leadership met with Intermountain Hospital leadership and clinical staff. Bi-monthly meetings now occur with St. Luke's Regional Medical Center leadership and clinical staff. Those meetings began on December 19, 2022, and are continuing every other month. On February 8, 2023, IDHW leadership met with leadership and clinical staff at Kootenai Medical Center and committed to quarterly meetings. During each of these meetings, there has been discussion of appropriate communication pathways, including when to escalate an issue, and appropriate referral processes. In addition, IDHW leadership has provided direct contact information for the Medicaid EPSDT team. The QRT purpose and process was discussed, as was the child welfare referral process. IDHW staff have also shared information with hospitals related to the IBHP, PRTFs, CCBHCs and youth crisis centers. Anecdotally, the regular meetings with hospital administrators and staff have led to greater collaboration on individual cases.

The YES Communications Workgroup, which includes parent stakeholders, is developing materials that will be made available in hospital emergency rooms to educate families about the QRT.

The development of the QRT has greatly improved cross-divisional collaboration within IDHW. As of April 3, 2023, the QRT had staffed thirty (30) cases, and referred another seven (7) cases back to the region for a CMH case to be opened. There is not currently a system in place to evaluate or measure effectiveness of the QRT. Counsel for the plaintiff class have reported that implementation of the QRT has been slow but is improving. Although the QRT and IDHW's work with hospitals has improved collaboration, access to services for children with intense needs continues to be a challenge. HB 233 identified a problem, provided only a partial solution, and included no request for additional funds to aid in identifying or providing services for the children it is aimed at serving. Additional information and data about access to services and defendants' efforts to improve access are included in later sections of this report.

I. Training and Administrative Directive for Child Welfare Workers

In addition to the development of the QRT, IDHW's Child Welfare Program within FACS adopted and refined an Administrative Directive providing guidance to Child Welfare workers about changes to Idaho Code Section 16-2426A. The Division Administrator of FACS attended several Interagency Governance Team (IGT) meetings and engaged with class counsel and families to address the language of the administrative directive. In addition to the discussions within IGT meetings, the Child Welfare program has engaged with class counsel, family advocacy organizations, and families on issues related to children coming into IDHW Child Welfare care and custody under the Child Protective Act when there are concerns of SED.

As noted above, HB 233 identified a problem, provided only a partial solution, and included no request for additional funds to aid in identifying or providing services for the children it is aimed at serving. When children cannot safely be cared for at home, they may come into care and custody of IDHW under the Child Protective Act even though parents are not substantiated for abuse, neglect, or abandonment under IDHW's administrative rules. IDHW is working with parent advocacy groups to improve parents' understanding of this process and cross-divisional collaboration has improved within IDHW. However, without more accessible services, including residential services, placement of children in IDHW custody for the safety of the child and the child's family may continue to be necessary in some instances.

As noted above, PRTF resources are expanding in Idaho and will be available as soon as this summer. Efforts to expand home and community-based services and residential services for children was a focus of the Agile Sprints addressed later in this report. Collaboration among the Divisions of Medicaid, FACS, and DBH has been focused on providing more accessible services for children and families who fall within Idaho Code section 16-2426A.

J. Development of Singular Vision and Sprints

In late 2022, IDHW approached class counsel, the IGT, and the IWG with a proposal to take a break in regularly scheduled monthly meetings so that IDHW's Divisions of Behavioral Health, Medicaid, and Family and Community Services could focus on developing a shared vision and action plans for continuing development of YES. The IGT and IWG stakeholders agreed it would be useful for IDHW to focus on and develop greater cross-divisional collaboration. As further described below, IDHW used this time productively and looks forward to sharing action plans with the IGT and IWG stakeholders. IDHW intends to seek guidance from the IGT to prioritize the recommendations that the IDHW teams developed.

When IDHW began to work on YES compliance measures per IAP Objective G, it became apparent that DBH and Medicaid were not looking at the implementation process in the same way. Historically, the programs have operated through different processes, perspectives, and goals. It also became apparent that the FACS Child Welfare and Developmental Disability programs needed to be included in developing

a shared vision. The pause from preparing for, attending, and doing follow-up work on the IGT, IWG, Due Process Workgroup, and other meetings established by the Agreement, has allowed the divisions and programs to learn how to work together. The decision was made to utilize the Agile style of project management to effectuate that goal.

IDHW chose to implement the Agile process[9] with four (4) cross-divisional teams of subject matter experts. The teams have been directed to focus on YES class members with the highest level of needs to fulfill the ultimate vision that minors with SED receive the behavioral health services they need when they need them. Each team addressed a critical issue and focused on provider capacity and service availability within the issue area. The prioritized issues include: (1) out of home care – residential services; (2) crisis services; (3) intensive home and community-based services, and (4) intensive care coordination. Each team focused exclusively on its assigned topic for a two-week "sprint," and presented priorities and proposed plans of action for addressing provider capacity and service availability in each topic area to the IDHW sponsors. The staff leading the sprints are currently further reviewing and refining the priorities recommended by the Sprint teams so that the IGT can assist with prioritizing the action items and next steps.

The decision to focus on class members with the highest level of needs and the four intensive service categories is supported by data collected by the QMIA System that shows children with the highest level of need are receiving proportionally less care than children with lower level of care needs and by recommendations in the Quality

[9] Agile is a mindset, a way of thinking. There are hundreds of Agile methodologies. Agile focuses on the people doing the work and how they work together. Solutions evolve through collaboration between self-organizing cross-functional teams utilizing the appropriate practices for their context. Some key things to know about the Agile process:

1. Agile is feature driven and focuses on deliverables and a working product as soon as possible. It is iterative in nature and the team keeps working on it until they get it, within a time box/frame.
2. Agile project managers answer the same five questions:
    i. When will the project be done?
    ii. How much will it cost?
    iii. Does the organization agree what "done" looks like?
    iv. What are the risks to delivering on time and on budget?
    v. How will we mitigate those risks?
3. Agile project managers are considered successful when they have worked with the performing organization to deliver the most scope possible, to the satisfaction of the project sponsors, within the time and cost constraints established by the business.
4. As you might imagine, this approach requires a great deal of trust between the project stakeholder and the performing organization and a much greater degree of ongoing collaboration. Agile project managers focus less on up-front project planning and more on managing the processes through which value is delivered to the organization. Agile project managers focus more on collaboration with the business and servant leadership to the team.

While the above description does not describe exactly the work needed for the implementation of the YES program, what happens in the Agile Sprint process is indeed what Medicaid, DBH, and FACS are undertaking.

Review Report. *See* Youth Empowerment Services, *QMIA Quarterly Report, Q1, SFY 2023* (January 13, 2023) (hereinafter *YES QMIA-Q1 2023 Report*);[10] Union Point Group, *Final Report of the YES Quality Review* (SFY 2022) (hereinafter referred to as "*2022 QR Report*").[11] The QR Report found that the network of behavioral health providers appears to be pulling back from Medicaid and that the care network is not routinely providing timely, appropriate, effective care for youth with complex behavioral health needs. *2022 QR Report* at 42. One of the key recommendations in the QR Report is to systemize access to care coordination for youth with highly complex needs. *Id.* at 45. As noted in the QR report, which relies upon a YES QMIA Quarterly Report for SFY 2022, quarter 3, less providers offered Targeted Care Coordination (an ICC service) in 2022 than in 2021. *Id.* at 45. The QR Report found that services offered are disproportionally focused on services, like psychotherapy, which are appropriate for youth with mild to moderate behavioral health concerns, even though 2021 sampling data indicated that 40% of youth completing an initial CANS may have intensive treatment needs. *Id.* at 29.

In the first quarter of SFY 2023, 449 youth had a CANS rating of "3" – indicating the highest level of care need. *Id.* at 8. Yet the number of youth accessing intensive services was much lower. See *Id.* at 15 (Table 5c1: outpatient services, including intensive outpatient services, provided to Medicaid youth); 39 (data for DBH Wraparound Intensive Services); forty-six (46) (data related to PRTF placement requests); and forty-eight (48) (data about DBH residential placements). Furthermore, the YES Provider Survey indicated that very few provider agencies (5-10%) currently offer intensive, community-based services. *Id.* at 62.

As noted above, IDHW intends to bring several recommendations from the Agile Sprints to the IGT so that the stakeholders can provide guidance about which efforts should be prioritized. Once prioritized, detailed work plans will be developed to ensure timely implementation. As noted, this is a time of great transition for IDHW, with the redesign of DBH, the creation of a new IBHP Joint Bureau and the procurement of a new, much more expansive, IBHP Contract. Timelines for implementation will account for those transitions, while prioritizing increased access to services. Some examples of recommendations coming out of the Sprints that relate to recommendations and findings from the QR Report and the QMIA Quarterly reports appear in Section V of this report addressing Challenges. Notably each Sprint Team stressed greater collaboration across IDHW divisions and identified current initiatives that may have been previously unknown to each division.

III. PROGRESS AND CONTINUING WORK ON IMPLEMENTATION

[10] The YES QMIA-Q1 2023 Report is attached hereto as Appendix A and is available on the YES website at: https://yes.idaho.gov/wp-content/uploads/2023/01/QMIA-Quarterly-YES-Report-Q1-2023.pdf

[11] The 2022 QR Report is attached hereto as Appendix B and is available at on the YES website at: https://yes.idaho.gov/wp-content/uploads/2023/01/QR-Report_Final-Report_2022v2.pdf.

ASSURANCE PLAN (IAP)

The 2022 Implementation Assurance Plan (IAP) is the roadmap for completing implementation of the Settlement Agreement, and thus is interpreted in accordance with the commitments, outcomes and exit criteria listed in the Agreement. The goal remains to comply with the Agreement and to satisfy the intent of the former Consent Decrees by developing and fully implementing a sustainable, accessible, comprehensive, and coordinated service delivery of publicly funded community based mental health services to children and youth with serious emotional disturbances in Idaho. This portion of the report specifically addresses defendants' progress and continuing work on the IAP.

The IAP Objectives include:

- OBJECTIVE A: Services and Supports
- OBJECTIVE B: Practice Model and Services Roll-out
- OBJECTIVE C: Access Model
- OBJECTIVE D: Sustainable Workforce and Community Stakeholder Development
- OBJECTIVE E: Due Process
- OBJECTIVE F: Governance and Problem-Solving
- OBJECTIVE G: Quality Management, Improvement, and Accountability
- OBJECTIVE H: Idaho Behavioral Health Plan

A. Compliance with IAP Timelines

The IAP established a number of deadlines that IDHW, the IWG, and the Parties must meet. IDHW can report that it has substantially met all of the IAP deadlines or has obtained agreement with class counsel and the IWG to extend the IAP deadlines. The chart below identifies and describes the deliverables and their timelines in chronological order. Further explanation of the state's efforts to meet the deliverables and timelines appears below within the description of each objective of the IAP. When developing the IAP, the parties agreed that many of the due dates for deliverables within the IAP are contingent upon the execution date of the new IBHP contract (defined as the date the new contract is signed) and the service start date of that contract (defined as the date the state and the contractor mutually agree that the contractor will assume daily operations for the IBHP). The chart below includes descriptions relative to the IBHP execution and service start dates. Because there is not yet an established execution date or service start date for the IBHP, specific dates have not yet been determined for the deliverables noted on the bottom half of the chart below.

IAP Deliverables	Due Date	Objective	Progress
Residential Index Listing	02/28/2022, Monitored and updated regularly	B	Original list completed and posted 03/01/22. IDHW is updating the list regularly, with the last update being December 2, 2022
Real Time Defined	03/31/2022	G	Completed by March 31, 2022.
Due Process Protocol	03/31/2022, Annually updated	E	Completed by March 31, 2022, and on track to review and revise annually, as required by the IAP, by March 31, 2023.
QR Process	06/30/2022	G	Completed by June 30, 2022.
IGT Securing staffing and funding	07/01/2022	F	Funding was approved by July 1, 2022; job was posted; position filled August 22, 2022.
Access Pathways Map – Final Draft to IWG	02/28/2023[12]	C	Maps were provided to the IWG on December 30, 2022 and on February 23, 2023. IWG is consulting with Department on drafts.
Services and Supports Crosswalk – Final Draft	03/31/2023[13]	A	IDHW provided update and sought feedback on format from IWG December 2022; provided draft for IWG review in February 2023.
QMIA Plan (Updated)	06/30/2023[14]	G	Drafts provided to IWG in June and July 2022; consultation on drafts July

[12] The IWG determined by vote on December 19, 2022, that IDHW was not substantially out of compliance with the deadline in the IAP of December 31, 2022 and agreed to extend the deadline for a final draft to February 2023 to allow time for IWG consultation. This deadline was met.

[13] Final draft is to be completed by the execution of the new IBHP, which has not occurred yet. The IWG determined by vote on December 19, 2022, that IDHW was not substantially out of compliance with this deadline and IDHW represented that a draft will be available for review by the IWG in February 2023 with delivery of a final revised draft by March 31, 2023.

[14] Originally due on August 31, 2022, but the parties entered into a signed agreement to push that deadline to June 30, 2023, or three (3) months after there is agreement on program compliance measures.

			2022. Ongoing revisions occurring.
Jeff D Implementation Compliance Task Force	08/31/2023	G	The IWG has determined the membership of the ICTF and is currently working on this Objective with Class Counsel.[15] This task force will operationalize implementation compliance measures that the parties agree upon
Other deliverables without specified dates			
Service and Supports Crosswalk-Authoritative Doc	Service Start Date of new IBHP Contract, reviewed and updated periodically	A	IDHW provided update and sought feedback on format from IWG December 2022; anticipates providing draft for IWG review in February 2023. Final negotiations will occur with new IBHP.
Practice Manual (Updated) – Final Draft	90 days following the completion Access Pathways Map	B	IDHW has begun work on appeals section. Ongoing updates will occur as other authoritative documents are completed.
Practice Manual (Updated) – Authoritative Document	Negotiated with IBHP Contractor, no later than 180 days following the Service Start Date of new IBHP Contract	B	Final negotiations will occur with new IBHP during implementation and beyond service start date.
Begin Implementation of CoE (Center of Excellence)	Execution date of the new IBHP Contract	B	The CoE provided a presentation to IWG members on February 28, 2023. CoE has begun implementation, hiring and onboarding of staff.
CoE Completed Implementation	Complete by the end of the Jeff D Implementation period	B	On track.
Service Roll-out	Service Start Date of the new IBHP Contract	B	Ongoing work to be completed during implementation of IBHP Contract
Process and procedures communicating about availability and expectations for Treatment Foster Care	Service Start Date of the new IBHP Contract	B	TFC contracts secured; contractors are having considerable difficulty recruiting families. Ongoing work to be completed during

[15] The IWG and Class Counsel agreed to develop the structure of the Implementation Task Force while IDHW worked on their Sprint process. To date, they have not completed this work.

			implementation of IBHP Contract
IWG- Identify and report on eligible youth populations that systematically do not engage in YES Programs	No later than twelve (12) months post Service Start Date of new IBHP Contract	B	Future work needed
Communication Plan (Updated)	Ongoing obligation to update and revise as needed	B	YES Communications Workgroup Charter Amended May 2022; ongoing work to identify subject matter experts.
Access Pathways Map- Authoritative Document	Service Start Date of new IBHP Contract	C	In progress. See details and footnotes above.
Workforce Development Plan	IDHW will consult with the IWG, subject to procurement restrictions, as IDHW develops the Workforce Development Plan and, with the IWG, will incorporate timelines interim deadlines for action items	D	IWG needs to define timelines. IDHW is exploring several initiatives that will be reported to the IWG for collaborative problem-solving.
Centralized Complaint System	Six (6) months following the Service Start Date of the new IBHP Contract	E	IDHW has made progress in coordinating complaints process among IDHW Divisions. Work needed to coordinate all defendant agencies.
Report on results of YES Performance Improvement Projects	Official Date not specified to be provided bi-annually	G	Updated QMIA Plan will address specific timelines
IBHP Contract Award	Final Contract Execution TBD	H	Notice of Intent to Award issued December 7, 2022. Appeal(s) pending.

B. Objective A: Services and Supports

Objective A relates to the commitments within the Agreement to provide all services set forth in the Services and Supports document, defined in Appendix C to the Agreement, that are necessary to meet class members' individualized mental health strengths and needs as medically necessary. Agreement ¶ 18. The Agreement clarifies that some class members shall receive more intensive services and defines those services based upon needed care that is measured by the class members' score on the Child Adolescent Needs and Strengths (CANS) assessment tool score. Agreement ¶ 19, 20, 21. The Defendants were required to develop an initial expected range of Class Members that will utilize the Services and Supports required under the Agreement and to update that utilization range annually. Agreement ¶ 24. Defendants committed to providing timely Services and Supports to class members within the annual established service utilization range. *Id.*

The IAP requires IDHW to complete an authoritative Services and Supports Crosswalk that provides authoritative guidance on Appendix C to all YES Providers and stakeholders.

Expected Results of Accomplishing Objective A*: The service array as described in the Agreement, has been operationally defined in a Services and Supports Crosswalk to provide cross-system, consistent, authoritative, comprehensive, publicly available guidance for all behavioral health services and supports required to be made available to YES Class Members.*

1. Progress on IAP Objective A

The final draft of the Services and Supports Crosswalk is to be completed by the execution of the new IBHP, which has not yet occurred. The IWG determined by vote on December 19, 2022, that IDHW was not substantially out of compliance with this first deadline related to the Crosswalk.

IDHW attempted to recruit consultants for this work, beginning in early March 2022 and had difficulty identifying qualified contractors with the availability and ability to perform the scope of work requested. Several candidates were vetted as possible options; however, none were able commit to completion of the identified tasks. On July 29, 2022, the Department finalized a contract with Zlatevski Consulting, LLC (Dr. Danijela Zlatevski). IDHW's contract monitors allowed Dr. Zlatevski an opportunity to familiarize herself with the provided materials and the assigned tasks, and then began holding regular meetings. Meetings are held with the consultant weekly and feedback is provided to ensure clear understanding of IAP requirements, the Settlement Agreement, governing law and regulations, defendant agencies' policies and procedures, and the YES system of care. This product is extremely detailed, and much time has been needed to ensure the quality product IDHW is expecting.

IDHW provided an update and sought feedback on the format of the crosswalk from the IWG on December 19, 2022. Feedback from class counsel was received on January 9, 2023 and was discussed in an attorney meet and confer meeting on January 11, 2023. IDHW provided a complete draft of the crosswalk on February 28, 2023 and received feedback from class counsel and other IWG stakeholders in mid-March 2023. Work on the crosswalk is ongoing.

2. Continuing Work on IAP Objective A

The Crosswalk will serve as an Authoritative Document that reflects IDHW's descriptions of the Services and Supports included in Appendix C, as those descriptions are supported by various sources including federal law and regulations, state statutes and rules, and IDHW policies and procedures. The format of the crosswalk complies with each of the requirements of the IAP and follows Appendix C of the Settlement Agreement. IDHW has worked extensively to put the crosswalk into a form that fulfills the Department's understanding of its purpose – to serve as a guide

for the Department to complete development of the YES SoC and to provide services set forth in Appendix C to the Settlement Agreement that are medically necessary to meet class members' individualized mental health strengths and needs. The crosswalk has been created in a way that will aid the Department and the IBHP in utilizing it as an authoritative source document but intends to simplify the document for ease of future use. As required by the IAP, the crosswalk will be used to update the other authoritative documents, including the Practice Manual. Additionally, as anticipated and required by the IAP, the crosswalk will be updated during implementation of the new IBHP contract. And it will be used to create and inform the new IBHP Provider Manual.

The IAP provides that the Final authoritative document will be negotiated with the IBHP Contractor and will be completed by the Service Start Date of the IBHP Contract. (IAP A.1.b.) Furthermore, the IAP allows that IDHW and the IBHP Contractor will prioritize completion of the Crosswalk if the development of services or supports parameters are not yet fully determined or defined in IDHW's final draft of the Crosswalk. (IAP A.3.) Any discrepancies between defendant agencies must be resolved within six (6) months following the service start date of the new IBHP contract. (IAP A.7.) The Crosswalk will be reviewed and updated periodically. (IAP A.8.) IDHW will incorporate the substance of the designated Services and Supports Crosswalk into all YES service delivery agreements and contracts, including the new IBHP Contract. *Id.*

C. Objective B: Practice Model and Services Roll-Out

The Agreement specifies that defendants shall adopt and implement a Practice Model for delivering publicly funded mental health services and supports to Class Members. The Practice Model provides a description of the framework for providing services and supports to Class Members under the Agreement and describes the expected client experience of care within Idaho's children's mental health system over the course of intake, assessment, treatment and transition. Agreement ¶25. The Principles of Care and Practice Model are described in Appendix B to the Agreement.

The IAP requires IDHW to review and update the existing Practice Manual consistent with the Principles of Care, Practice Model, and Appendix B, and to include relevant operational details and directions that are not already spelled out in the other authoritative documents. Additionally, Objective B of the IAP requires IDHW to describe and implement its plan for the Center of Excellence, lays out tasks for the IWG at its quarterly meetings, and requires the IBHP to provide medically necessary access to the full array of intensive community based and psychiatric residential services to eligible YES Class Members. Rolling out services includes plans to successfully communicate and inform class members of available resources.

***Expected Results of Accomplishing Objective B**: Defendant Agencies and YES Providers in the SoC serving Class Members deliver services and supports consistent with the Principles of Care and the Practice Model. The Operational guidelines are readily accessible and available on-line; accurate and up-to-date; and written in plain English so as to be easily understood by Providers, Class members and their families,*

and stakeholders.

1. Progress on IAP Objective B

Practice Manual, IAP Objective B.2: Although the final draft of the updated Practice Manual is not required to be delivered to the IWG until ninety (90) days following the completion of the Access Pathways Map (described in Objective C), which is no later than the service date of the new IBHP, IDHW has begun updating the Practice Manual consistent with the completed Authoritative Due Process Protocol.

Center of Excellence (CoE), IAP Objective B.1: The CoE provided a presentation to IWG members on February 28, 2023, during which it described its role in relation to the new IBHP MCO. The CoE will support and expand best practices throughout Idaho's Behavioral Healthcare System, through training, coaching, mentoring and fidelity monitoring of the provider network. With regard to YES, the CoE will specifically focus on the following four programs: CANS, Crisis Services, Wraparound, and Parenting with Love and Limits. The CoE has begun implementation, hiring and onboarding of staff. The IAP implies that implementation of the CoE must begin by the execution date of the new IBHP, and will be complete by the end of the *Jeff D.* Implementation period. IDHW is on track to meet these timelines.

Services Roll Out, IAP Objective B.3: Ultimately, the IAP requires IDHW, who will provide services through the use of a new IBHP Contractor, to provide class members with medically necessary access to the full array of services. As noted above, IDHW intends to fulfill this requirement with the execution and implementation of the IBHP Contract and the Joint IBHP Bureau within IDHW. IDHW and DOP, along with IDJC, spent several years developing a scope of work that includes, among other things, the services and supports that must be made available to YES Class Members. Throughout 2022, DOP and IDHW entertained and evaluated bids for potential IBHP contractors.

In addition, the work that IDHW is doing in the Agile Sprints process (described above) is intended to identify plans for developing provider capacity and service availability in four main service areas for youth with the highest level of need: (1) out-of-home or residential treatment; (2) intensive home and community-based services, (3) crisis services, and (4) intensive care coordination.

Out of Home Care options and Index of Residential Facilities. The IAP required IDHW to complete an index listing all residential facilities identified or authorized to serve YES class members by February 28, 2022. (IAP B.3.c.) The initial list was completed on March 1, 2022 and IDHW continues to update the list regularly, with the last update being December 2, 2022.[16] The IAP also requires IDHW to commence a preliminary provider network agreement process. The Agile Sprint team addressing out-of-home placements generated several actionable items related to out-of-home placements that will be described to the IGT with an opportunity for the IGT to establish priorities. The addition of PRTF facilities in Idaho (referenced above) will

[16] The listing is available on the YES website: https://yes.idaho.gov/wp-content/uploads/2022/08/Residential-Index-12.2.2022.pdf

help provide PRTF facilities closer to home for Idaho youth. In addition, Medicaid has enrolled two (2) specialty inpatient hospitals, Foundations Behavioral Health in Doylestown, PA, and Cumberland Hospital in New Kent, Virginia, that can serve the dual diagnosis population. Neither of these are PRTFs, but Foundations is currently in the process of enrolling their PRTF as a Medicaid provider. Additionally, Medicaid has established weekly meetings with its finance team to discuss current and upcoming single-case agreement requests with a focus on streamlining the process.

Additionally, the IAP requires the development and implementation of processes and procedures to communicate the availability of out-of-home care, including treatment foster care (TFC) to youth, families, providers and other relevant stakeholders. (IAP B.3.a, b.) IDHW has entered into contracts with two TFC providers who are required to recruit and train foster parents for TFC placements. Unfortunately, the contractors are experiencing significant difficulty recruiting families. At least one family has agreed to become a certified TFC provider. IDHW is working with the contractors and family advocacy agencies to further expand public awareness and to encourage additional families to sign up to provide this important service.

In Home and Community Based Services: DBH contracted with Seneca Family of Agencies to provide training for a new service for Idaho families: Therapeutic Behavioral Services (TBS). Fifty-nine (59) providers attended the TBS Trainings and are qualified to provide this service; twenty (20) of those providers attended a Training for Trainers and are qualified to train others to provide the services. DBH provided a financial stipend to providers, who attended the TBS trainings, to offset the time away from their practice. TBS is an intensive behavioral service for youth who are experiencing behavioral challenges that place them at risk of requiring out-of-home care or placement disruption. The service, which lasts an average of six (6) months, focuses on involving caregivers so that they can learn TBS skills to support the youth they care for. TBS can be used in conjunction with Wraparound. Five agencies (located within regions 2, 3, 4, 6, and 7) have completed the required audit required by the current IBHP contractor and are providing TBS services. One more agency is pending approval of its audit. Several other agencies completed TBS training but do not currently have sufficient staffing to offer the service.

The IHCBS Sprint Team identified several different IHCBS modalities to address specific populations of youth with intensive needs. Some of the Sprint Team's recommendations stemmed from research and collaboration with other states that have large rural areas. One modality explored was Multisystemic Therapy (MST). IDHW and IDJC are currently utilizing American Rescue Plan (ARP) funds and the federal Mental Health Block Grant to support up to three MST teams throughout the state. The Sprint Team explored alternative reimbursement models and examined actions to incentivize providers with higher reimbursement rates for youth accessing IHCBS.

Communication Plan, IAP B.4: DBH is undergoing an internal transition, which began in 2022. As part of the transition, the Division looked at the YES Communication Plan to determine how it is constructed, and how it may need to be reevaluated and updated. Different bureaus within DBH are being tasked with assigning subject matter experts (SMEs) to the plan, and they will work with parents,

families, youth, and stakeholders to update the plan. To that end, in May 2022, the YES Communications Workgroup amended its charter. Originally established in January 2017, it was a workgroup that consisted of multiple team members from each of the *Jeff D.* Settlement Agreement partners, as well as family and community stakeholders. The workgroup has evolved and is now tasked with identifying system-wide communication needs and working with the IGT. Discussion has been had in the YES Due Process Workgroup about whether it should engage with the Communications Workgroup to assist with the revision of the plan. This plan is changing and moving in the right direction. Defendant agencies have an ongoing obligation to update communication materials. Additional communication efforts are described below in relation to the YES website.

Maintain the YES Website, IAP B.4.h.: On a monthly basis in 2022, the YES website was updated with meeting agendas and minutes, newly created and updated workgroup strategic plans and bylaws, as well as authoritative documents and deliverables as they were completed. Additionally, since January 2022, several new communication documents have been published – the majority of which are targeted to families – including a Child and Family Teams/Coordinated Care Planning trifold; a dual sided one-pager on Participating in a Child and Family Team; a rebranded document on YES Program Access; and updates to documents titled Maintaining Eligibility for Medicaid's YES Program and Next Steps After Independent Assessment. Quarterly YES Newsletters were added, which are also distributed to a subscriber list of about 1,500 people, in January, April, July, and October of 2022, and again in January 2023. The Fourth Youth Empowerment Services Implementation Progress Report was published in January 2022. An amended YES Communications Strategic Planning Workgroup charter was posted in May 2022. Front page navigation was improved to provide clearer links to information for mental health providers. Reports by Boise State University and Union Point Group were added regarding the 2022 YES Family Survey Results, a report on the Provider Survey of the YES Quality Review, and a final report of the YES Quality Review.

New information for youth or families in crisis has been added to the top of the YES website, which directs individuals to 988, the Idaho Crisis and Suicide Hotline or recommends emergency care. A new page was created to improve the accessibility of Quarterly Quality Management Improvement and Accountability (QMIA) reports, emphasizing the Executive Summary and providing links to the full reports and data. This page also houses additional reports, including the YES Quality Review Process, Rights and Resolutions reports, Idaho WInS: Wraparound Intensive Services reports, the QMIA Plan, and YES Class Size estimates.

In late 2022, updates recommended by the IGT as well as parent and youth leaders were made, including: updating language and phone numbers, as well as updates to published documents, to reflect the transition to the nationwide 988 dialing code; clarification of language regarding mental health diagnosis; updated wording on the homepage YES.idaho.gov to better direct people to a page of available publications and communications; and new links to information on appeals.

In addition, a page related to Appeals has been added and is being filled with information in close collaboration with the YES Due Process Work Group.

2. Continuing Work on IAP Objective B

Practice Manual: Ongoing updates will occur as other authoritative documents are completed. The final Practice Manual must be negotiated with the new IBHP Contractor and is due no later than one hundred eighty (180) days following the service start date of IBHP.

Center of Excellence (CoE): The CoE has begun implementation, hiring and onboarding of staff. As DBH continues developing this new bureau, the CoE will work with YES stakeholders, community partners, and providers. The CoE plans to formalize how each program area's training, coaching, mentoring, and evaluating will be evaluated within the first quarter of 2023. Once the IBHP is executed, the CoE will engage with the MCO throughout implementation. Additionally, the CoE intends to develop and complete internal evaluation forms and an external website, to engage with network providers, and to provide training for the external provider network.

Services Roll Out: Based on the results of the Family Survey described in more detail below, access to mental health services for youth remains a significant challenge for many Idaho families. Three out of ten caregivers (31%) indicated they could not easily access the mental health services their child or youth needs. While there has been improvement in this area from 2020 to 2022, there remains significant need to improve access to mental health services for youth and families in Idaho.

Youth who face the most significant mental health challenges have the worst care experiences. This is evidenced by Family Survey results showing that youth with higher CANS scores were significantly less likely to have access to community-based services than providers recommended and caregivers felt were necessary.[17] Deficits were especially pronounced in the area of access to a community-based service array, suggesting youth with the most severe needs do not have adequate access to an intermediate range of services necessary to support them in the community. The QR Report included findings supporting the Family Survey results. Reviewers noted that at least twelve (12) percent and as many as forty (40) percent of youth entering the YES program may have intensive treatment needs and noted that the array of services available are "disproportionately focused on services which are appropriate for youth with mild to moderate behavioral health concerns." *2022 QR Report* at 29. The provider survey reported upon in the QR Report indicated a thirteen (13) percent drop in agency locations providing targeted care coordination, and an eight (8) percent drop in agency sites providing case management in 2022. *2022 QR Report* at 12. The 2022 QR "found that the care youth received was often delayed, not well matched to the intensity of their needs, and somewhat collaborative." *Id*. at 13. Reviewers compiled data about agency and individual providers' offered services. Only eleven (11) percent of agencies and five (5) percent of individual practitioners provided Intensive Outpatient Programs in the summer of 2022. *Id*. at 27-28.

The Report included findings that youth who demonstrated improvements in their

[17] Family Survey Results are available on the YES Website at: https://yes.idaho.gov/wp-content/uploads/2022/10/2022IdahoYESFamilySurveyResults.pdf, p. 26.

CANS ratings were provided with timely, appropriate, and collaborative care. *Id*. And noted providers' concerns about unsustainable reimbursement rates, administrative burdens to standing up new services, workforce shortages, and the high costs and productivity losses associate with training staff. Id. at 32-33, 41. These findings provide a framework for improvements that should be implemented across the system of care. IDHW is committed to further developing provider capacity and enhancing service delivery, but is facing many challenges in this area. The ICC Sprint team considered how other states utilize Family Care Coordinators, instead of licensed clinicians, to perform ICC and TCC services as one idea for addressing a workforce shortage. Additionally, that team recommended assessing workforce development needs focused on challenges specific to targeted geographic areas. The group addressed the need to provide greater frequent, low-cost training to providers across the state, focusing on areas with lower penetration of services. The QMIA-Q3 Report provides helpful data for identifying these areas. Expanding the workforce and using a decision support model to identify appropriate levels of care are two of the methods that will be presented to the IGT for prioritization. Work with the new IBHP contractor on improving access, reducing wait times to care, and supplying a trained workforce will be essential. The CoE will be ready to begin providing low cost training and working to support IBHP providers in the fall of 2023.

Communication Plan & YES Website: More work is needed to further develop a communication plan that complies with all requirements of IAP Objective B.4. The current communication workgroup functions well. For example the workgroup recently incorporated feedback and recommendations from the Due Process Work Group to develop a new Appeals page on the website. One of the valued parent stakeholders has requested adding family-friendly language related to filing complaints on the website as well and the communication workgroup is working with the Q-FAS work group to appropriately address those recommendations. The communication workgroup will need additional support of IDHW SMEs, YES families, and other stakeholders to fully develop the robust plan required in the IAP. The YES Website will continue to be regularly updated and the YES communications workgroup will continue to send quarterly YES newsletters.

D. Objective C: Access Model

The Agreement requires defendant agencies to utilize the Access Model in Appendix A of the Agreement, which provides an overarching protocol for how Class Members are identified, and how they move into, through, and out of the YES system of care. Additionally the Agreement requires defendants to implement the CANS assessment tool.

The IAP requires Defendant agencies to develop an authoritative Access Pathways Map to comprehensively detail planned service pathways through the YES SoC from identification through transition, consistent with the YES Authoritative Documents.

Expected Results of Accomplishing Objective C: *Defendant Agencies have*

developed, adopted, and are consistently using the specified models, protocols, and tools necessary to identify, assess, and serve Class Members and their families. Defendant Agencies are communicating this process and are providing informative materials statewide to the community, stakeholders, and families. Class Members, their families, and stakeholders are informed about who is eligible for services under the Agreement, what services are available, and how to access services.

1. Progress on IAP Objective C

Access Pathways Map: The Department attempted to recruit consultants for this work, beginning early March 2022 and had difficulty identifying qualified contractors with the availability and ability to perform the scope of work requested. On June 16, 2022, the Department finalized an amendment to the contract with Union Point Group (Dr. Nate Israel). The Department's contract monitors provided Dr. Israel materials needed for the assigned tasks and allowed for time for Dr Israel to familiarize himself with said materials. Materials provided were from the DBH, FACS, Medicaid, IDJC, and SDE. This product is extremely detailed, and required many resources to be shared with and reviewed by the contractor. Dr. Israel began drafting maps and the contract manager and monitor held regular meetings to review the draft maps. In addition, an initial meeting with Class Counsel was held in order to demonstrate the planned work. Changes to the contracted product were made as a result of that initial meeting and follow-up feedback. Meetings are held with the consultant weekly and feedback is provided to ensure clear understanding of IAP requirements; the Settlement Agreement; governing statutes, regulations, and rules; defendant agencies' policies and procedures; and the YES system of care.

The IAP required Defendants to provide the IWG with a Final Draft of the Access Pathways Map by December 31, 2022. IAP C.1.a. However, on December 19, 2022, the IDHW presented an update on progress on the maps to the IWG. The IWG voted that IDHW was not substantially out of compliance with the deadline in the IAP and agreed to extend the deadline for a final draft to February 2023 to allow time for IWG consultation. Three maps were provided to the IWG on December 30, 2022. Four additional maps were provided to the IWG on February 23, 2023. Class counsel and some members of the IWG have provided feedback on the form and structure of the Access Pathways Map and a collaborative discussion about the maps was held on February 27, 2023. Additional meetings have been held with the IWG which resulted in an extension of the dates by which Defendants and their contractor will produce final drafts of the Access Pathways Maps to class counsel and the IWG. As Defendants have continued to work with the consultant on the Access Pathways Maps, the process has been useful to indicate where access gaps exist in the current system. The maps describe the current system in place but have helped to identify areas where additional policies, standards, and procedures are needed to meet the Access Model requirements of Appendix A to the Agreement. The Department and its consultant are continuing work on two additional maps and are identifying areas of need as the maps evolve and are further developed, finalized and negotiated with the new IBHP contractor in compliance with IAP Objective C, strategy 1.b.

2. Continuing Work on IAP Objective C

The final document is to be reviewed and approved by the parties no later than the Service Start Date of the new IBHP contract. (IAP C.3.) With agreement by the parties, approval of the Access Pathways Map may be accomplished incrementally over time, as long as a fully completed Access Pathways Map is adopted within ninety (90) days of the Service Start Date of the new IBHP Contract. (IAP C.4.)

E. Objective D: Sustainable Workforce and Community Stakeholder Development

The Agreement requires Defendants to develop and implement a plan to develop and strengthen the workforce in order to deliver Services and Supports as required by the Agreement and to operationalize the Principles of Care and Practice Model.

Objective D, strategy 3 of the IAP, requires IDHW to develop a Workforce Development Plant that includes plans to: (a) assess, develop and strengthen the workforce; (b) identify and address gaps in the workforce capacity necessary to meet the needs of Class Members; and (c) develop sustainable regional and statewide education, training, coaching, mentoring, and technical assistance to providers.

Expected Results of Accomplishing Objective D: *The workforce is developed and available to deliver YES services and supports in compliance with the YES Authoritative Documents. A sustainable infrastructure is in place for ongoing education, training, and technical assistance for YES Providers.*

1. Progress on IAP Objective D

Idaho Behavioral Health Council (IBHC) Workforce Development Plan, IAP D. 1.: IDHW developed the "Idaho Behavioral Health Workforce Plan for 2022 – 2024" in accordance with the IBHC's Strategic Action Plan. The IBHC Workforce Development Plan was developed in 2021 and revised July 2022.[18] The plan recognizes that the entirety of Idaho has been designated as a Health Professional Shortage Area – a federal designation describing geographic areas or populations "with a deficit in primary care, dental, and mental health professionals." IBHC Workforce Development Plan at p. 4. The Plan outlines five goals: (1) Promotion – to increase awareness and recruitment of individuals to careers in behavioral health; (2) Education – to increase training and education opportunities for behavioral health professionals; (3) Credentialing – to improve efficiency and effectiveness of credentialing processes across behavioral health careers; (4) Employment – to increase behavioral health employment opportunities and system improvements; and (5) Retention – to retain Idaho's existing workforce through quality and effectiveness. Each of the five goals is supported by several objectives, performance measures and tasks.

[18] The plan is accessible through the IBHC website at: https://behavioralhealthcouncil.idaho.gov/.

IDHW Workforce Development Plan for YES: IDHW is charged by the IAP to use the IBHC Plan to develop a Workforce Development Plan for YES that incorporates the requirements of the Agreement. IAP D., 3. In addition, BSU developed a Workforce Capacity and Gaps Analysis in July 2018 for IDHW, and the YES Workforce Development work group created a Report in January 2020. Notably, the COVID-19 pandemic occurred after the recommendations from each of those reports were created. The pandemic dramatically impacted workforce shortages in Idaho and throughout the nation. Nonetheless, IDHW has responded to some of the recommendations in those reports. The BSU report recommended providing trainings to the provider network. Optum reports that four hundred four (404) of its providers have completed TCC training; one thousand thirty-two (1032) providers have completed Respite training, and one hundred forty-one (141) providers have completed Youth Support training since Optum began providing these services. In addition, some of the work of the CoE (discussed above) will assist in meeting the requirements that IDHW has a plan to develop and strengthen the workforce, IAP D.3.a., and to "develop sustainable regional and statewide education, training, coaching, mentoring, and technical assistance to providers that serve Class Members." IAP D.3.c. DBH has current contractors for training of TBS service providers, Wraparound providers, and Treatment Foster Care providers. As noted in the 2022 QR Report, this is an ongoing concern for providers. During the Agile Sprints process each team addressed capacity issues as part of its work related to specific service areas. That work led to identifying and addressing gaps in workforce capacity and exploring creative solutions. The BSU Report, the IHCBS Sprint Team, and the ICC Sprint Team addressed incentive programs such as stipends, loan repayment and/or tax credits for YES providers in targeted areas for specified periods of time. The IHCBS Sprint Team suggested a pay differential for IHCBS done after hours or in rural communities. The ICC Sprint Team recommended a coordination of workforce development efforts across the various defendant agencies and the IBHC who are currently addressing this topic.

Contractual Workforce Development Requirements of IBHP, IAP D.5:
The current IBHP contract with Optum requires an Annual Network Development Plan report. The report includes results from a provider survey that identifies areas of opportunity to work towards over the next year. Optum has also elicited feedback from providers of Respite/Youth Support and Targeted Care Coordination (TCC) to assess why specific providers declined recruitment attempts to offer those services. Optum facilitated a discussion with a respite provider as to why they were not longer going to provide respite and recommendations for how to improve the service.

Under the direction of Medicaid, Optum developed a proposal of rate increases that would have the biggest impact on the provider network and submitted this proposal to Medicaid early 2022. In July 2022, reimbursement rates were increased by fifteen percent (15%) for nine (9) services. These rate increases served to help stabilize the network. Medicaid intends to raise provider rates again next year, which should further stabilize the system, retain and increase the number of providers that provide services to YES youth.

Also in 2022, Medicaid partnered with Optum to work on decreasing administrative burden for providers. Medicaid and Optum sought feedback from various provider stakeholder committees and through Optum's annual Provider Survey to develop recommendations to decrease administrative burden. Medicaid and Optum have decreased the number of times the Optum Provider Manual is updated to only twice per year.

Due to the Public Health Emergency (PHE), Optum continued to permit the below allowances to decrease administrative burden throughout 2022 and will continue to do so until the Federal PHE ends:

- Prior authorization requirements are suspended for Skills Building/CBRS or Day Treatment.
- Prior authorization requirements are suspended for services beyond the annual threshold amounts for Case Management, Peer Support, Youth Support, Family Support, Recovery Coaching and Extended Visits Psychotherapy.
- The reimbursement rates for Crisis Services are currently twenty percent (20%) above pre-COVID levels.
- Certain rules governing telehealth service delivery are suspended.

Optum and Medicaid are working together on several initiatives extending into 2023 that will remove prior authorizations from CBRS and Extended Visits Psychotherapy and allow some services to keep being delivered through telehealth. Medicaid and Optum continue to partner together and identify other areas of opportunity where administrative burden can be decreased.

Optum worked with IDHW to operationalize and expand modalities for Intensive Home and Community Based Services. Optum recruited providers to engage in the trainings for this service and hosted a roundtable for providers. Optum performed a rate analysis and made recommendations to the state which resulted rate increases for multiple services in July of 2022. Optum has also been working with IDHW on a 1915i Performance Improvement Plan, to increase the number of Person-Centered Service Plans being completed annually. This effort has led to action items to increase the TCC workforce that included requiring the system providers to submit completed Person-Centered Service Plans, as well as multiple provider alerts and guidance documents.
Optum continues to improve existing trainings and create new trainings based off provider feedback. In 2022, there were approximately one thousand two hundred (1200) participants who attended trainings Optum offered such as CPI Verbal Intervention and Trauma Foundation Training, Youth Endorsement Training, and Mental Health in Schools Training, as well as many additional YES related trainings.

2. Continuing Work on IAP Objective D

IDHW Workforce Development Plan for YES: The IAP requires IDHW to consult with the IWG, and, with the IWG, incorporate timelines and interim deadlines for action items in the development of the IDHW Workforce Development Plan for YES. IDHW will continue work in this area through the Agile Sprint process, and the implementation of the CoE.

Additionally, IDHW is working on implementing recommendations made in the Quality Review Report (discussed further below). That report identified needs to proactively expand services, including: reimbursement rates consistent with service costs, less onerous paperwork and more understandable policies and procedures, specialized training that is accessible and low cost, and assistance developing and recruiting from a sufficient pool of practitioners. Legislative appropriations have made providing competitive reimbursement rates challenging.

Contractual Workforce Development Requirements of IBHP, IAP D.5:
The IBHP ITN includes the creation of a registry for the paraprofessional workforce in the Contractor's network who do not have a National Provider Identifier (NPI) or another unique identifier. The requirement in the contract is that the Contractor must use the registry to inform efforts around workforce development, assist members and families with locating providers, and identifying which licensed providers the paraprofessional workers are associated with; and that all paraprofessionals included in the registry must be included in the required provider network reporting to the Department.

Within the current and future contracts, the IBHP Contractor must submit an Annual Network Development and Management Plan (ANDMP), which contains specific action steps and measurable outcomes that are aligned with the DHW provider network requirements. The ANDMP must consider regional needs and incorporate region-wide, network-specific goals and objectives developed in collaboration with IDHW.

Medicaid program managers will be focusing their work in the near future on an approach to ensure Idaho Medicaid is meeting compliance with the network adequacy provision within the latest CMS Managed Care Final Rule. Most of Idaho Medicaid's network adequacy provisions lie within each managed care contract separately, so it will be looking at possible standardization while also identifying gaps in access to, and availability of, all services for Medicaid members. Medicaid would like to begin this work with IBHP, working with the Contractor(s), current and future, on workforce development strategies to expand the supply of behavioral health providers in the state and increase participation in the IBHP provider network. This work is still in its initial stage and a plan for Medicaid Administration to review will include measures that could be used to provide a comprehensive picture of adequacy and access to healthcare available to Idaho Medicaid members.

F. Objective E: Due Process

The Agreement requires many elements related to providing lawful and complete written notices and due process to Class Members as well as the development of a centralized and impartial process to address and track complaints and report upon notices of action, complaints, fair hearing requests, and outcomes. Agreement ¶ 43 – 48.

To that end, the IAP requires the parties to develop an Authoritative Due Process Protocol; a Due Process Workgroup to review and approve Notices of Agency Action and to evaluate informational materials; and a Centralized Complaint System.

Expected Results of Accomplishing Objective E: *Due process mechanisms exist and afford Class Members' and their families' due process of law in exercising their rights under the Agreement and federal and state laws and regulations. Class Members' and their families' concerns or complaints relating to informing, access, service appropriateness, service effectiveness, quality, and accountability are timely and fairly heard and resolved. The complaint and due process procedural mechanisms and associated outcomes will be documented and tracked for compliance and continuous quality improvement.*

1. Progress on IAP Objective E

Due Process Protocol, IAP E.1: Due March 31, 2022. Counsel for both parties worked to complete the Authoritative Due Process Protocol by March 31, 2022. [19] The Protocol was reviewed by the Due Process Work Group, and IDHW is on track to review and revise annually, as required by the IAP, by March 31, 2023.

Review of Notices of Agency Action, IAP E.2: The Due Process Workgroup is revising and updating its purpose to be consistent with the IAP and the Authoritative Due Process Protocol. The workgroup has completed its review and approved twenty-seven (27) notices. Additional notices are being worked on in other areas (by IDHW teams, contractors, or class counsel in other lawsuits) and will be reviewed by the Due Process Workgroup.[20]

A Medicaid Rights Form that is sent with every Medicaid Notice of Decision was finalized and approved by the Due Process Workgroup and Class Counsel in mid-2018. It was fully integrated into the Medicaid system, and has been in use since 2019. However, Class Counsel is now insisting that it be revised again, using his preferred language. IDHW sent the Form to Class Counsel for the *KW* Lawsuit for their input on August 3, 2022, as the Form will be used for Adult Development Disability cases as well. It was only in the past month that it was returned to IDHW, and it is now in

[19] https://yes.idaho.gov/wp-content/uploads/2022/04/YES-DP-Protocol-2022-for-YES-Website.pdf

[20] Four forms related to cost-sharing and hardship waivers were placed on hold during the COVID-19 PHE. Two Liberty Healthcare notices are on hold pending the Due Process Workgroup's review of the Medicaid Rights Form (discussed above). A DBH Denial of Eligibility Letter was placed on hold due to concerns about confusion between DBH and Medicaid appeals.

being reviewed by Medicaid. When they finish that review, it will come back to the Due Process Workgroup for finalization.

Informational Materials, IAP E.4.: As noted above, IDHW has begun to update the YES Practice Manual consistent with the Due Process Protocol. When ready for review the Due Process Workgroup will review the portions of the Practice Manual related to appeals and complaints.

State Fair Hearing Process, IAP E.3: The IAP requires IDHW to provide the Authoritative Due Process Protocol to the Fair Hearings Unit of the Attorney General's Office, the entity that currently is charged with operating a standardized administrative hearing system for IDHW. Legal counsel for IDHW provided the Authoritative document to the Fair Hearings Unit in June 2022 along with a description of its purpose and required use in hearings involving *Jeff D.* class members.

Centralized Complaint System, IAP E.5: Based on agreement from the YES Partners, DBH published the current DBH CMH Complaint Line as the YES Complaint Line; however, each partner agency has its own individual process for addressing and responding to complaints as required in federal regulations or state IDAPA rules. DBH and Medicaid have developed a strong collaboration to respond to YES complaints. When necessary, the team includes FACS as well. Inquiries or complaints can also be referred to IDJC or SDE. DBH monitors the complaint submission form on the YES website[21] as well as a YES@dhw.idaho.gov email inbox for questions and complaints. Medicaid's YES Program team maintain a phone number and the YESProgram@dhw.idaho.gov email, where complaints and inquiries are received. Medicaid's YES Program team also works with other Medicaid teams to handle any additional complaints or inquiries that come through other channels, including family engagement groups. DBH and Medicaid maintain a centralized tracker, and they meet weekly and as needed, to handle complaints quickly and collaboratively. Categories for the complaints have been developed, allowing them to be tracked, turnaround time to be monitored, and actions taken. DBH and Medicaid are also in the process of developing a standardized set of letters that can go out to complainants to acknowledge receipt, summarize the outcome(s), and provide contact information and appeal rights, as needed.

Defendants compile a Rights and Resolutions Report each quarter that describes the complaints and appeals received and outlines how and how quickly the issues were resolved.[22] The QMIA Council continues to work with the YES partners to improve complaint reporting and thoroughly understand the complaints themselves with the goal of developing of targeted quality improvement projects to address common issues within the overall YES system.

[21] The YES Complaints form is available on the YES website at: https://app.keysurvey.com/f/1391131/5d8d/.

[22] The latest Quarterly Rights and Resolutions Report is available on the YES website at: https://yes.idaho.gov/wp-content/uploads/2023/01/YES-Rights-and-Resolutions-Q1-SFY-2023.pdf

2. Continuing Work on IAP Objective E

Due Process Protocol, IAP E.1: The parties must review the Due Process Protocol annually and agree to any updates or proposed changes. IDHW's Administrative Rules for Contested Case Proceedings, IDAPA 16.05.03, are up for review in 2023 under the Governor's Zero-Based Regulation Executive Order No. 2020-01.[23] IDHW will publish a notice of proposed rulemaking and stakeholders will have opportunities to engage in negotiated rule making. Due to the revision of the Contested Case Rules, the parties may agree to defer updates to the Due Process Protocol until the rule revisions are adopted.

Review of Notices of Agency Action, IAP E.2: The Due Process Workgroup will complete revision of its purpose to be consistent with the IAP and the Authoritative Due Process Protocol and will resume review of notices when revisions are complete.

Informational Materials, IAP E.4.: When ready for review, the Due Process Workgroup will review the portions of the Practice Manual related to appeals and complaints. The Workgroup has discussed the possibility of developing or reviewing informational materials created from the Authoritative Practice Manual once it is complete.

Centralized Complaint System, IAP E.5: The implementation of the IBHP contract and the Joint IBHP Bureau will allow IDHW to further centralize its complaint process. The disconnect between other defendant agencies' respective state and federal reporting obligations may be a challenge in developing one centralized intake system However, increased involvement of IDJC and SDE in the Due Process workgroup, and a centralized IBHP provider network that provides most YES services will assist the group in further centralizing the complaints process. IDHW will continue to compile and the Quarterly Rights and Resolutions report which provide a central location for tracking purposes and the development of targeted quality improvement projects.

Additional work on Due Process issues: In addition to the IAP work related to Due Process, IDHW will be undertaking a review of the Mental Health Early Periodic Screening, Diagnostic and Treatment (MH EPSDT) Medicaid benefit. A portion of that review will specifically address concerns that class counsel has raised about due process rights of individuals who have applied for the MH EPSDT benefit. This review is further discussed below.

Furthermore, the Division of Medicaid has resumed a review of its appeals processes, a project that began prior to the COVID-19 pandemic. The program anticipates that this work will be complete prior to the implementation of the IBHP.

G. Objective F: Governance and Problem-Solving

[23] Executive Order No. 2020-01 is available on Governor Brad Little's official website at: https://gov.idaho.gov/wp-content/uploads/2020/01/eo-2020-01.pdf

The Agreement requires the use and establishment of an Interagency Governance Team that encourages engagement and active involvement of Class Members, their families, and other community stakeholders. Agreement ¶ 49 – 51.

Similarly, the IAP addresses the IGT and its duty to collaboratively coordinate and oversee implementation of the Agreement.

Expected Results of Accomplishing Objective F: *Governance group provides leadership, problem-solving, information sharing, cooperation among Defendant Agencies, transparent decision-making, and accountability for meeting the Agreement outcomes. Problems with implementation are surfaced and resolved expeditiously and by consensus to the greatest extent possible.*

1. Progress and Continuing Work on IAP Objective F

IGT Governance Duties, IAP F.1.a.: During 2022, the IGT updated its bylaws[24] and conducted significant work to define and identify roles and responsibilities of those who serve on the IGT or its subcommittees or groups that interact with the IGT.[25] The "Roles and Responsibilities Grid," finalized in November 2022, summarizes the IGT Work Process, describes the IGT Issue Management Process, and the process for state entities to interact with the IGT. Finally, the document includes a grid showing the roles and responsibilities of the IGT, the IGT's Interagency Clinical and Training subcommittee, the IGT's Family and Advocacy Meeting subcommittee, the Implementation Work Group, The QMIA Council, and other YES workgroups.

Secure Staffing and Funding Resources, IAP Objective F.1.c. Due by July 1, 2022. Funding was approved by July 1, 2022; job was posted; position filled August 22, 2022.[26]

IDHW approved a new position for a Project Coordinator, whose tasks will include supporting the coordination of the IGT and its subcommittees by collaborating with both internal and external stakeholders on project implementation and outcome management, providing logistical support, distributing agendas, setting actionable items following a working meeting, providing reminders of assignments, and distributing minutes. The position was posted by July 1, 2022, and was filled, with an individual who is well-versed in the YES SoC and who has been providing administrative support to several YES stakeholder workgroups for many years. The Project Coordinator began work on August 22, 2022. She has continued to manage several of the administrative support tasks she previously provided to the IGT, while

[24] IGT Bylaws, as updated January 12, 2022 are available on the YES Website at: https://yes.idaho.gov/wp-content/uploads/2022/01/220112-IGT-Bylaws_January-2022_Final_Signatures.pdf

[25] The IGT Roles and Responsibilities Grid adopted in November 2022, is available on the YES Website at: https://yes.idaho.gov/wp-content/uploads/2022/11/IGT-Roles-Responsibilities-Grid-Final-1.pdf

[26] https://yes.idaho.gov/wp-content/uploads/2022/04/YES-DP-Protocol-2022-for-YES-Website.pdf

taking on some additional duties as well. For example, the Project Coordinator worked closely with the IGT Co-chair, a Consultant, and the IGT subcommittees and the IGT members to develop an IGT Roles and Responsibilities Grid that describes the work of the IGT subcommittees and their relationship to tother YES stakeholder groups. It is anticipated that the Project Coordinator will continue work on similar special projects, and further development of IGT Strategic Plans and specific IGT documentation as the will of the group demands. The Project Coordinator and works incredibly well with stakeholders, parents, and government agency staff and has knowledge, understanding, and experience with Idaho's Open Meeting Law. The Project Coordinator has worked to onboard a new Co-Chair who was recently appointed to the IGT.

Despite all that the new Project Coordinator is already doing in this position, she has not been able to take on as many additional specific IGT projects as she would like due to the DBH transition, delays in approvals and ability to hire for administrative assistant positions that will ultimately assume her prior responsibilities. The new Project Coordinator has extensive knowledge of different platforms and processes and has supported many areas of DBH. New administrative staff has been hired and the Project Coordinator has been working to train and onboard new staff to assume some of the new Project Coordinator's prior duties.

In addition to the dedicated IGT Project Coordinator, IDHW has committed four (4) IDHW employees to the newly re-formed One Kid, One CANS IGT subcommittee. IDHW staff dedicate significant time preparing for, attending, presenting at, and engaging in regular IGT meetings.

H. Objective G: Quality Management, Improvement, and Accountability (QMIA)

The Agreement requires defendants to develop and implement a QMIA Plan for monitoring and reporting on Class Member outcomes, system performance, and progress on implementation of the Agreement. Agreement ¶¶ 52, 54. The Agreement includes specific requirements for the QMIA System, and data that must be included in regular reports. Agreement ¶¶ 53, 55. Finally, the Agreement requires the parties to jointly develop a Quality Review (QR) process that will be used to conduct and report upon periodic QRs. Agreement ¶¶ 56-58.

A QMIA Plan was developed and approved in 2016 and has been implemented for several years. The IAP requires that plan to be updated and requires several minimum requirements of the new plan. In addition, to the updated QMIA Plan and the QR Process, the IAP authorizes the creation of an Implementation Compliance Task Force to gather compliance information, operationalize outcome and exit criteria measures and to assess and report on progress toward full implementation and exit.

Expected Results of Accomplishing Objective G: *The Defendant Agencies sustainably operate a QMIA System that monitors, measures, assesses, and reports on Class Member outcomes, system performance and implementation of the Agreement, and improves quality at the clinical, program and system levels over time. The Defendant Agencies routinely measure, analyze, and publicly report on regional and statewide QMIA indicators and data. Over time, cost-effectiveness is increased and access to care is improved.*

1. Progress on IAP Objective G

QMIA Plan, IAP Objective G.1. Originally due on August 31, 2022. IDHW exerted significant resources into revising and updating the QMIA Plan to comply with the IAP and to account for the revised QMIA System structure. IDHW provided drafts to the IWG in June and July 2022 and consultation on the drafts occurred in July 2022. Ultimately, however, the parties determined additional work and development of implementation compliance measures were needed to adequately complete the update. Parties entered into a signed agreement to extend the deadline to June 30, 2023, or three (3) months following the date of agreement on program compliance measures. IDHW is holding internal meetings to further develop the revised QMIA plan.

The QMIA Plan requires quarterly reports. In 2022, IDHW created a QMIA page on the YES Website so that stakeholders can easily access up to date information about the quality and quantity of YES services provided throughout the state. The last QMIA Quarterly Report, published in January 2023, incorporates some changes to the format and includes trends over the past five (5) years of YES implementation. The latest report includes detailed information about the seven (7) regions across the state. It also includes data about the newly defined Key Quality Performance Measures. *YES QMIA-Q1 2023 Report* at p. 59-61 (attached hereto as Appendix A).

CANS Data Collection, Reporting Protocols, and "Real Time" definition, IAP Objective G.1.b.: The parties agreed upon a definition of "real time" needed to develop a CANS data system as a real-time platform, and as required by the IAP. On March 31, 2022, the parties agreed to the following definition of real-time:

> Completed and updated CANS information will be individually maintained in a secure platform accessible by parents, guardians, and youth over age fourteen (14); providers, program managers, and control agencies in real time using basic internet access and a commercial web browser, or in pdf format, subject to appropriate authorization, privacy and security controls. IDHW will require authorized providers to enter/upload CANS data for completed or updated CANS within five (5) business days of completion. Additionally, IDHW will require providers to authorize access to CANS and CANS updates to authorized individuals or agencies within five (5) business days of a valid request. For the purpose of maximizing real-time access to CANS, IDHW will

establish policies and procedures regarding when a CANS is "completed" or "updated" and when and under what circumstances providers must timely authorize access.

In addition, IDHW has finalized data collection and reporting protocols that will be used to provide a quality assessment report biannually.[27]

Implementation Compliance Task Force (ICTF), IAP Objective G.2. The IWG will design and describe the ICTF by August 31, 2023. The IWG has determined the membership of the ICTF and is currently working on this Objective. This task force will operationalize implementation compliance measures that the parties agree upon.

Quality Review Process, IAP Objective G.4. Due June 30, 2022. The YES partners worked with Plaintiffs to further develop the plan for conducting QR.[28] The QR assesses whether YES services are being provided in accord with the YES principles of care and will identify root causes of barriers that youth and families experience. Three components to the QR that were included in the final plan: 1) A detailed review of client records; 2) Interviews with youth and families; and 3) Interviews with providers. Results of the QR process will be utilized by the QMIA council to establish projects for YES system improvement.

A QR Report utilizing this process was published in December 2022 and is available on the YES website. *2022 QR Report*. The QR Report highlights some significant challenges and provides important insight that is guiding IDHW in its work on the Agile Sprints.

The report shows better outcomes (as indicated by improvements in CANS ratings) for youth who receive care that is timely, appropriate, and collaborative. *See 2022 QR Report* at 13. It also addresses barriers that youth and their caregivers experience when trying to access and participate in community-based services. *Id.* at 9-12. And it provides recommendations for improving the system. *See Id.* at 42-48. The report recommends increasing the number of specialized providers by making it more rewarding to serve youth with complex needs. *Id.* at 47. It also recommends focusing the system on providing engaging, high-quality care within the first thirty days of a youth's treatment and systematizing access to intensive care coordination for youth with highly complex needs. *Id.* at 43. IDHW leadership and the Sprint Teams are utilizing the QR findings in Workforce Development efforts and Service Roll Out initiatives (see further discussion in the Challenges section). This information will also guide future QR assessments.

[27] The CANS Data Collection and Reporting Protocols document can be found on the Publications page of the YES Website within the CANS documents. https://yes.idaho.gov/youth-empowerment-services/resources/publications/

[28] https://yes.idaho.gov/wp-content/uploads/2022/06/Idahos-YES-QR-Process-final_6.30.2022.pdf

2. Continuing Work on IAP Objective G

QMIA Plan, IAP Objective G.1. IDHW and other defendant agencies are continuing to develop the Updated QMIA Plan and are incorporating feedback received from IWG members. The updated plan will include Quality Measures required by IAP Objective G.1.d. and due June 30, 2023.

Implementation Compliance Task Force (ICTF), IAP Objective G.2. The IWG is currently working on this Objective. We anticipate a proposal related to the ICTF in March 2023. The task force will operationalize implementation compliance measures that the parties agree upon. The parties anticipate that landing upon mutually agreeable implementation compliance measures may be difficult.

Quality Review Process: IDHW will provide another QR review in the spring. Class counsel has indicated that they would like additional input into the process. IDHW's consultant is preparing an initial proposal based upon lessons learned from the 2022 Quality Review that will be shared with class counsel shortly. IDHW will continue to utilize information and recommendations from the *2022 QR Report* to improve systems and outcomes.

I. Objective H: Idaho Behavioral Health Plan

The IAP added a new objective specific to the IBHP contract. The new IBHP contract is intended to ensure compliance with the requirement in the Agreement that IDHW maximize Medicaid's role in the YES SoC and facilitating full implementation and sustained performance under the Agreement.

Expected Results of Accomplishing Objective H: *The IBHP contract and service agreement(s) will fully incorporate the requirements set forth in the Services and Supports Crosswalk, Access Pathways Map, Due Process Protocol, QMIA Plan, and Practice Manual. IBHP Providers will deliver YES services and supports to YES Class Members consistent with the requirements in the Services and Supports Crosswalk, Access Pathways Map, Due Process Protocol, QMIA Plan, and Practice Manual and the Settlement Agreement.*

1. Progress on IAP Objective H

When drafting the Invitation to Negotiate, the state incorporated references to and requirements of the Agreement and IAP. The state has engaged in the negotiation process with bidders on the IBHP contract with knowledge and awareness of the Agreement and IAP requirements.

2. Continuing Work on IAP Objective H

Once the IBHP Contract is executed, the IWG will be offered the opportunity to meet with the contractor during the implementation period of the contract.

IDHW will begin collaborating with the IBHP contractor to finalize and implement the Services and Supports Crosswalk, the Access Pathways Map, and the Practice Manual within the required timelines.

In addition, once finalized, the YES Authoritative Documents will be incorporated into the IBHP Contract as amendments.

IV. RELEVANT INFORMATION DRAWN FROM YES REPORTS

A. Key Quality Performance Measures Provide Useful Data

The QMIA Council has developed several Key Quality Performance Measures (KQPMs). The KQPMs include identified Performance Metrics, Measurements, the Frequency with which each measure will be assessed, and set Quality Targets. The Performance Metrics are tied to Settlement Agreement requirements including the YES Principles of Care and utilize data collected from three quality review processes to assess the quality of service delivery. The results from this assessment, and additional information about the process of developing them can be found on page 59 of the QMIA Quarterly Report. *YES QMIA-Q1 2023 Report* (attached hereto as Appendix A). The KQPMs provide significant detail about the quality-of-service delivery. Class counsel has indicated they are not in agreement with the KQPMs developed by the QMIA Council.

B. Continue to Provide Children and Youth with YES Medicaid Benefits

In the fourth quarter of SFY 2022, 14,029 Medicaid members between the ages of 0-17 accessed mental health services. Of that total, 2092 of the members accessing services were enrolled in the Medicaid YES program. *YES QMIA-Q1 2023 Report* at p. 14. The YES Medicaid Program provides Medicaid benefits to children and youth with SED whose household income is less than 300% of the federal poverty limit. More information regarding service delivery and system performance may be found in the QMIA quarterly reports, including *YES QMIA-Q1 2023 Report* attached as Appendix A.

C. Child and Adolescent Needs and Strengths (CANS) Used Statewide to Assessfor Mental Health Needs

The CANS has been adopted as the statewide functional assessment tool for children with mental health needs in Idaho. Children and youth of all ages, genders and race/ethnicity are assessed throughout the state. IDHW's Division of Family and Community Services, Child Welfare Program utilizes the CANS to identify strengths, needs, and appropriate treatment for children and youth in its care who are being assessed for admission to Qualified Residential Treatment Programs consistent with Idaho Code section 16-1619A. In 2022, IDHW worked with Plaintiffs to further determine the ways that the CANS can be used, and reactivated the One Kid, One CANS workgroup to further refine this important tool. As noted above, IDHW has developed a CANS Data Collection and Reporting Protocol tool to provide regular quality assessments of the CANS system. Several assessments utilizing these protocols are included in the *YES QMIA-Q1 2023 Report* attached as Appendix A.

D. Family Involvement in Quality Improvement

The SFY 2022 YES family survey included forty-five (45) questions that asked about families' experiences of care in five (5) areas: (1) the extent to which youth and families care adheres to the Idaho YES principles of care and practice model; (2) the adequacy of crisis safety planning; (3) the extent to which the CANS Assessment process followed guidelines; (4) select services the youth participated in (e.g., Wraparound, psychiatric hospitalization); and (5) caregiver's perceptions of service outcomes such as improvement in youth overall mental health and day-to-day functioning at home, school and in the community. Research has shown these questions are valid and reliable indicators of families' experiences of care and the variation in participants responses predicts variation in the extent to which youth benefit from care (Williams et al., 2021)

The survey was fielded via postal mail from February 2022 to April 2022. The sample included 5,999 caregivers of youth who participated in YES mental health services during 2021. Caregivers were randomly sampled with proportional allocation across Idaho's' seven (7) behavioral health regions to ensure adequate representation across the state. Following an evidence-based process the survey entailed a pre-survey letter, survey with postage paid return envelope, reminder card, and final survey with postage paid return envelope. The survey asked specifically about 1 identified child within the household. A total of 1,048 caregiver's responded (20.4% response rate after excluding returned mail).

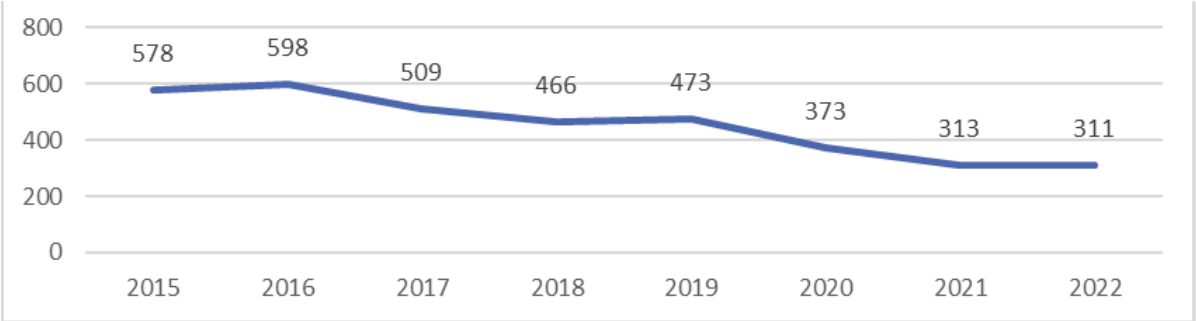
Mental Health Questions and Trends for the Last Three Years	2020 Result	2021 Result	2022 Result
Family Centered Care			
Provider encourages me to share what I know about my child/youth	85%	85%	85%
The goals we are working on are the ones I believe are most important	88%	88%	87%
My child and I are the main decision makers	79%	83%	83%
Family and Youth Voice and Choice			
Provider respects me as an expert on my child/youth	82%	85%	85%
The assessment completed by the provider accurately represents my child/youth	78%	81%	81%
My youth/child is an active participant in planning services	58%	67%	71%
My child/youth has the opportunity to share his/her own ideas when decisions are made	72%	83%	82%
I know who to contact if I have a concern or complaint about my provider	62%	68%	68%
New- I was able to participate in my child/youth's mental health services as much as I want	-	-	83%
Strengths-Based Care			
Services focus on what my child/youth is good at, not just problems	78%	84%	84%
Provider discusses how to use things we are good at to overcome problems	70%	77%	76%
Individualized Care			

Provider makes suggestions about what services might benefit my child/youth	75%	76%	77%
Provider suggests changes when things aren't going well	69%	74%	75%
Provider leads discussion of how to make things better when services are not working	62%	69%	68%
Access to Community-Based Service array			
My family can easily access the services my child needs	61%	71%	69%
Meetings occur at times and locations that are convenient for me	79%	83%	83%
New- We are able to access all the mental health services recommended by the provider.	-	-	70%
Collaborative/Team -Based Care			
The provider makes sure everyone involved on my child's treatment team is working together in a coordinated way.	65%	73%	74%
New-The provider communicates as much as needed with others involved in my child/youth's care-	-	-	73%
Culturally Competent Care			
Services are respectful of our family's language, religion, race/ethnicity and culture.	92%	93%	93%
Outcome-Based Care			
The provider often works with our family to measure my child's progress towards his/her goals.	73%	75%	73%
Adequacy of Safety/Crisis Planning			
Provider helped make a safety/crisis plan	48%	60%	61%
I feel confident that my child/youth's safety/crisis plan will be useful	54%	61%	61%
Total	70.2%	75.8%	75.8%

E. Court Ordered Services Under Idaho Code § 20-511A

One of the goals of the Agreement is to avoid delinquency and commitment to the juvenile justice system. As indicated in the chart below the number of children/youth who have been under court order to receive MH services has steadily decreased over the past six years, declining from 598 in SFY 2016 to 311 in SFY 2022: a decrease of 48%. This is a positive indicator that an increasing number of children's mental health services are being provided on voluntary basis.

Total Idaho Code § 20-511A Orders



F. Wraparound Services Provided

It is estimated that approximately 1,350 children and youth in Idaho may need

Wraparound services. During SFY 2020, 335 children and youth received Wraproud services, 188 in SFY 2021, 180 in SFY 2022. Since the initial implementation of Wraproud in Idaho, and through September 2022, 732 children and families have received Wraparound. The number of families who have accessed Wraparound services doubled from 2021 to 2022, from 7% of families to 14% of families. Additionally, the CoE is addressing Wraparound and is ensuring that it is delivered with fidelity.

V. CHALLENGES, ADDITIONAL WORK NEEDED, AND REVIEW OF COLLABORATIVE EFFORTS

Idaho has more to do in the coming years, including the work summarized below.

A. Availability of Services and Service Rollout

As it was in 2021, in 2022, the availability and delivery of publicly funded children's mental health services continues to be a challenge. The availability of mental health providers in Idaho (a designated healthcare provider shortage for mental health statewide), difficulties in both recruiting new qualified providers and in retaining providers, the growth of the state population, and access in both rural and frontier areas of the state are factors that impact the availability of services.

To address availability to care, YES partners continue to research best practices to increase the effectiveness of services, enhancing coaching and training, implementing new strategies forincreasing the number of healthcare providers and increasing the focus on development and expansion of the use of telehealth. IDHW is optimistic that the expansion of the IBHP, further development of the CoE, and other strategies like value-based healthcare initiatives will assist in building the workforce. Additionally, this challenge is a focus of IDHW in the Agile Sprint process referred to above. Having said that, the delay in the awarding of the new IBHP contract, due to procurement appeals, is an additional challenge. To counteract that challenge, IDHW is continuing to prepare for the new IBHP. That preparation includes continuing development of standards, policies and procedures, as identified in developing the Access Pathways Maps and Services and Supports Crosswalk that will support a smoother transition of the IBHP. In addition, the full staffing and development of the IBHP Joint Bureau and the CoE is underway. One of the challenges that IDHW faces is the difficulty in planning for a future system of care administered largely through an MCO while simultaneously administering the current system with a dwindling workforce[29] and recognized gaps.

As previously noted, the recent Quality Review report provides valuable information from providers and is being utilized to improve access as well.

[29] DBH has recognized an increase in its vacant positions. Leadership attributes some of the turnover to reorganization and a changing focus for the division as well as the general pattern of a shortage of clinicians statewide. The Division has incorporated hiring and retention bonuses to attempt to address this issue.

Some examples of the recommendations that came out of the sprints include the following recommendations that relate to Recommended Actions from the QR Report.

QR Report Recommended Action: "*Create, and publish online, a CANS-based algorithm for determining the need for care coordination.*" *2022 QR Report* at 46. Three of the four Sprint teams addressed further refining an existing Decision Support Tool for the purpose of identifying children in need of out of home placement, ICC services, and intensive home and community based services (IHCBS). The CANS Decision Support Model is a tool created by the Center for Innovation and Population Health (formerly Praed Foundation). The Decision Support Model is not a substitute for clinical decision making, but a baseline for gathering information that should be considered. IDHW staff have collaborated with doctors at the Center to create a Decision Support Model specific to Idaho which is currently utilized by DBH Residential Review Teams when residential placement is indicated or requested by families. The Residential Care Sprint team developed action steps needed for the Decision Support Model to be utilized more broadly by Medicaid and FACS teams, in addition to DBH. The ICC Sprint team addressed what steps are needed to further develop the tool to as a way to screen youth into ICC services, support transitions in care, and monitor the care the youth receives, to ensure the services and supports provided are meeting each youth's unique needs. Although not specifically addressed by the Crisis Sprint Team, the Decision Support Model can be utilized in crisis response to effectively determine appropriate level of care needs. The IHCBS Sprint Team also prioritized further development of the decision support model that can be used by Child and Family Teams to identify and initiate services and supports for youth with high needs and noted that such a tool would ultimately provide date on the outcomes for specific youth. DBH's Center of Excellence has engaged with the Center on further development and refinement of the Decision Support Model. It is expected that a model can be developed by June 30, 2023. For use in CFTs, the IHCBS Sprint Team noted that training and technical assistance for community providers would need to be developed prior to implementation of the IBHP in late 2023, early 2024 so that providers, families, and other stakeholders can provide feedback on the use of the tool. If prioritized this effort would require implementing a feedback or evaluative process within 6 months of the IBHP go live will assist providers and the system to plan for adjusting within the system, adjustments with the MCO and for the CoE to support system change.

QR Report Recommended Action: "*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.*" *2022 QR Report* at 44. The IHCBS Sprint Team focused on the need to develop standards for IHCBS within Idaho compiled by cross-divisional policy units. The sprint team estimated six to twelve months to establish standards and recommended that the CoE incorporate IHCBS so that adequate technical assistance and training could be offered to providers within the IBHP network. The CoE would also be tasked with assisting and building and increasing provider capacity to provide IHCBS to at risk youth in Idaho within a twelve to eighteen month period. Medicaid is currently implementing consultation billing codes that were recently approved by CMS.

B. Medicaid Approvals

Idaho Medicaid must secure continued approval from the Centers for Medicare & Medicaid Services (CMS) for the continuation of its 1915(b) waiver, which covers YES services, as well as update its state plan authority for the program. That work is in process and will not cause any delays in full implementation of the new IBHP.

C. Budgetary Constraints

As highlighted in recent legislative hearings with the Idaho Legislature's Joint Finance and Appropriations Committee (JFAC), Idaho legislators have voiced serious concerns about cost containment related to IDHW's Medicaid budget.[30] In Idaho, all changes to provider payment rates are subject to approval of the legislature by appropriation. Idaho Code § 56-265(4). To adjust provider rates, IDHW must request line-item adjustments each fiscal year. *Id.* For Fiscal Year 2024, Idaho Medicaid requested seventy-two million dollars ($72,000,000) in all funds to bring on new services to be covered by Medicaid under the new IBHP contract ($50,000,000) and for a ten percent (10%) rate increase for outpatient services ($22,000,000). This request passed out of JFAC, but met with resistance on the floor of the Legislature, which asked for cuts to the total Medicaid budget and did not pass it. It was only in the waning days of the 2023 Legislative Session that Medicaid's budget passed, and with a reduction of approximately two hundred million dollars ($200,000,000) between what was requested and what was ultimately appropriated.

IDHW struggles to balance cost containment measures with building and sustaining a provider network and is exploring ways to address this conflict. The Medicaid Division is now in its second year of value-based payment agreements with eleven (11) value care organizations through it's Healthy Connections Value Care Program. While the programs do not include behavioral health services, they do include other primary care, specialty care, and hospital services that are used by YES class members. In addition to leveraging value-based payment agreements, IDHW is exploring ways to decrease administrative burdens placed upon providers and other ways to encourage providers to join the IBHP network. The One Kid, One CANS work group and the Agile Sprint groups are addressing some of these issues as well.

D. Mental Health Early and Periodic Screening, Diagnostic, and Treatment (MH EPSDT) Review

Class counsel has requested a review of the Division of Medicaid's Mental Health EPSDT process and has raised concerns about IDHW's delivery of the benefit, including the application process, the review and approval process, the access to care provided through delivery of the benefit, and the due process procedures associated with the processing and denial of the benefit. IDHW has agreed to engage an

[30] IDHW presented its budget requests to JFAC on January 17, 18, and 19, 2023, with Medicaid and DBH's budgets being discussed on January 17 and 18. Audio/Video files and Presentations can be accessed through JFAC's website at: https://legislature.idaho.gov/sessioninfo/2023/joint/jfac/

independent evaluator to conduct a comprehensive review of the MH EPSDT benefit and the parties are discussing the scope of the evaluation. To this end, Medicaid requested a one hundred-thousand-dollar ($100,000) appropriation from the Idaho Legislature and is in the final stages of contract negotiation, including timeliness for deliverables, with Health Management Associates (HMA), an independent consulting firm for healthcare and social service providers that is recognized as an expert in Medicaid, to perform the review. The review is intended to independently evaluate Medicaid's EPSDT process, and through the evaluation, the Department expects to receive a comprehensive assessment of the MH EPSDT benefit, as well as recommendations to maintain and/or establish compliance with federal and state authorities and improve program operations and access to services. The review will cover the regulatory framework for the program, operational and clinical decisions-making processes, access to medically necessary services, and due process. Medicaid anticipates finalizing this contract in mid- to late-April, with work to start in May 2023.

E. Compliance Measures and Exit Criteria

In developing the IAP, the parties agreed to establish an Implementation Compliance Task Force. IAP, Objective G., Strategy 2. Before the Task Force can do its work evaluating compliance with the Agreement's Commitments and Outcomes, the parties will need to agree upon appropriate measurements of compliance. This has already proven to be a difficult task and, in fact, was the impetus for IDHW's determination that it needed to take a pause from regular Jeff D. meetings to refocus and develop a cross-divisional shared vision for continuing work on the YES SoC. Some of the significant challenges with defining compliance measures include: agreeing on standards to assess compliance, and agreeing how to utilize available data to determine appropriate measurement. IDHW anticipates that the current climate of collaboration amongst the parties will make this task even more challenging. IDHW has requested a meeting with class counsel to implement the Agreement's dispute resolution processes to establish a mutually agreeable methodology for developing compliance measures.

F. Collaboration Challenges

Following this Court's approval of the IAP in January 2022, IDHW was hopeful that a clear roadmap to full implementation and a reset of the relationship between the parties would lead to swift progress. Unfortunately, this has not come to pass. Deficiencies in the collaborative relationship between IDHW and Class Counsel have become a significant challenge. IDHW understands and appreciates that one of the purposes of the IAP is to make IDHW accountable to deadlines and requirements that are monitored by Class Counsel. In developing the IAP, however, the parties agreed that IDHW should be allowed the freedom to develop a sustainable system that will function in Idaho while working toward fulfilling the Agreement's Commitments, Outcomes, and Exit Criteria.

Feedback and coordination thus far on the authoritative documents indicates that the

documents are incredibly complicated and that the parties may not be entirely aligned on what the IAP requires of the authoritative documents or what would make those sources most useful to IDHW when implementing the system.

Instead of a collaborative atmosphere where strategies can be openly discussed, IDHW has come to expect that whatever it presents will be determined inadequate to Class Counsel. IDHW would prefer to focus on the *content* of the deliverables and the effect they will have upon developing a workable, sustainable SoC. Class Counsel appears to be focused on the *form* of the deliverables and controlling the process. Time that could be spent focusing on developing a sustainable workforce and accessible services has instead been spent chasing class counsel's expectations about what Idaho's system should look like. Class counsel has expressed that more aggressive action is required to hold the state accountable as it is concerned that implementation is delayed and access to services is waning. IDHW acknowledges that implementation has been slower than anticipated and that access to care and service rollout is challenging, particularly for children with intensive needs. Implementation is an evolving process and IDHW has encountered many challenges along the way. IDHW has several initiatives underway that will assist implementation, most notably the expanded IBHP contract, which specifically requires compliance with the Agreement and includes provisions to enforce compliance.

Both parties have indicated a desire to reestablish a collaborative relationship. Counsel made efforts to meet and confer regularly in an attempt to realign collaborative efforts. Both parties agree that approach has not been productive. For that reason, IDHW has requested to initiate the Agreement's dispute resolution provisions to address the collaboration amongst the parties.

G. Treatment of Individual Cases

The parties have been unable to agree whether Class Counsel's representation of the class authorizes counsel for the class to represent individual class members under the terms of the Agreement. Class Counsel has advocated that as counsel for the class they may raise concerns with IDHW on behalf of individual class members for specific service delivery and treatment outcomes, and at times has engaged in treatment team meetings. Defendants assert that the Agreement and the current status of the suit necessitate a focus on the system as a whole. While individual class member's circumstances can sometimes provide insight to systemic issues, IDHW takes the position that the Agreement clearly anticipates that individual representation was not expected as a regular occurrence. *See* Agreement ¶¶ 90, 94. When Class Counsel becomes involved and demands immediate responses from IDHW executive level administrators on individual treatment and case planning issues, many problems ensue.

IDHW asserts that individuals should work through the appeals process provided by federal and state law and seek legal counsel from DisAbility Rights Idaho or Idaho Legal Aid Services when necessary. Notably, IDHW contracts with FYIdaho (formerly the Idaho Federation of Families) to provide education and advocacy support for

families and, consistent with the Agreement, encourages families to reach out to FYIdaho and legal advocacy groups with concerns about their individual cases.

In short, it has become clear that it is unproductive and harmful to the system as a whole when Class Counsel attempts to raise issues on behalf of individual class members that do not rise to the level of the criteria in Paragraph 90 of the Agreement – "*systemic risk of imminent harm to a broad group of Class Members.*" Counsel for the parties have been unable to reach agreement on the best way to address individual issues. IDHW has requested invoking the Agreement's dispute resolution process to address this issue.

VI. MOVING FORWARD

IDHW is excited about the new resources that are becoming available and is dedicated to developing a system of care that will benefit the state's youth with SED. The state will continue to put its full weight behind implementation of the new IBHP, which will provide needed critical services for youth in Idaho with SED. The state sees a clear path to that goal and will not stop until that is fully realized.

FIFTH YOUTH EMPOWERMENT SERVICESIMPLEMENTATION PROGRESS REPORT

Appendix A:

Youth Empowerment Services

QMIA Quarterly Report

January 2023

Youth Empowerment Services

Quality Management Improvement & Accountability (QMIA)

YOUTH EMPOWERMENT SERVICES QMIA Quarterly Report

Q1, SFY 2023

Jan 13, 2023

Youth Empowerment Services

YES, QMIA Quarterly Report SFY 2023, Q1

YES QMIA-Q SFY 2023, 1st Q includes data from July, August, September 2022

and trends from previous years

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YES, QMIA Quarterly Report Q1, SFY 2023

Purpose of YES OMIA Quarterly (OMIA-O) Report

The goal of Idaho's Youth Empowerment Services (YES) program is to develop, implement, and sustain a child, youth, and family-driven, coordinated, and comprehensive children's mental health delivery system of care. The enhanced YES child serving system will lead to improved outcomes for children, youth, and families who are dealing with mental illness.

The purpose of the QMIA-Q is to provide YES Partners and children's mental health stakeholders with information about the children and youth accessing YES services, the services they are accessing, and the outcomes of the services. The data in the QMIA-Q tells the story about whether YES is reaching the children, youth and families who need mental health services, if the services are meeting their needs, and if they are improving as result of the services.

The QMIA-Q is assembled with information about the children, youth, and families accessing mental health care in Idaho primarily through the Medicaid/Optum Network and the Division of Behavioral Health's (DBH's) Children's Mental Health (CMH) Regional clinics. Most of the data is from Medicaid or DBH as these two child serving systems provide most of the outpatient mental health care for children and youth. Data in the report includes children and youth who have Medicaid, children who do not have insurance and children whose family's income is over the Medicaid Federal Poverty Guideline, children under court orders for mental health services including Child Protective Act (CPA) and Juvenile Corrections Act (JCA)orders, and children with developmental disabilities and co-occurring mental illness.

The QMIA-Q is available publicly on the YES website and delivered to all YES workgroups to support decision making related to plans for YES system improvement by building collaborative systems, developing new services, and creating workforce training plans.

Questions? If information provided within this QMIA-Q creates questions or an interest in additional data collection, please contact YES@dhw.idaho.gov with your questions, concerns, or suggestions.

OMIA-O report dates for SFY 2023

YES QMIA-Q SFY 2023 Timelines	*Published on YES Website*
1st quarter- July- Sept + Annual YES projected number	January
2nd quarter- Oct-Dec	April
3rd quarter Jan- March	July
4th quarter and year end April- June and full SFY, 2023	October

YES, QMIA Quarterly Report, includes data from Q1 of SFY 2023
(July, August, September 2022),
and trends over past 5 years comparing previous quarters and SFYs.

Executive Summary – SFY 2023, Q1

The QMIA-Q report for SFY 2023, Q1 provides information about the delivery of YES services for July, August, September 2022, and trends over the past five years of YES implementation. There have been some changes in the format for the QMIA-Q for Q1 which are intended to make the data that is provided more useful and easier to understand.

The major changes are in Section 5 of the report on Medicaid Outpatient services. First, we have added new information into the statewide portion of this section. The statewide information now includes both a table with all services with number of youth serviced and a table with penetration rates of all services. There is also new data about services that had not previously been reported including: Case Management, Therapeutic After School (TASSP), Crisis Services, and Family Support Partners. In this portion of the report there is a new analysis that includes a statewide comparison of 5 specific targeted services: Psychotherapy, Case Management, Community Based Rehabilitation (CBRS), Targeted Care Coordination (TCC) and Intensive Home and community Based Services (IHCBS).

In this same section of the QMIA-Q report (Section 5), a switch has been made from reporting service utilization by service type to reporting on all services by region. For example, Region 1 has all the YES services in Region 1, Region 2 has all the YES services in Region 2, etc. All of the previously-available data about services will remains, but by breaking out the data about utilization of service by region the QMIA-Q provides a clearer picture of how service utilization varies across the state. In addition, reports are provided for each region with the number of youth served, the percent of the type of services that were used by those accessing services, and the penetration rate. This change standardizes the information for each region and provides a basis for comparing each region to the statewide results.

Data for QMIA-Q Q1 includes the updated Estimation of YES Eligibility (E1), statewide access to YES Outpatient Medicaid services (E2), average Medicaid expenditure per member served by region (E3), access to intensive outpatient Medicaid services (E4), updates on quality improvement projects, and a list of the YES reports that have been published.

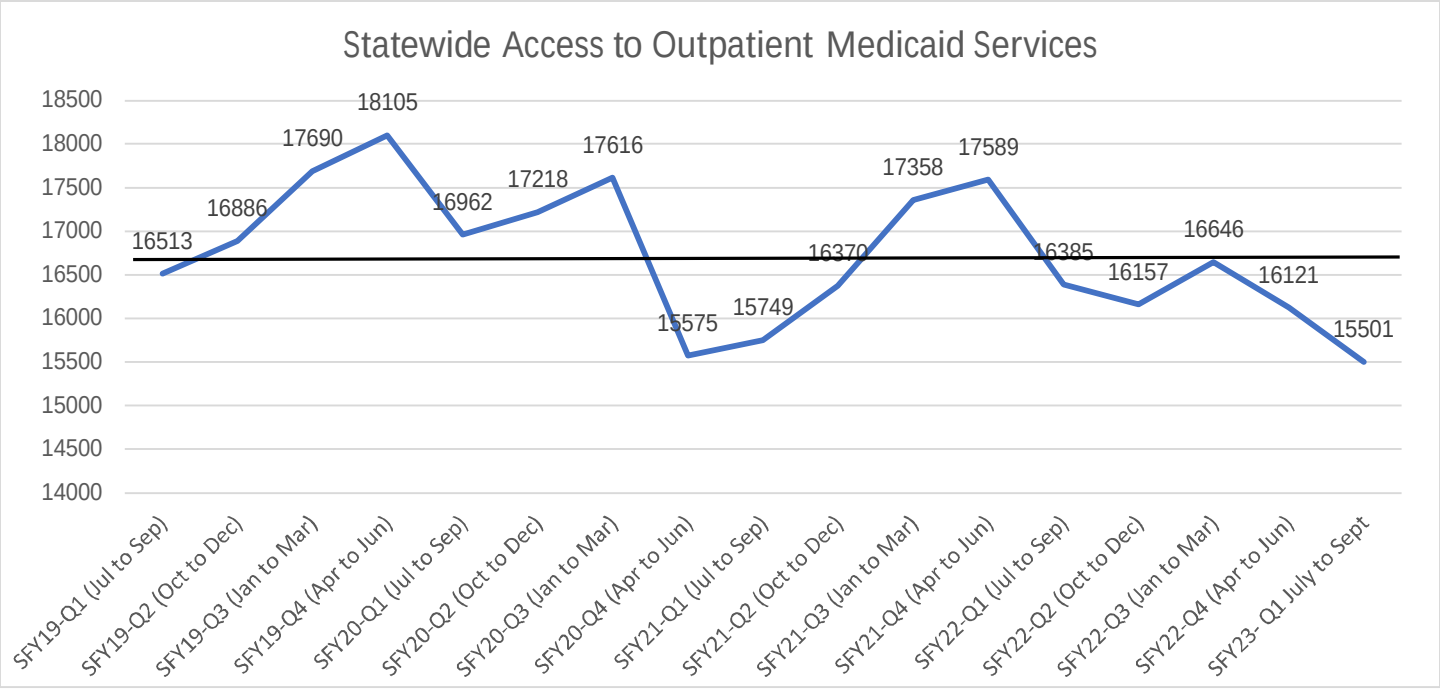
E1 Annual YES Eligibility Estimation, updated for Dec 2022

	Type of insurance				
	Employer	Non-Group	Medicaid	Uninsured	Total
Insured rate based on 2020 Estimated Census	50.70%	5%	34.90%	7.10%	
Population	246,000	25,000	170,000	35,000	
Estimated prevalence	6%	6%	8%	12%	
Estimated need	14,760	1,500	13,600	4,165	
Expected Utilization Lower Estimate 15%	2215	225	13,600	4,165	20,205
Expected Utilization Higher Estimate 18%	2655	270	13,600	4,165	20,690

E2: Statewide access to YES Outpatient Medicaid Services

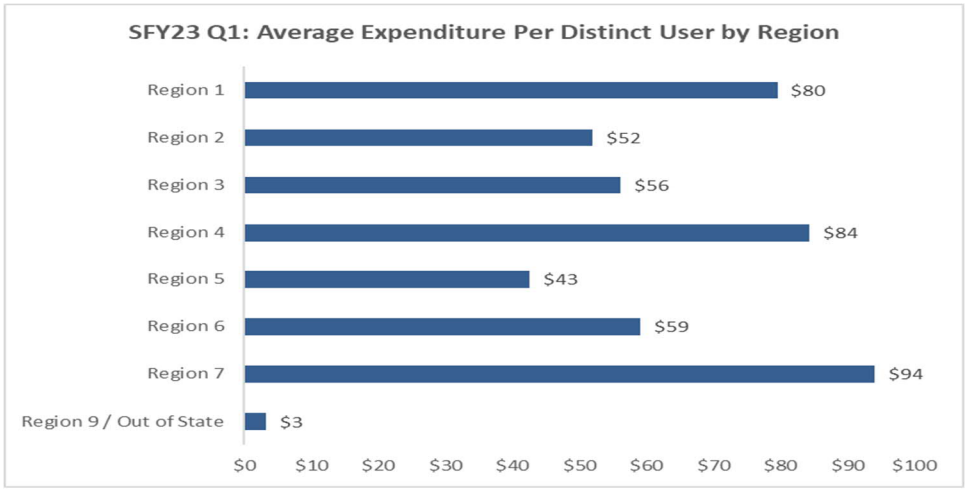
A Quality Improvement Project (QIP) to address the need for service availability across all 7 regions has been implemented. The first step of the QIP is to identify the gaps in services.

One aspect of identifying the gaps is to analyze access statewide. As the graphic chart below indicates the number of Medicaid members under the age of 18 that received outpatient services has varied over the last 16 quarters with the highest number being 18,105 in April - June 2019, and the lowest number of 15,501 in July - Sept 2022. An analysis for the past quarters indicates that the average number of children and youth receiving services per quarter is approximately 16,800 (bold black line). For the most recent 5 quarters the number accessing services has been trending below the average.



E3 Average Medicaid Outpatient Expenditure Per Distinct User by Region

An analysis of Medicaid outpatient expenditure by region indicates that there is substantial variation in expenditures across the state – from $94 per person served in Region 7 to $43 per person served in Region 5.



E4 Access to Intensive Outpatient Medicaid Services by Type and Region

Based on data about access to services and on-going concerns from families and advocacy groups, the QMIA Council recommended to the YES Sponsors and Defendants Workgroup (DWG) that a QIP be implemented for services needed specifically for children and youth with complex/high needs.

The following tables show the number serviced and the penetration rate (number receiving services/number of Medicaid members) for outpatient services provided to Medicaid members under the age of 18, with rates noted by type of service and by the region in which the service was delivered.

# of Medicaid Members Accessing Intensive Outpatient Treatment Services									
	1	2	3	4	5	6	7	9	Total
TASSP[1]	0	0	0	0	0	0	19	0	19
Partial Hospitalization (PHP)	0	0	29	39	4	0	6	0	78
Day Treatment	0	0	1	1	12	1	9	0	24
IHCBS[2]	0	0	4	8	1	16	5	0	34

Penetration Rates for Intensive Outpatient Treatment Services									
	1	2	3	4	5	6	7	9	Total
TASSP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%
Partial Hospitalization (PHP)	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Day Treatment	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
IHCBS	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%

Short term goals for the QIP are to define the population, identify missing and needed services, identify the reason why services are not available and research interventions used in other states that have been successful in responding to this issue.

E5 Quality Improvement Projects (QIPs)

Crisis and Safety Plans

To help families with the need for higher quality, effective Crisis and Safety Plans, the Division of Behavioral Health implemented a QIP.

In SFY 2021, standardized forms for crisis and safety planning, and other helpful information related to a crisis, were added to the Youth Empowerment Services (YES) website. In addition, a collaborative workgroup of parents and youth, the IDHW Divisions of Behavioral Health and Family and Community Services, and the Idaho Department of Juvenile Corrections, and SDE created a video for youth and parents about how to create an effective crisis and safety plan. The video is available in English and Spanish on YouTube and the YES website (https://yes.idaho.gov/).

In SFY 2022, training for community providers on the creation and use of effective safety planning was provided in five total sessions. Attendance at the training was very good with over 500 participants. Based on the 2022 family survey[3], there has not yet been an improvement in the effectiveness of crisis safety plans (still at 60%), however the training took place later in the FY, so it is possible that there will be more of an impact that can be evaluated in SFY 2023.

The Crisis and Safety plan training provided in the fall of 2022, was based on recommendations from family representatives on the Family Advisory Subcommittee (Q-FAS), families gave input on the training and participated in the

[1] TASSP- Therapeutic After School Support Program
[2] IHCBS - Intensive Home and Community Based Services
[3] A YES Family Survey is conducted annually to assess the YES Principles of Care

fall training. We will continue to collect data about the issue of Crisis and Safety Plans through the survey sent to families each spring.

Hospital Discharge Standard

Over the past years, there have been several complaints related to children/youth being discharged home without families having input on the discharge plan. During SFY 2022, a small workgroup (DBH Quality staff and Family Members from the Council) began research into the development of a hospital discharge standard. The workgroup's goal was to draft a standard based on policies, guidelines best practices and rules in other states and to propose a new standard be adopted by Idaho and used by Idaho's' community hospitals. This team felt that "Transitions of Care" would be a more appropriate name for this standard as there are times in which individuals require a higher level of care. A draft of this Behavioral Health Transitions of Care standard was forwarded to the DBH Policy Unit for review on June 27, 2022. The proposed standard has not yet been adopted.

YES reports:

The following are links to the YES reports noted within the QMIA-Q

QMIA-Q historical reports**: https://yes.idaho.gov/yes-quality-management-improvement-and-accountability/**

YES Rights and Resolutions**: https://yes.idaho.gov/yes-quality-management-improvement-and-accountability/,** click on "Additional QMIA Data and Reports" and scroll down the page

Quality Review (QR): Provider Survey; https://yes.idaho.gov/youth-empowerment-services/about-yes/yes-history/?target=8

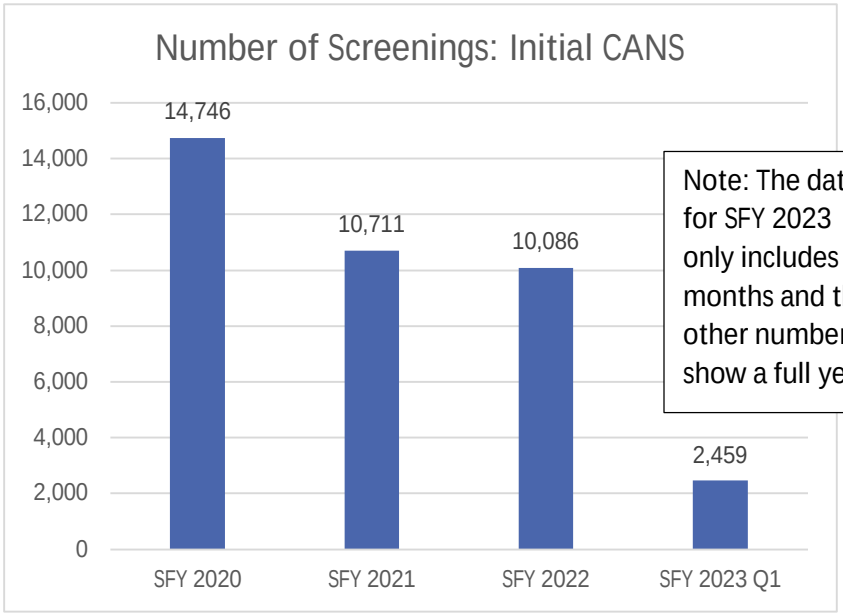
YES Family Survey Results : https://yes.idaho.gov/youth-empowerment-services/about-yes/yes-history/?target=8

QMIA-Q SFY 2023, Q1 Report

1. Screening for Mental Health Needs

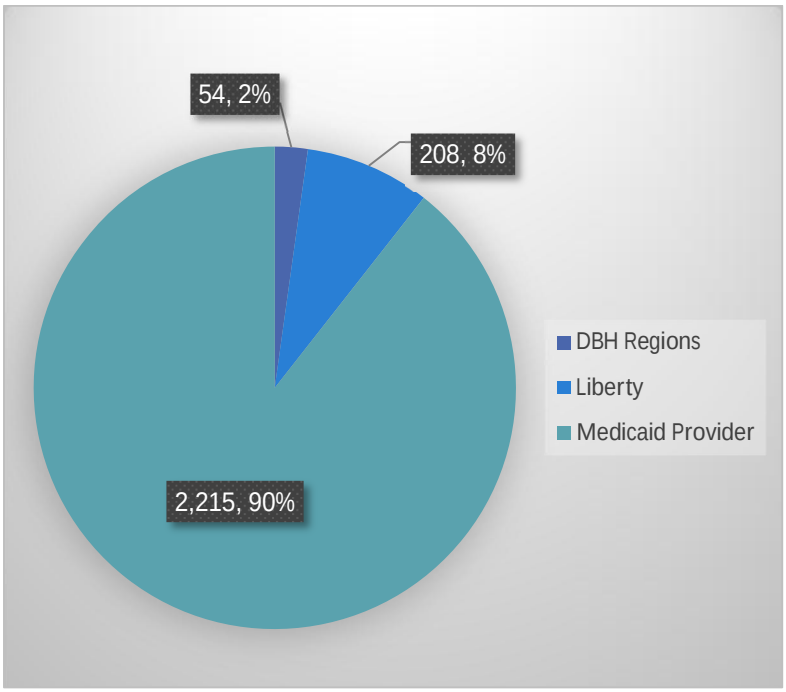
1a: Total Number of Children and Youth Screened for mental health needs

The number of initial CANS completed for SFY 2023, Q1 was 2,459. If this rate continues then the number of initial cans for SFY 2023 will be close to 10,000. The expectation for how many children and youth would be expected to access services through an initial CANS each quarter or each year is not yet established and therefore the data currently only tells us that children and youth are being screened. The number of initial CANS completed by quarter will be reported in each successive QMIA-Q so that over time, quarterly and/or annual trends in the number of initial CANS may be established.



Note: The data for SFY 2023 only includes 3 months and the other numbers show a full year.

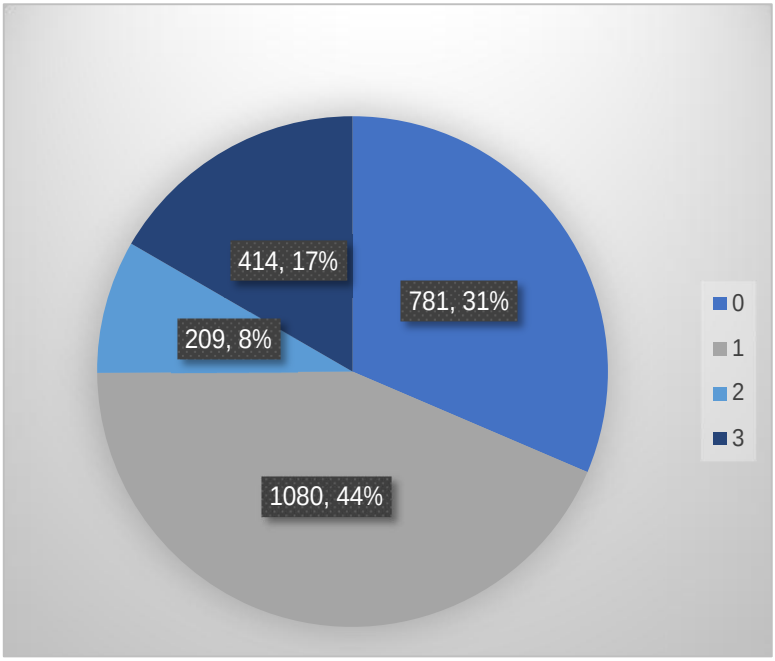
1b: Number and Percent of CANS Completed By DBH, Liberty, Medicaid Provider:



The screening for mental health services through the CANS assessment may be conducted by DBH, Liberty or a Medicaid Provider. For SFY 2023, Q1 90% of CANS Assessments were completed by Medicaid providers, 8% by Liberty, and 2% by DBH.

2. YES eligible children and youth based on initial CANS

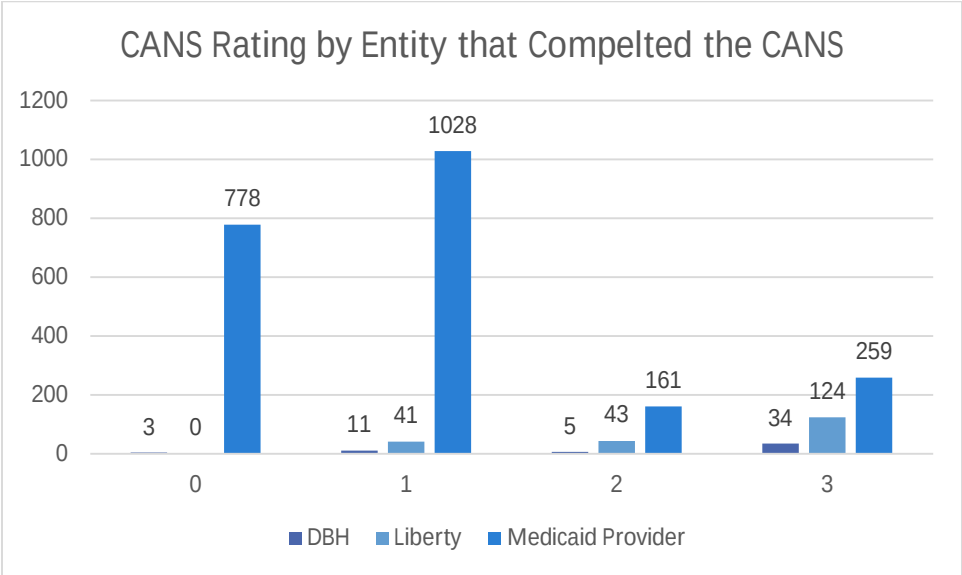
2a: CANS Rating - Result of initial CANS Statewide



An algorithm based on the CANS was developed by stakeholders in collaboration with the Praed Foundation for Idaho to support identification of YES members. The algorithm results in an overall rating of 0, 1, 2, or 3. Based on that algorithm, all children who have a CANS rating of "1, 2 or 3" are considered to meet the criteria for eligibility for YES membership. Children and youth with a rating of "0" on the CANS may still have mental health needs and are still provided mental health services but they do not meet the eligibility criteria established in the Jeff D. Settlement Agreement to be considered a class member of the Jeff D. lawsuit.

2b: CANS Rating - Result of Initial CANS by Entity that completed the CANS

Based on that algorithm, all children who have a CANS rating of "1, 2 or 3" are considered to meet the criteria for eligibility for YES membership. Children and youth with a rating of "0" on the CANS may still have mental health needs and are still provided mental health services but they do not meet the eligibility criteria established in the Jeff D. Settlement Agreement to be considered a class member of the Jeff D. lawsuit.



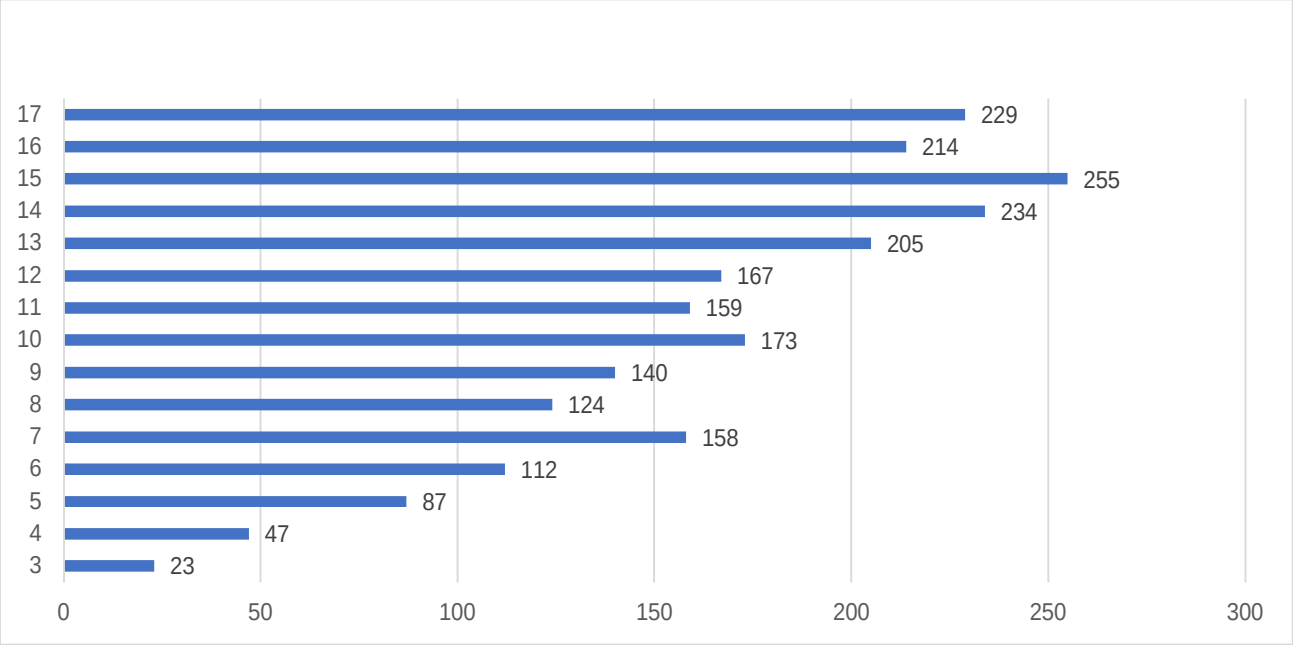
What is this data telling us?

Of all the initial CANS completed in SFY 2023, Q1 approximately 70% met the criteria for eligibility for YES class membership (CANS 1, 2, or 3 rating) and 30% did not meet the criteria (CANS rating of 0). The percentages of those found eligible vs. those found not eligible across time continues to be consistent, which indicates that there may be crude reliability in the percentage of children and youth who are assessed who likely qualify for YES class membership (e.g., it is expected that approximately 70% of children accessing mental health services will meet criteria to be YES eligible).

3. The characteristics of the children and youth who were assessed are noted by age, gender, race/ ethnicity, and geographic distribution by county.

CANS by Age:

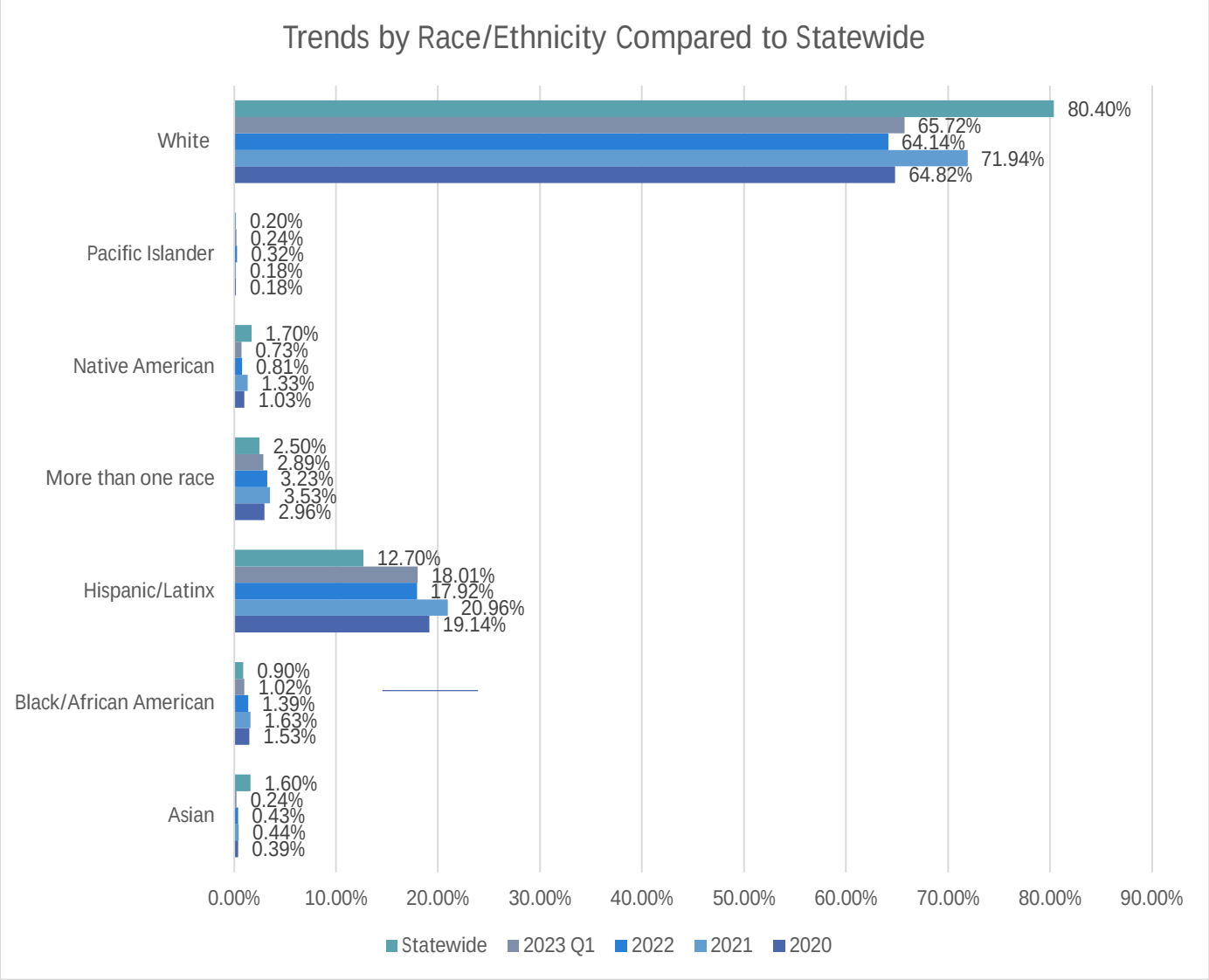
2c: Ages of children and youth who had an initial CANS



CANS by Race and Ethnicity:

The number and percentage of children and youth based on the initial CANS by Race/Ethnicity for SFY 2023 indicates that there may be some disparities in the children and youth being assessed with the CANS. Black/African American and Hispanic children and youth appear to be assessed at a higher rate than the general population percentage in Idaho. Asian and Native American children and youth appear to be underassessed.

Chart 2e : Historical Trends; Race and Ethnicity of children and youth who received an initial CANS:

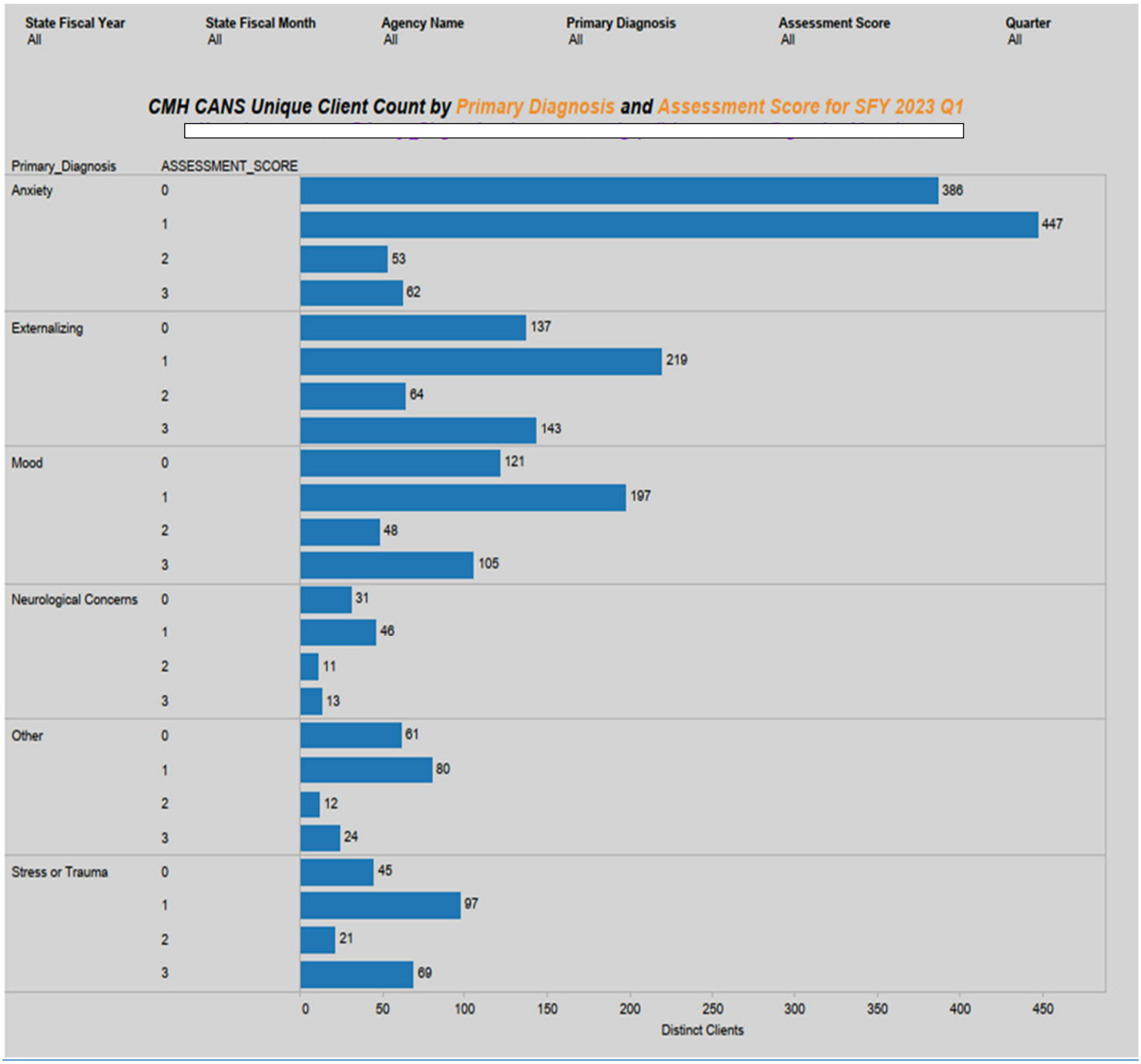


What is this data telling us?

Age- The trend has been very similar over the last three years with one noticeable dip in 2021 of 9-11 year old's.

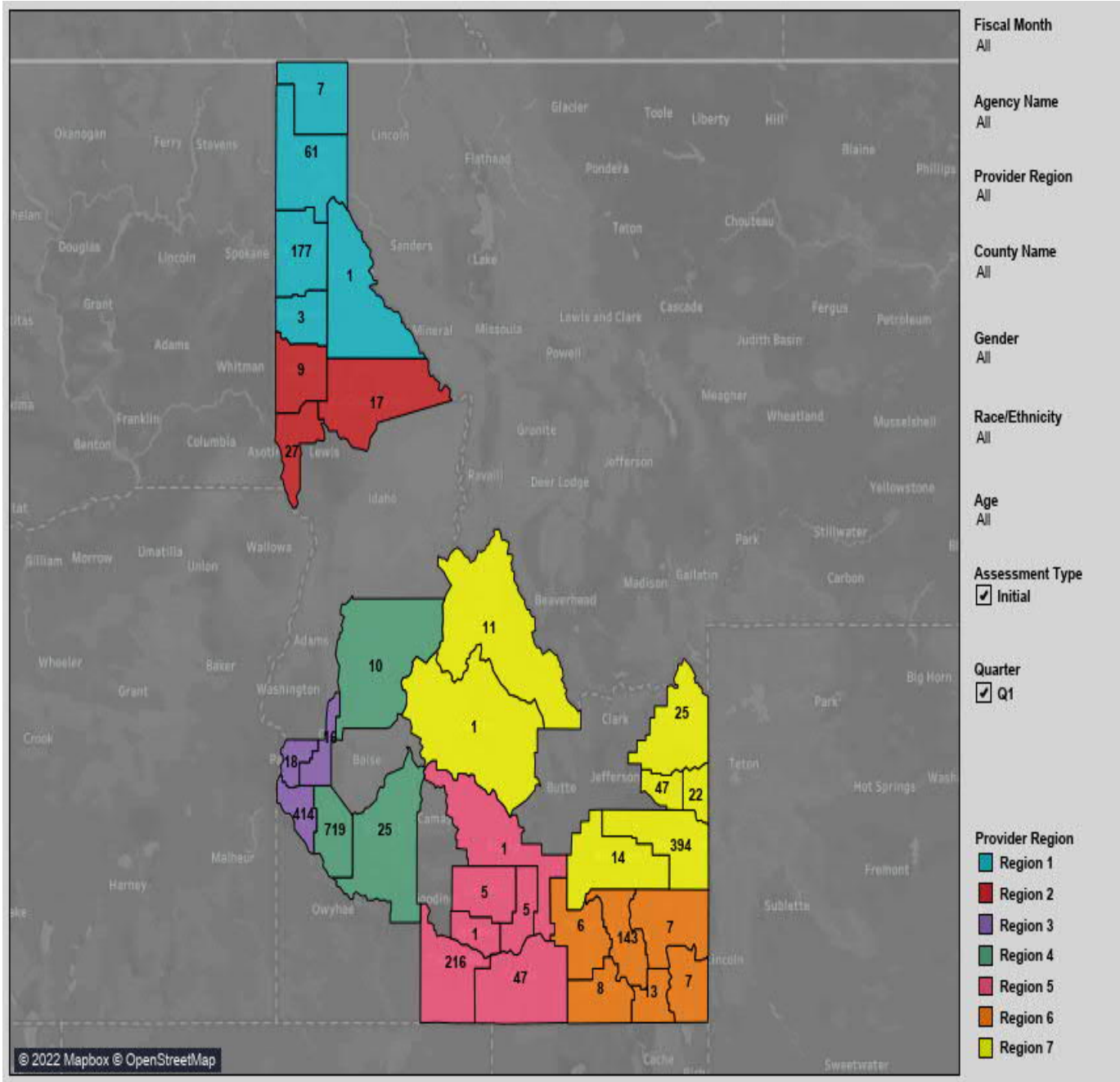
Race/Ethnicity- While the trend does not point to any majority disparities (e.g., specific racial or ethnic groups not getting a CANS) there are trends towards certain groups receiving more assessments compared to other populations (e.g., Hispanic- percent served (between 17.92% to 20.96%) is above percent of Idaho's population of Hispanic (12.70%).

CANS Diagnosis by CANS Rating



4: CANS Assessment Geographic Mapping

The map below shows the number based on the initial CANS provided in SFY 2023. In Q1 there are 11 counties with “0” completed CANS: Adams, Boise, Butte, Clark, Camas, Gooding, Idaho, Jefferson, Lewis, Owyhee, and Washington. In addition, there were 3 counites with 3 or fewer CANS.



What is this data telling us?

The number of counites in which there were no CANS assessments (11) and the number of counties in which there were 3 or fewer (5) has increased substantially. The counites in which there were no CANS or few CANS are either mostly rural or frontier counties. The geographic distribution of the initial CANS assessments indicates that there is likely to be unmet need in those regions as children and youth are not being assessed using the CANS.

Utilization of Outpatient Services-

5. Medicaid Outpatient Utilization

All Medicaid Members accessing Services by Quarter- Ages 0-17 Only

Total number of children and youth served with Medicaid Outpatient services

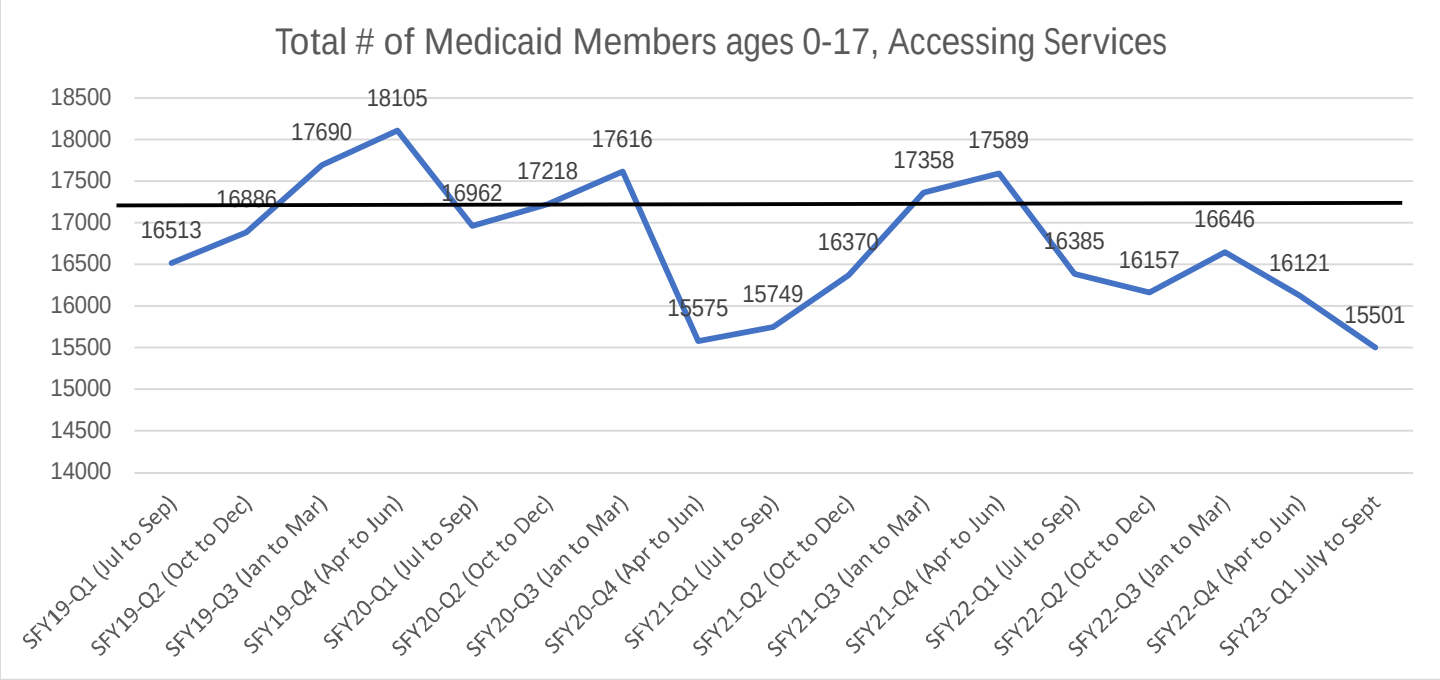
The following table combines the number of unduplicated children and youth who received Medicaid via 1915(i) and those with other types of Medicaid (regular Medicaid, Foster Care Medicaid, etc.) who accessed mental health services in SFY 2023, Q1.

5a: Total number of Medicaid members served

SFY19 -Q1 (Jul to Sep)	SFY19 -Q2 (Oct to Dec)	SFY19 -Q3 (Jan to Mar)	SFY19 -Q4 (Apr to Jun)	SFY20 -Q1 (Jul to Sep)	SFY20 -Q2 (Oct to Dec)	SFY20 -Q3 (Jan to Mar)	SFY20 -Q4 (Apr to Jun)	SFY21 -Q1 (Jul to Sep)	SFY21 -Q2 (Oct to Dec)	SFY21 -Q3 (Jan to Mar)	SFY21 -Q4 (Apr to Jun)	SFY22 -Q1 (Jul to Sep)	SFY22 -Q2 (Oct to Dec)	SFY22 -Q3 (Jan to Mar)	SFY22 -Q4 (Apr to Jun)	SFY23 - Q1 (July to Sept)
15,810	16,102	16,766	16,963	15,555	15,635	15,867	13,703	13,709	14,289	15,279	15,438	14,292	14,166	14,509	14,029	13,394
703	784	924	1142	1407	1583	1749	1872	2040	2081	2079	2151	2093	1991	2137	2092	2107
16,513	16,886	17,690	18,105	16,962	17,218	17,616	15,575	15,749	16,370	17,358	17,589	16,385	16,157	16,646	16,121	15,501

The following chart shows the quarterly trend of access to services. The median number of Medicaid members served over the past 4 years is 16,513- represented by the black line.

5b: Quarterly trend of Medicaid members accessing services



What is this data telling us?

The average number of children and youth accessing services per quarter is 16,732, and median number is 16,513 represented by the bold black line. The trend in number served has varied with the lowest numbers during the start of COVID 19.

5c: Statewide

The following table shows the outpatient services provided to Medicaid members ages 0-17 are noted by type of service and the region in which the service is delivered. The number served is SFY 2023, Q1 and is unduplicated within the specific category of services (e.g., the number children and youth who received that specific service).

Note: Data regarding utilization of services is based on Medicaid claims data.

5c1: Summary of Utilization of YES OP Services Provided by the Optum Medicaid Network by Region

SFY 2023, Q1	1	2	3	4	5	6	7	Out of state	Total
	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers	Distinct Utilizers
Assessments									
CANS- Billed to Medicaid	509	150	1,226	1,538	496	330	1,408	9	5,663
Psych and Neuropsych Testing	37	10	87	121	40	84	146	0	525
Behavior Assessment	40	0	16	46	0	0	0	0	102
Outpatient Treatment Services									
Psychotherapy	1,081	417	2,143	2,662	992	780	2,605	14	10,639
Case Management	39	28	161	272	117	98	585	0	1,297
Med Management	72	131	649	789	213	241	388	2	2,481
Skills Building (CBRS)	67	86	220	401	58	121	736	1	1,686
Targeted Care Coordination (TCC)	22	26	96	140	46	79	335	1	742
Substance Use Services	17	6	49	46	76	32	131	0	353
Child and Family Interdisciplinary Team (CFIT)	4	15	19	32	26	9	41	0	145
Skills Training and Development (STAD)	0	8	0	0	73	2	48	0	130
Behavior Modification and Consultation	60	1	25	44	1	0	0	0	130
Crisis									
Crisis Intervention	1	8	5	5	5	9	48	0	81
Crisis Psychotherapy	8	4	18	22	12	6	45	0	115
Crisis Response	4	1	2	4	1	2	9	0	23
Crisis Services	11	12	24	29	18	16	97	0	207
Intensive Outpatient Treatment Services									
TASSP[4]	0	0	0	0	0	0	19	0	19
Partial Hospitalization (PHP)	0	0	29	39	4	0	6	0	78
Day Treatment	0	0	1	1	12	1	9	0	24
IHCBS[5]	0	0	4	8	1	16	5	0	34
Support services									
Respite	1	61	70	107	27	47	146	0	459
Youth Support Services	1	8	30	101	39	19	69	0	265
Family Support	0	2	32	8	7	7	190	0	246
Family Psychoeducation	11	0	8	8	20	0	2	0	49

[4] TASSP- Therapeutic After School Support Program
[5] IHCBS - Intensive Home and Community Based Services

5c2: Medicaid Outpatient Penetration Rates by Region

"Penetration Rate", also called utilization, is calculated by dividing the number of Medicaid beneficiaries served (numerator) by the total number of Medicaid eligible members (denominator). Penetration rate tells us what percentage *of the eligible population* received a given service.

SFY 2023, Q1	Penetration Rate by Region								
	1	2	3	4	5	6	7	OOS	Total
Assessments									
CANS- Billed to Medicaid	2.1%	1.8%	2.8%	3.8%	1.7%	2.1%	3.6%	0.4%	2.8%
Psych and Neuropsych Testing	0.2%	0.1%	0.2%	0.3%	0.1%	0.5%	0.4%	0.0%	0.3%
Behavior Assessment	0.2%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
Outpatient Treatment Services									
Psychotherapy	4.5%	4.9%	5.0%	6.6%	3.5%	4.9%	6.7%	0.7%	5.3%
Case Management	0.2%	0.3%	0.4%	0.7%	0.4%	0.6%	1.5%	0.0%	0.6%
Med Management	0.3%	1.5%	1.5%	1.9%	0.8%	1.5%	1.0%	0.1%	1.2%
Skills Building (CBRS)	0.3%	1.0%	0.5%	1.0%	0.2%	0.8%	1.9%	0.0%	0.8%
Targeted Care Coordination (TCC)	0.1%	0.3%	0.2%	0.3%	0.2%	0.5%	0.9%	0.0%	0.4%
Substance Use Services	0.1%	0.1%	0.1%	0.1%	0.3%	0.2%	0.3%	0.0%	0.2%
Child and Family Interdisciplinary Team (CFIT)	0.0%	0.2%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%
Skills Training and Development (STAD)	0.0%	0.1%	0.0%	0.0%	0.3%	0.0%	0.1%	0.0%	0.1%
Behavior Modification and Consultation	0.2%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
Crisis									
Crisis Intervention	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%
Crisis Psychotherapy	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.1%
Crisis Response	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Crisis Services	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.0%	0.1%
Intensive Outpatient Treatment Services									
TASSP	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.0%	0.0%
Partial Hospitalization (PHP)	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Day Treatment	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
IHCBS	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
Support services									
Respite	0.0%	0.7%	0.2%	0.3%	0.1%	0.3%	0.4%	0.0%	0.2%
Youth Support Services	0.0%	0.1%	0.1%	0.2%	0.1%	0.1%	0.2%	0.0%	0.1%
Family Support	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.5%	0.0%	0.1%
Family Psychoeducation	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%

What is this data telling us?

Outpatient services such as CANS Assessments, Psych and Neuropsych Testing, Psychotherapy, Medication Management, Skills Building, Targeted Care Coordination, Substance Use, Crisis, Child, and Family Interdisciplinary Teams are available statewide. Outpatient services such as Behavior Assessments, Skills Training and Development (STAD), and Behavioral Modification and Consultation are not available statewide.

Intensive outpatient services such as Partial Hospitalization, Day Treatment, and Intensive Home and Community Based Services are not available statewide and overall appear to be very limited even in regions in which they are available. It is notable that intensive outpatient services in Regions 1 and 2 appear to be the most limited.

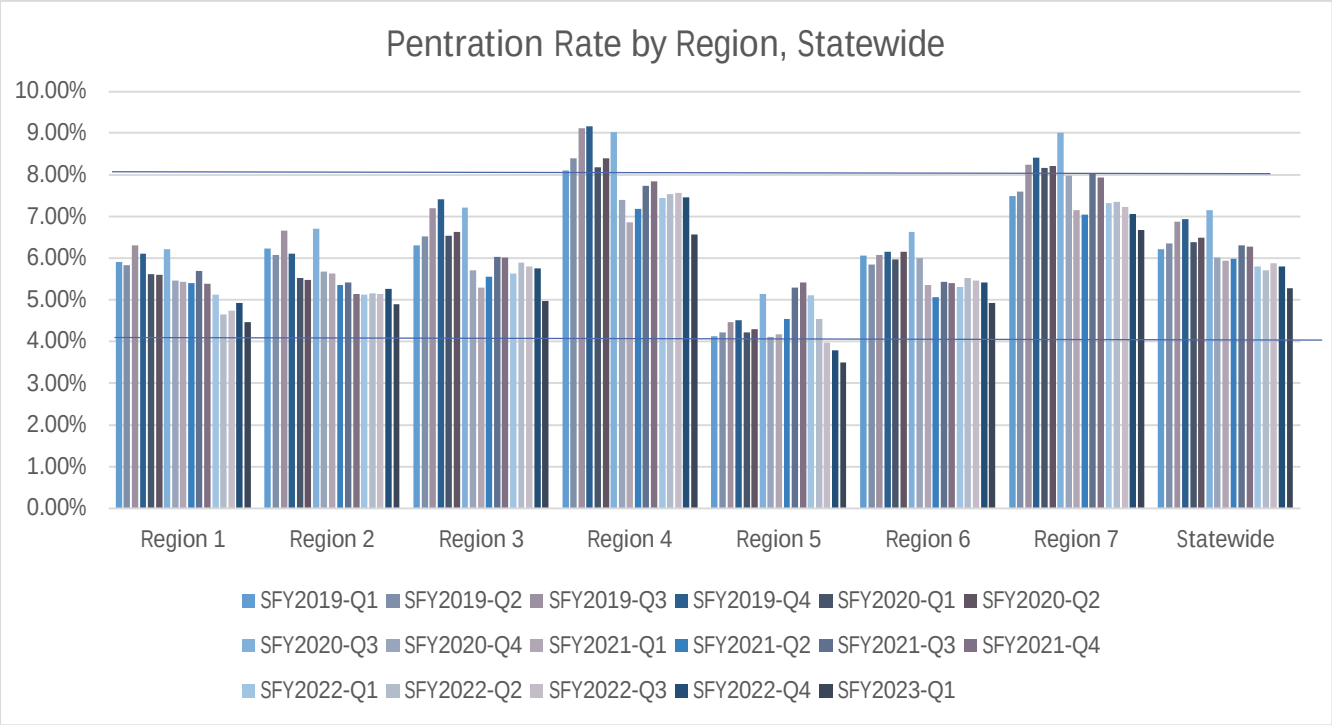
Statewide penetration rates also indicate that the most utilized services are Psychotherapy (5.3%), CANS assessment (2.8%), and Medication Management (1.2%)

5d: Targeted Service:

Analysis of targeted services by region-

- Psychotherapy
- Case Management
- Skills building : Community Based Rehabilitation Services (CBRS)
- Targeted Care Coordination (TCC)
- Intensive Home and Community Based Services (IHCBS)

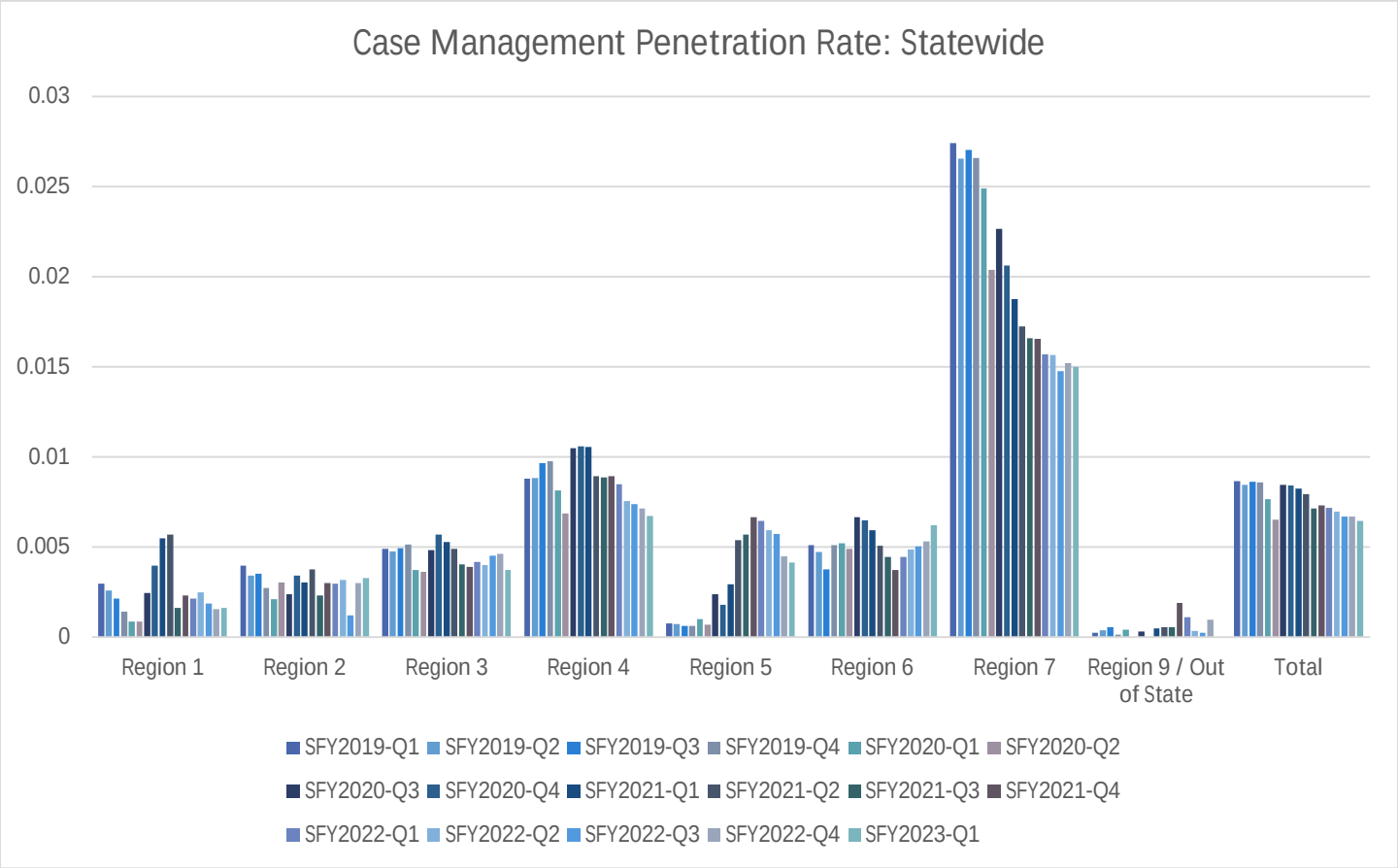
5d1: Psychotherapy



What is this data telling us?

Although penetration rates for psychotherapy are high as compared to all other outpatient services, penetration appears to be on the decline for all regions in SFY2023, Q1. Even in Regions 4 and 7 where psychotherapy penetration has at times met or closely approached the goal of 8% penetration, rates have declined sharply from their peaks. Historically, Region 5 has had lower penetration psychotherapy rates than all other regions. Further, because rates in Region 5 have followed the overall pattern of decline in recent quarters, with rates dipping below 4%, accessing this cornerstone mental health service may be especially difficult for Region 5 youth and their families.

5d2: Case Management

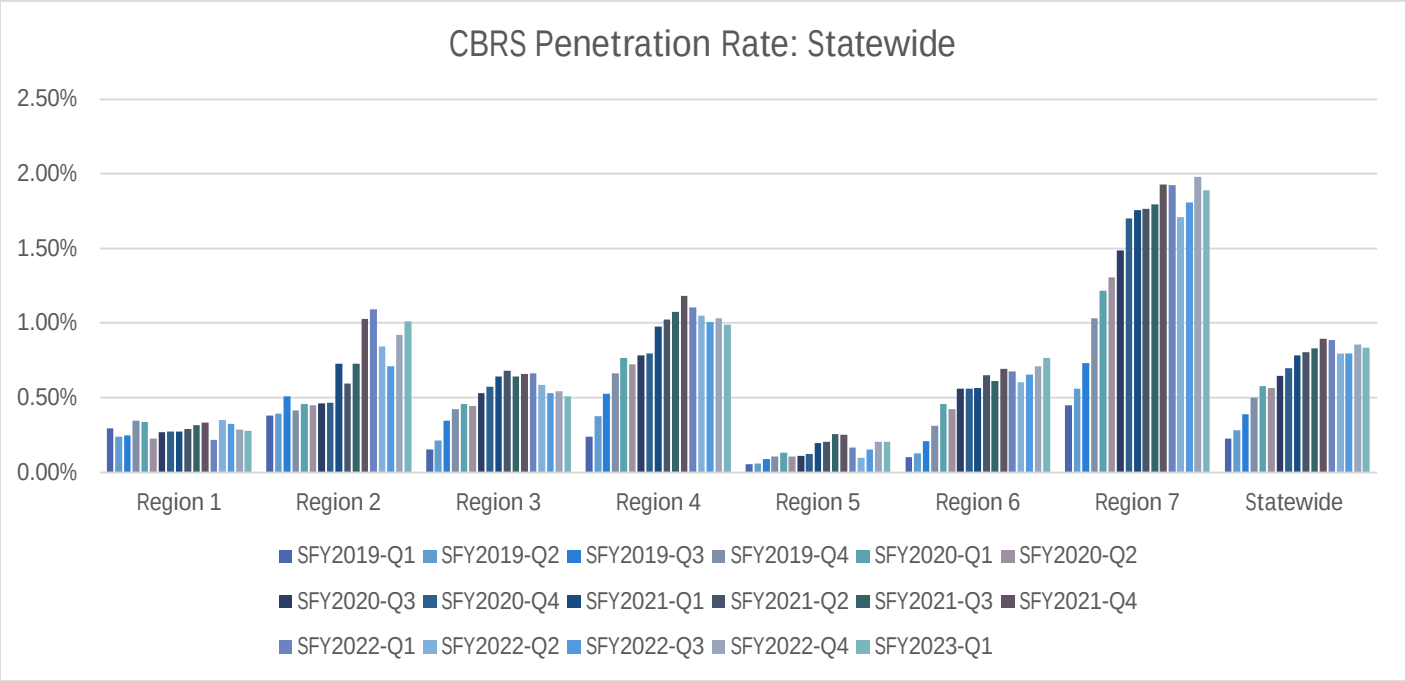


Note the scale for Case Management is less than 1%

What is this data telling us?

Historically, Case Management penetration rates have rarely exceeded one-half of one percent (0.50%) in regions 1, 2, 3, 5 and 6. While Case Management penetration rates have been higher in Region 4 (close to 1.00% in some quarters) and in Region 7 (peaking at 2.7% in SFY 2019), rates have declined in these two regions in recent quarters. Defining a target Case Management penetration rate and understanding how Case Management services may be linked to CANS ratings may be useful steps to consider if it is determined this service should be utilized at higher rates.

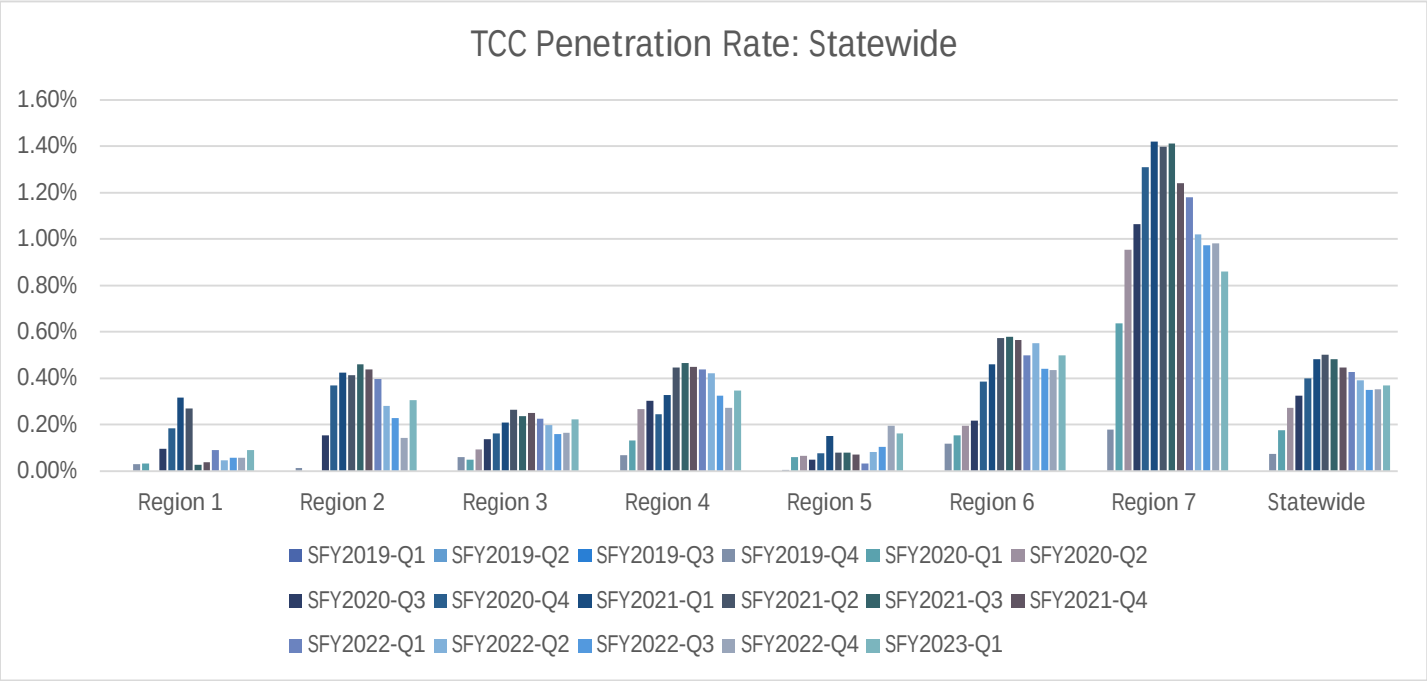
5d3: Skills Building: CBRS



What is this data telling us?

Skills building (CBRS) penetration rates have remained noticeably and persistently low in regions 1 and 5, never exceeding one-half of one percent. While other regions have somewhat higher skills building penetration rates, only Region 7 has approached 2.0% penetration in this service area. The development of strengths/skills has been linked to need reduction. As such, regional discrepancies in skills building (CBRS) penetration may need to become a focus area and strategies to ensure more youth receive these services may be a useful focal area for the YES system of care.

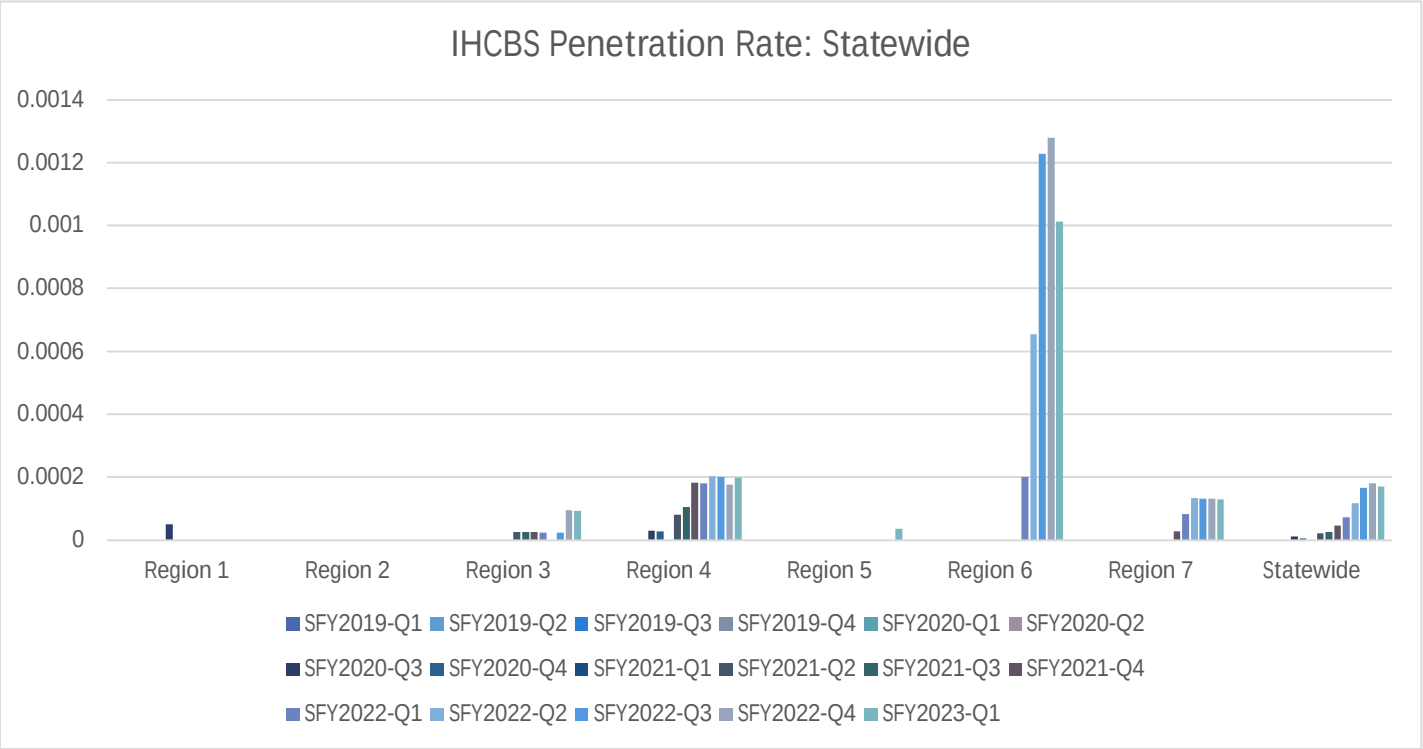
5f4: Targeted Care Coordination: TCC



What is this data telling us?

Targeted Care Coordination (TCC) penetration rates are very low in all regions except Region 7. The overall penetration rate patterns for TCC at the regional level closely mirror those of skills building (CBRS) but with lower penetration across all regions, except Region 6.

5d5:Intensive Home and Community Based Services: IHCBS



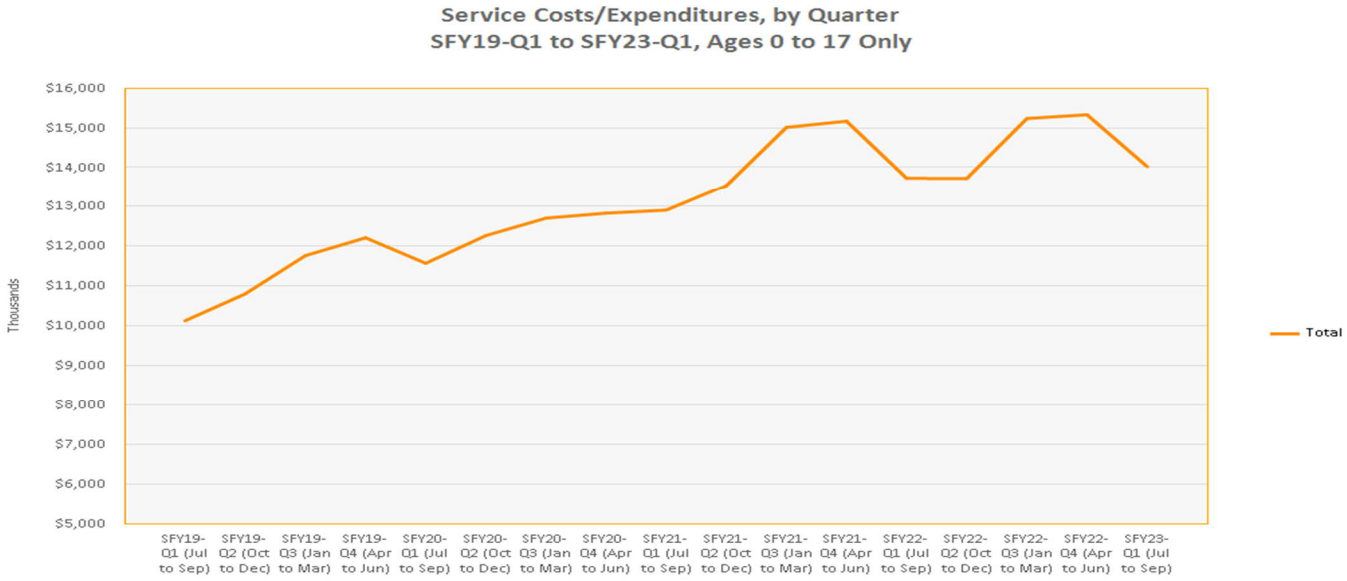
What is this data telling us?

The penetration rates for Intensive Home/Community-Based Services are exceeding low in all regions and across all quarters. Even in Region 6 where these services are most used utilized, penetration does not approach one-quarter of one percent (0.25%) during any quarter.

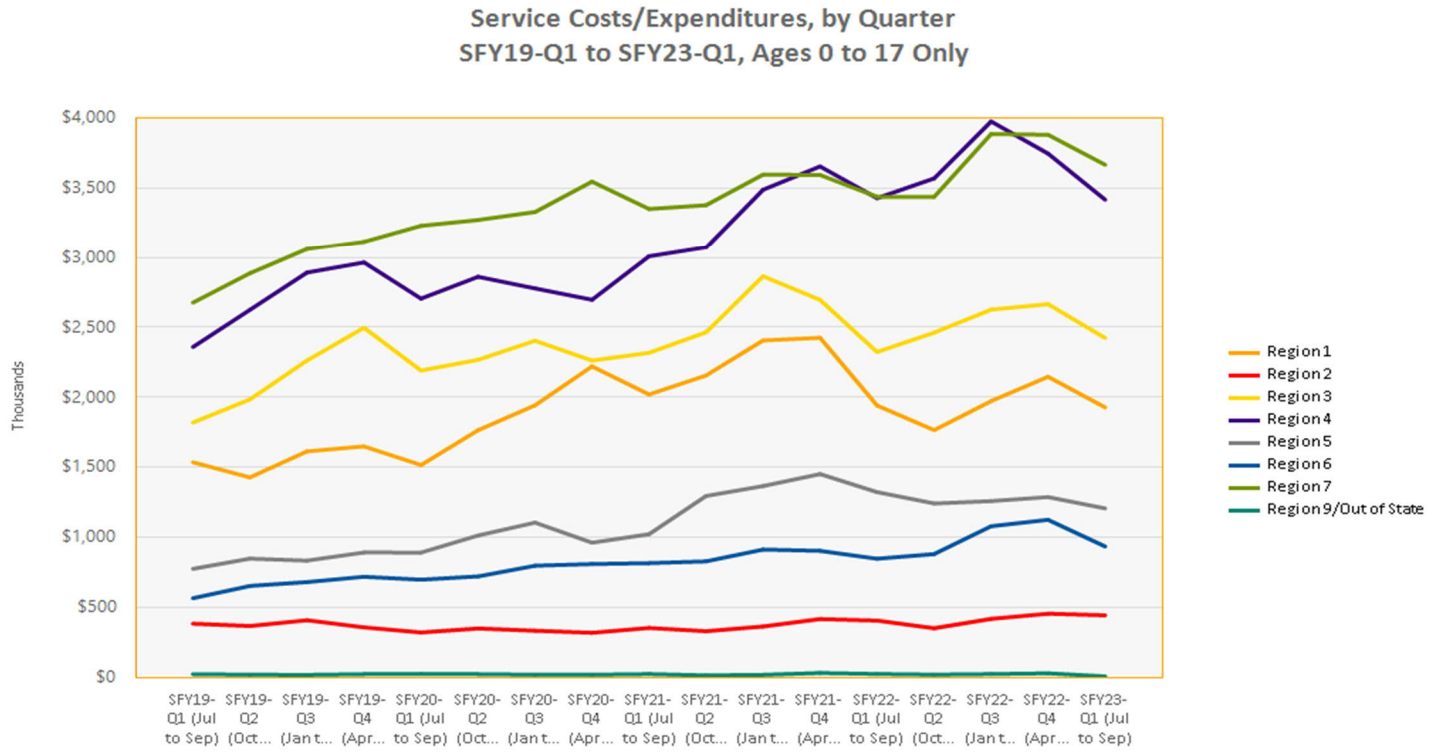
5e: YES Medicaid Expenditures

The following is the Medicaid Outpatient Expenditures as of the report run date (8/4/2022) and represents the total dollars paid for services rendered to members between the ages of 0 to 17 by region by quarter.

5e1: Medicaid Outpatient Expenditures by Quarter



5e2 Medicaid Outpatient Expenditures by Region



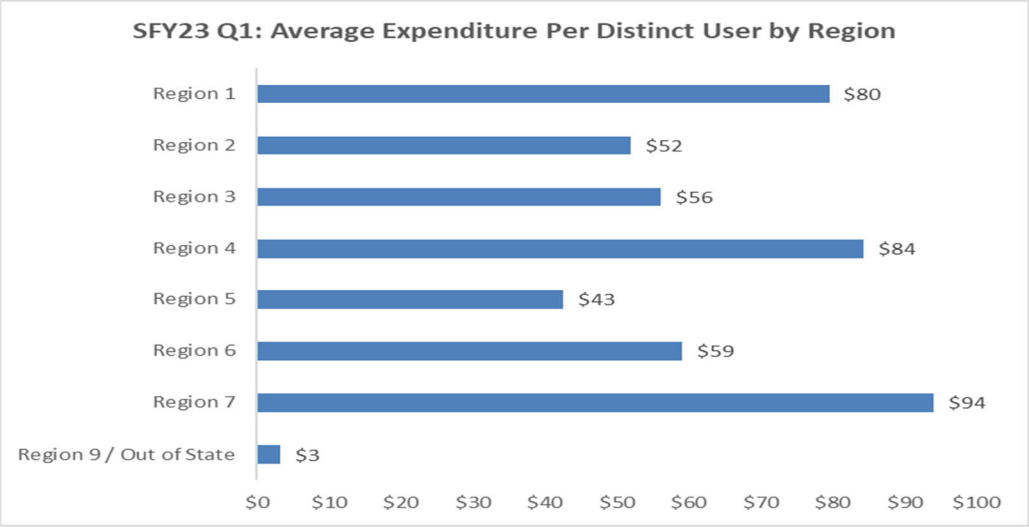
5e3: Regional comparison of Outpatient expenditures

	Total Distinct Members SFY 23-Q1 (July-Sept)	Expenditures SFY 23-Q1 (July-Sept)	$ per Distinct User	% Distinct User	% Expenditures
Region 1	24,245	$1,927,426.38	$79.50	12.0%	13.7%
Region 2	8,517	$442,591.74	$51.97	4.2%	3.2%
Region 3	43,124	$2,422,926.30	$56.19	21.4%	17.3%
Region 4	40,520	$3,416,679.67	$84.32	20.1%	24.4%
Region 5	28,360	$1,205,837.77	$42.52	14.1%	8.6%
Region 6	15,816	$934,016.05	$59.06	7.8%	6.7%
Region 7	38,996	$3,665,249.01	$93.99	19.3%	26.1%
Region 9/Out of State	2,121	$6,864.37	$3.24	1.1%	0.0%
Total	201,699	$14,021,591.29	$69.52	100.0%	100.0%
QoQ Change	0.6%	-8.5%			
YoY Change	2.8%	2.2%			

What is this data telling us?

Resources are not being distributed equitably across all geographic regions in Idaho. Dollar amounts spent vary dramatically with as little as $43 per person in Region 5 and as much as $94 per person in Region 7 (see 5g). Ideally, regional percentages of distinct utilizers should be very close to regional expenditure percentages. However, there are substantial mismatches (defined for the purposes of this report as greater than a 2% difference between percentages of distinct utilizers and expenditures) in four regions. Regions 3 and 5 are under-resourced (red font) while regions 4 and 7 receive higher percentages of system-wide expenditures than their distinct user populations suggest they should (blue font).

5e4: Average Expenditure per User by Region



5f: Medicaid Outpatient Service Utilization and Service Use Rates: Regional Snapshots SFY2023 - Q1

The following region-by-region tables display distinct number of members served through the Medicaid Network between the ages of 0 and 17 for Quarter 1 of state fiscal year 2023 (July, August, and September 2022). Services that are not covered by Optum (such as DBH services, Residential or Inpatient) are noted in Sections 6, 7 and 8.

Note: Data on utilization is based on claims made by providers. Providers have several months to claim payment for the services and therefore the data reported may not be updated in each quarter. The change ranges between a 3% from one quarter to the following quarter, to less than 1% from one year to the previous year (and these percentages vary by service).

New Data: Monitoring by Penetration and Service Use Rates

Two new data elements (penetration rate and service use rate) have been added to the QMIA-Q for SFY 2023. These rates facilitate comparisons between regions because they are standardized rather than based on counts of the number served.

"Penetration Rate", also called utilization, is calculated by dividing the number of Medicaid beneficiaries served (numerator) by the total number of Medicaid eligible members (denominator). Penetration rate tells us what percentage *of the eligible population* received a given service.

One example of this data is included below. Based on the predictive models for Idaho, the penetration rate for psychotherapy that is desired is at least 8% (based on expected prevalence of SED) . Over the past 16 quarters, the median[2] rate has been 6.25%.

Currently the penetration rate is trending down. The high of 7.2% was in Q3 of 2020 and there have been 9 quarters of lower rates since that time. The decrease is most likely due to workforce shortages across the state.

"Service Use Rate" is calculated by dividing the number of Medicaid beneficiaries who received a particular service (numerator) by the number of Medicaid beneficiaries receiving any service (denominator). Service Use Rate tells us what percentage *of total youth receiving services* received a given service.

Service Use Rates are presented in the new Regional Profiles section. They aid understanding of what services youth in the system of care are receiving and facilitate regional comparisons. For example, of all the youth who received services in Region 7, 16.1% were provided Case Management while just 2.4% of the youth receiving services in Region 1 were provided Case Management. The respective Case Management penetration rates, 1.5% for Regions 7 and 0.2% for Region 1, reveal the same pattern but service use rates highlight the differences between regions more profoundly.

Region 1

Counties: Benewah, Bonner, Boundary, Kootenai, and Shoshone (Panhandle)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 24,245 (12% of total Medicaid eligible members statewide)

Expenditures: $1,927,426.38 (13.7% of total expenditures statewide)

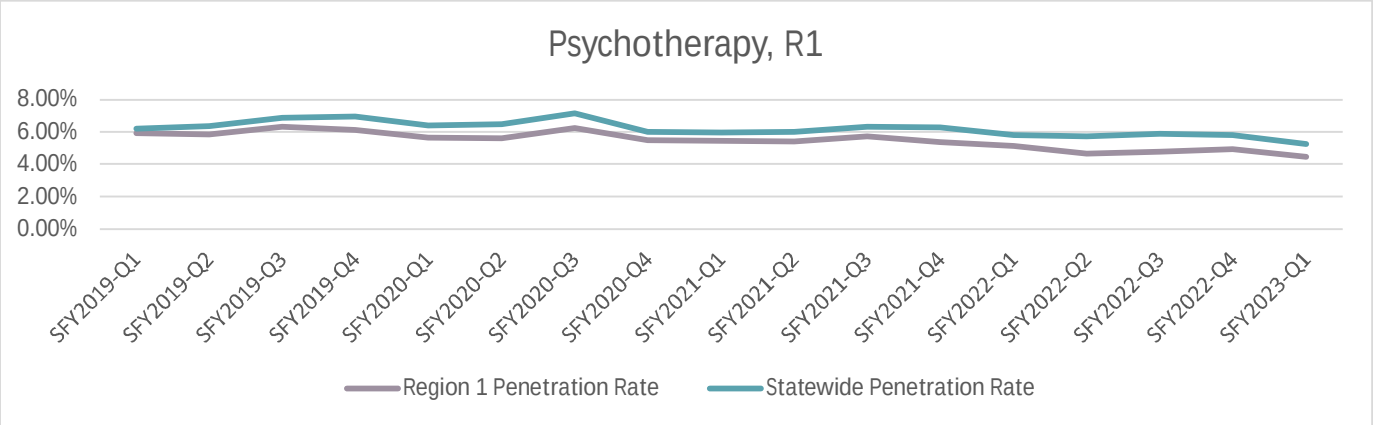
Expenditures per Medicaid Eligible Member: $79.50

Medicaid Eligible Members Receiving Any Service(s): 1,646

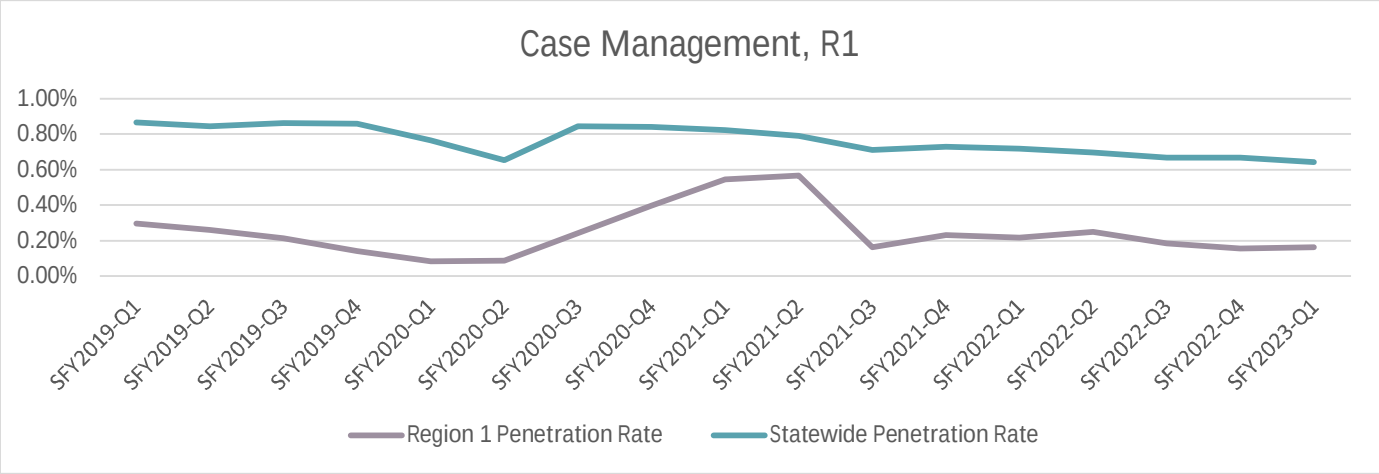
SFY 2023, Q1	Region 1			*Statewide*	
	Distinct Utilizers	Service Use Rate	Penetration Rate	*Service Use Rate*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	509	30.9%	2.1%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	37	2.2%	0.2%	*3.4%*	*0.3%*
Behavior Assessment	40	2.4%	0.2%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	1081	65.7%	4.5%	*68.6%*	*5.3%*
Case Management	39	2.4%	0.2%	*8.4%*	*0.6%*
Med Management	72	4.4%	0.3%	*16.0%*	*1.2%*
Skills Building (CBRS)	67	4.1%	0.3%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	22	1.3%	0.1%	*4.8%*	*0.4%*
Substance Use Services	17	1.0%	0.1%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	4	0.2%	0.0%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	0	0.0%	0.0%	*0.8%*	*0.1%*
Behavior Modification and Consultation	60	3.6%	0.2%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	1	0.1%	0.0%	*0.5%*	*0.0%*
Crisis Psychotherapy	8	0.5%	0.0%	*0.7%*	*0.1%*
Crisis Response	4	0.2%	0.0%	*0.1%*	*0.0%*
Crisis Services	11	0.7%	0.0%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
Therapeutic After School (TASSP)	0	0.0%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	0	0.0%	0.0%	*0.5%*	*0.0%*
Day Treatment	0	0.0%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	0	0.0%	0.0%	*0.2%*	*0.0%*
Support services					
Respite	1	0.1%	0.0%	*0.2%*	*3.0%*
Youth Support Services	1	0.1%	0.0%	*1.7%*	*0.1%*
Family Support	0	0.0%	0.0%	*1.6%*	*0.1%*
Family Psychoeducation	11	0.7%	0.0%	*0.3%*	*0.0%*

Regional Trends for Targeted Services-R1

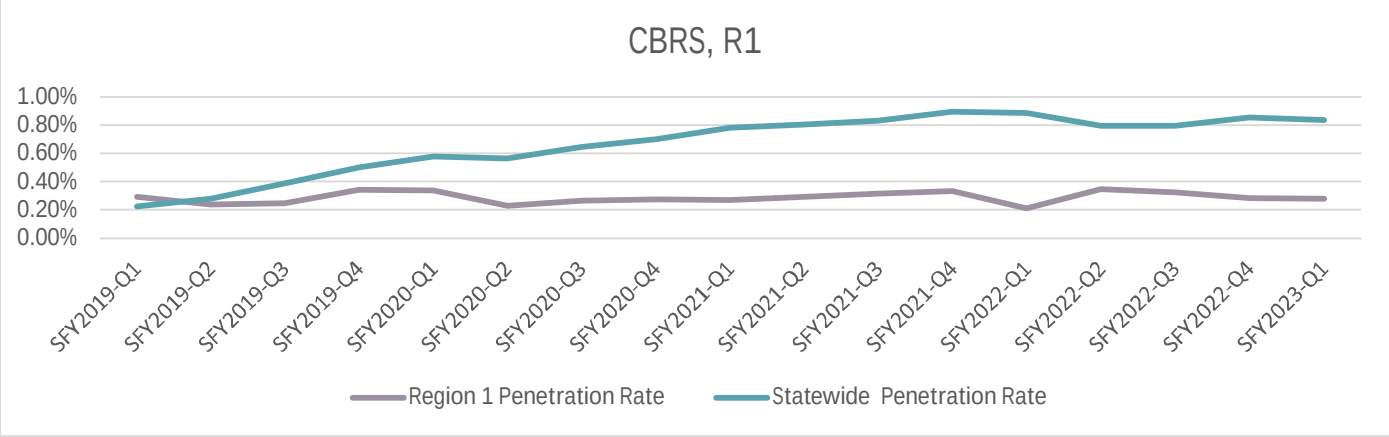
Psychotherapy



Case Management



CBRS



What is this data telling us?

Region 1 receives more expenditures (13.7% of total state expenditures) than its statewide share of the Medicaid Eligible population (12%). While Psychotherapy penetration rates in Region 1 have closely mirrored statewide penetration, Case Management and CBRS penetration rates have historically lagged behind the statewide rate indicating there is a potential need to understand why these services are being under-utilized in Northern Idaho.

Region 2

Latah, Clearwater, Nez Perce, Lewis, and Idaho counties (North Central)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 8,517 (4.2% of total Medicaid eligible members statewide)

Expenditures: $442,591.74 (3.2% of total expenditures statewide)

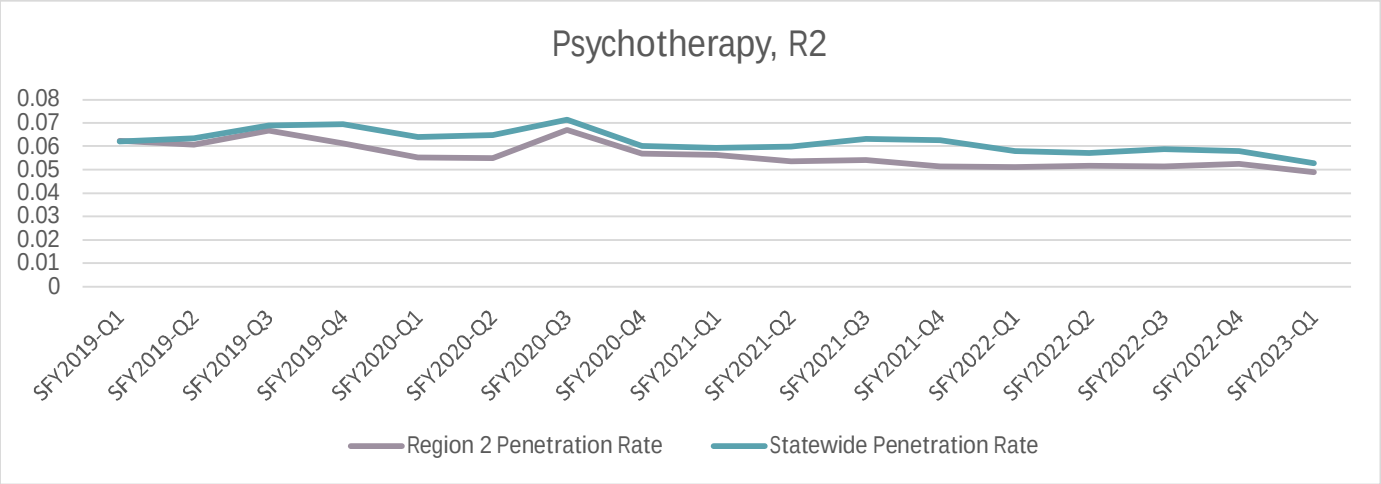
Expenditures per Medicaid Eligible Member: $51.97

Medicaid Eligible Members Receiving Any Service(s): 561

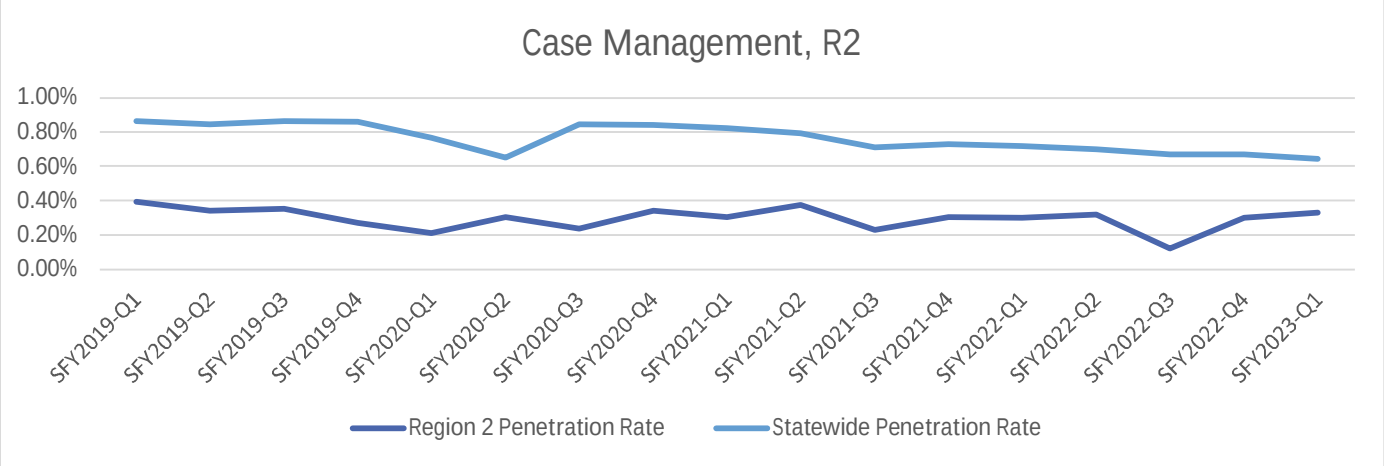
SFY 2023, Q1	Region 2			*Statewide*	
	Distinct Utilizers	% service used	Penetration Rate	*% service used*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	150	26.7%	1.8%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	10	1.8%	0.1%	*3.4%*	*0.3%*
Behavior Assessment	0	0.0%	0.0%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	417	74.3%	4.9%	*68.6%*	*5.3%*
Case Management	28	5.0%	0.3%	*8.4%*	*0.6%*
Med Management	649	23.4%	1.5%	*16.0%*	*1.2%*
Skills Building (CBRS)	86	15.3%	1.0%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	26	4.6%	0.3%	*4.8%*	*0.4%*
Substance Use Services	6	1.1%	0.1%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	15	2.7%	0.2%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	8	1.4%	0.1%	*0.8%*	*0.1%*
Behavior Modification and Consultation	1	0.2%	0.0%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	8	1.4%	0.1%	*0.5%*	*0.0%*
Crisis Psychotherapy	4	0.7%	0.0%	*0.7%*	*0.1%*
Crisis Response	1	0.2%	0.0%	*0.1%*	*0.0%*
Crisis Services	12	2.1%	0.1%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
TASSP	0	0.0%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	0	0.0%	0.0%	*0.5%*	*0.0%*
Day Treatment	0	0.0%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	0	0.0%	0.0%	*0.2%*	*0.0%*
Support services					
Respite	61	10.9%	0.7%	*3.0%*	*0.2%*
Youth Support Services	8	1.4%	0.1%	*1.7%*	*0.1%*
Family Support	2	0.4%	0.0%	*1.6%*	*0.1%*
Family Psychoeducation	0	0.0%	0.0%	*0.3%*	*0.0%*

Trends for Targeted Services-R2

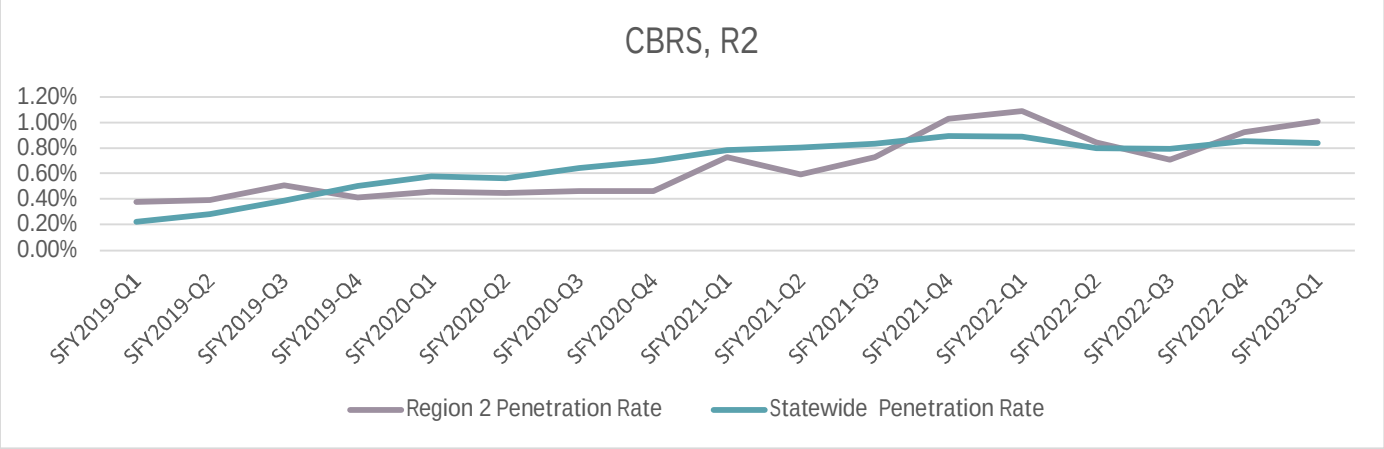
Psychotherapy



Case Management



CBRS



What is this data telling us?

Region 2 receives less expenditures (3.2% of total state expenditures) than its statewide share of the Medicaid Eligible population (4.2%). Further, Region 2 is among the regions with the lowest average dollars spent per eligible member at $52. Psychotherapy penetration rates in Region 2 have historically been slightly lower than the statewide average. Trends for Case Management penetration and CBRS are strikingly different in Region 2 with CBRS closely mirroring, and at times exceeding the statewide average, while Case Management penetration rate in Region 2 has consistently lagged when compared to the statewide average.

Region 3

Adams, Washington, Payette, Gem, Canyon, and Owyhee counties (Southwest)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 43,124 (21.4% of total Medicaid eligible members statewide)

Expenditures: $2,422,926.30 (17.3% of total expenditures statewide)

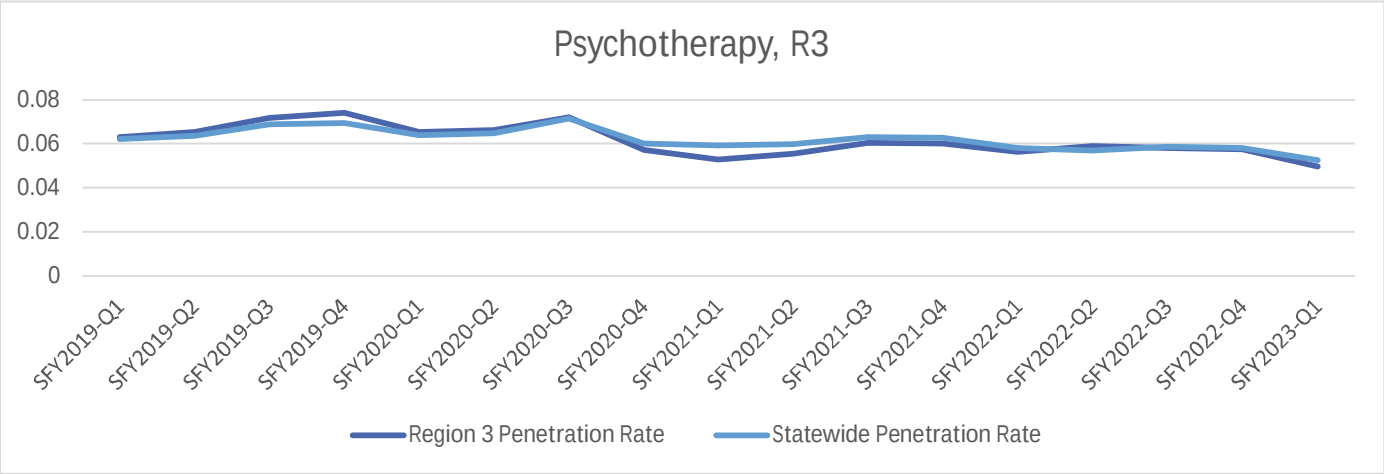
Expenditures per Medicaid Eligible Member: $56.19

Medicaid Eligible Members Receiving Any Service(s): 3,185

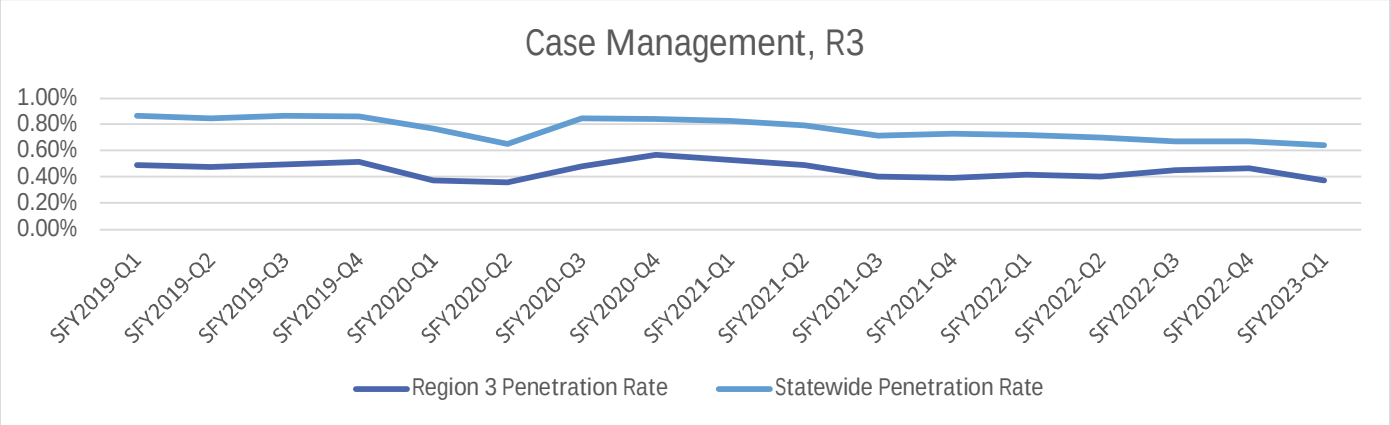
SFY 2023, Q1	Region 3			*Statewide*	
	Distinct Utilizers	% service used	Penetration Rate	*% service*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	1226	38.5%	2.8%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	87	2.7%	0.2%	*3.4%*	*0.3%*
Behavior Assessment	16	0.5%	0.0%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	2143	67.3%	5.0%	*68.6%*	*5.3%*
Case Management	161	5.1%	0.4%	*8.4%*	*0.6%*
Med Management	649	20.4%	1.5%	*16.0%*	*1.2%*
Skills Building (CBRS)	220	6.9%	0.5%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	96	3.0%	0.2%	*4.8%*	*0.4%*
Substance Use Services	49	1.5%	0.1%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	19	0.6%	0.0%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	0	0.0%	0.0%	*0.8%*	*0.1%*
Behavior Modification and Consultation	25	0.8%	0.1%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	5	0.2%	0.0%	*0.5%*	*0.0%*
Crisis Psychotherapy	18	0.6%	0.0%	*0.7%*	*0.1%*
Crisis Response	2	0.1%	0.0%	*0.1%*	*0.0%*
Crisis Services	24	0.8%	0.1%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
TASSP	0	0.0%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	29	0.9%	0.1%	*0.5%*	*0.0%*
Day Treatment	1	0.0%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	4	0.1%	0.0%	*0.2%*	*0.0%*
Support services					
Respite	70	2.2%	0.2%	*3.0%*	*0.2%*
Youth Support Services	30	0.9%	0.1%	*1.7%*	*0.1%*
Family Support	32	1.0%	0.1%	*1.6%*	*0.1%*
Family Psychoeducation	8	0.3%	0.0%	*0.3%*	*0.0%*

Trends for Targeted Services-R3

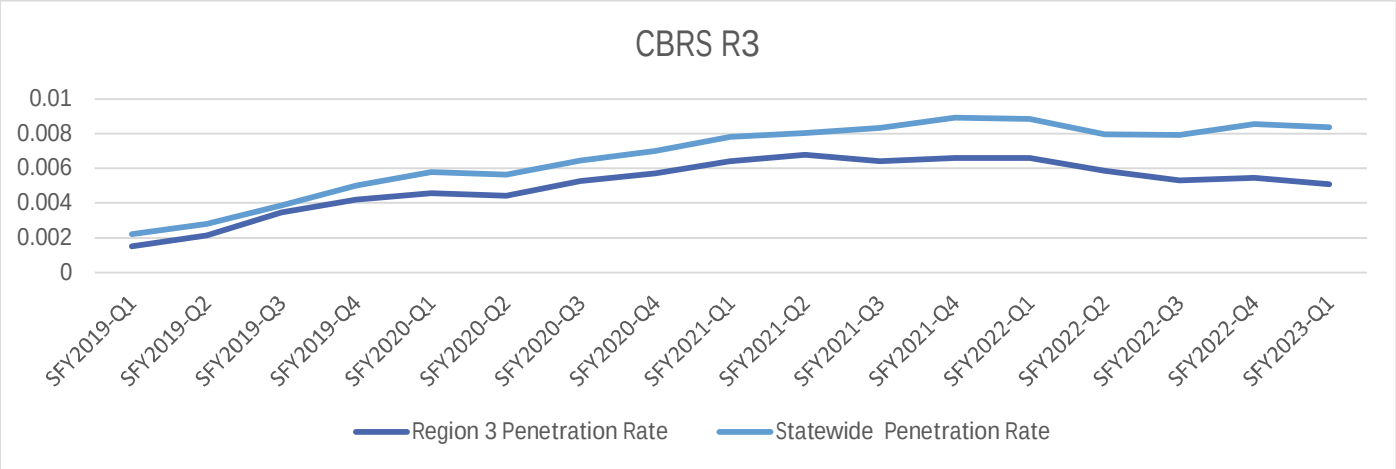
Psychotherapy



Case Management



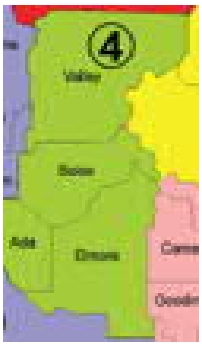
CBRS



What is this data telling us?

Region 3 receives substantially less expenditures (17.3% of total state expenditures) than its statewide share of the Medicaid Eligible population (21.4%) and is also a region with low average dollars spent per eligible member ($56). Historically, Psychotherapy penetration rates in Region 3 are extremely close to the statewide average. However, Case Management and CBRS penetration rates in Region 3 are consistently lower than the statewide averages suggested youth in Region 3 have less access to key services than youth who reside elsewhere in Idaho.

Region 4



Valley, Boise, Ada, and Elmore counties (Central)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 40,520 (20.1% of total Medicaid eligible members statewide)

Expenditures: $3,416,679.67 (24.4% of total expenditures statewide)

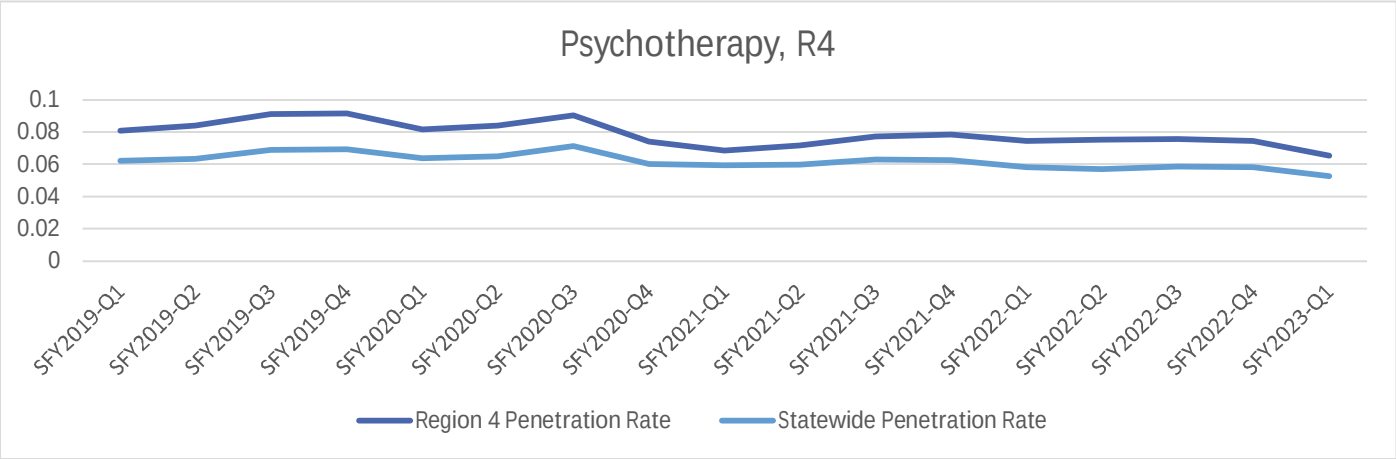
Expenditures per Medicaid Eligible Member: $84.32

Medicaid Eligible Members Receiving Any Service(s): 3,761

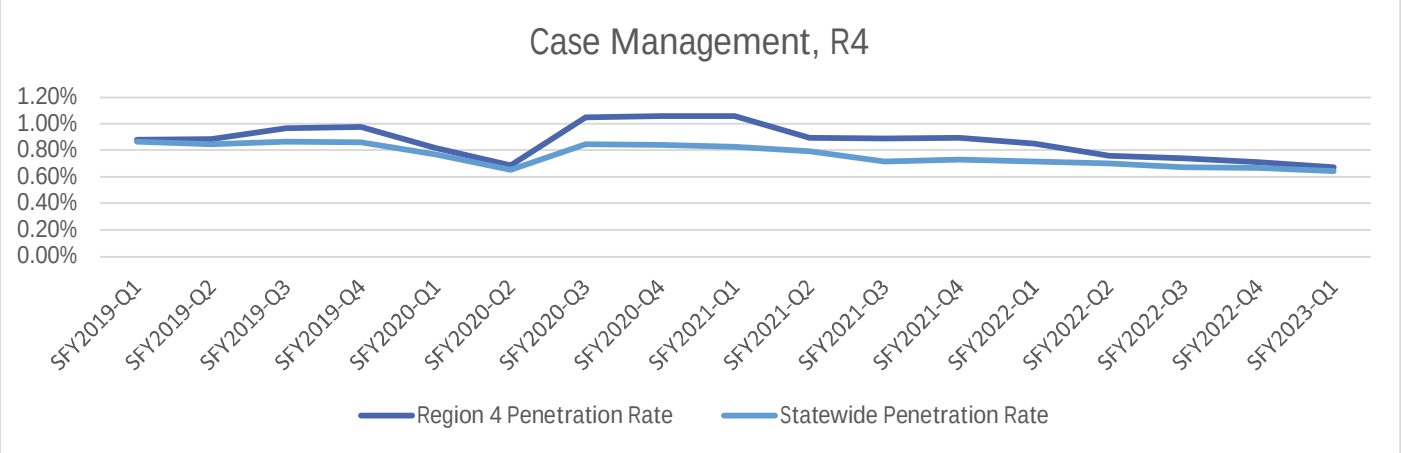
SFY 2023, Q1	Region 4			*Statewide*	
	Distinct Utilizers	% service used	Penetration Rate	*% service used*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	3761	40.9%	3.8%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	121	3.2%	0.3%	*3.4%*	*0.3%*
Behavior Assessment	46	1.2%	0.1%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	2662	70.8%	6.6%	*68.6%*	*5.3%*
Case Management	272	7.2%	0.4%	*8.4%*	*0.6%*
Med Management	789	21.0%	1.9%	*16.0%*	*1.2%*
Skills Building (CBRS)	401	10.7%	1.0%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	140	3.7%	0.3%	*4.8%*	*0.4%*
Substance Use Services	46	1.2%	0.1%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	32	0.9%	0.1%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	0	0.0%	0.0%	*0.8%*	*0.1%*
Behavior Modification and Consultation	44	1.2%	0.1%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	5	0.1%	0.0%	*0.5%*	*0.0%*
Crisis Psychotherapy	22	0.6%	0.1%	*0.7%*	*0.1%*
Crisis Response	4	0.1%	0.0%	*0.1%*	*0.0%*
Crisis Services	29	0.8%	0.1%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
TASSP	0	0.0%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	39	1.0%	0.1%	*0.5%*	*0.0%*
Day Treatment	1	0.0%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	8	0.2%	0.0%	*0.2%*	*0.0%*
Support services					
Respite	107	2.8%	0.3%	*3.0%*	*0.2%*
Youth Support Services	101	2.7%	0.2%	*1.7%*	*0.1%*
Family Support	8	0.2%	0.0%	*1.6%*	*0.1%*
Family Psychoeducation	8	0.2%	0.0%	*0.3%*	*0.0%*

Trends for Targeted Services-R4

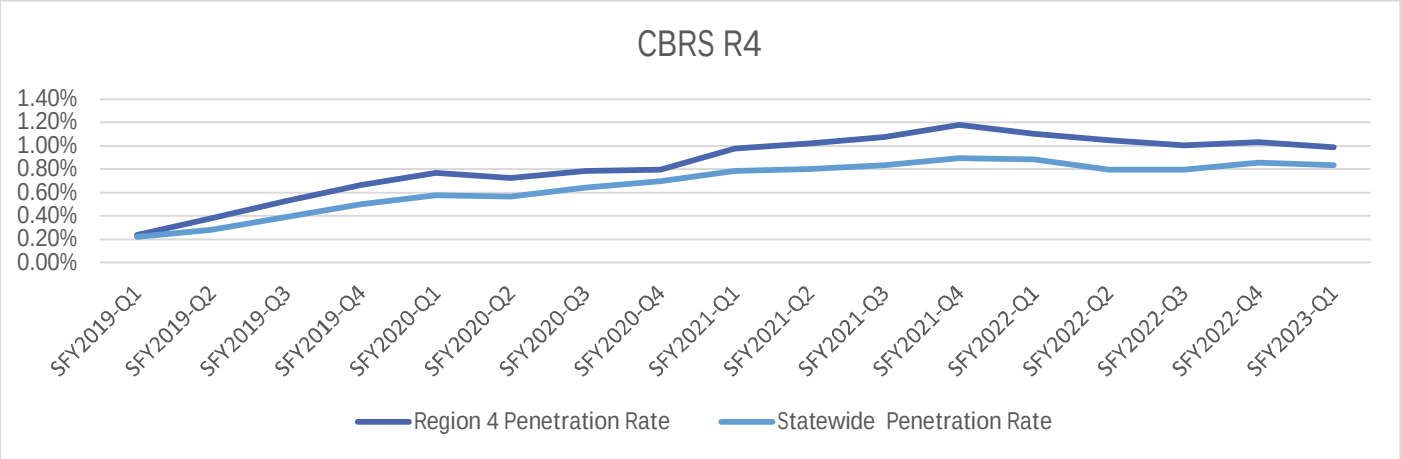
Psychotherapy



Case Management



CBRS



What is this data telling us?

Region 4 receives substantially more expenditures (24.4% of total state expenditures) than its statewide share of the Medicaid Eligible population (20.1%). Region 4 has the second highest average dollars spent per eligible member ($84). Penetration rates trends for Psychotherapy, Case Management, and CBRS all follow a similar pattern of consistently exceeding average statewide penetration over time.

Region 5

Camas, Blaine, Gooding, Lincoln, Jerome, Minidoka, Twin Falls, and Cassia counties (South Central)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 28,360 (14.1% of total Medicaid eligible members statewide)

Expenditures: $1,205,837.77 (8.6% of total expenditures statewide)

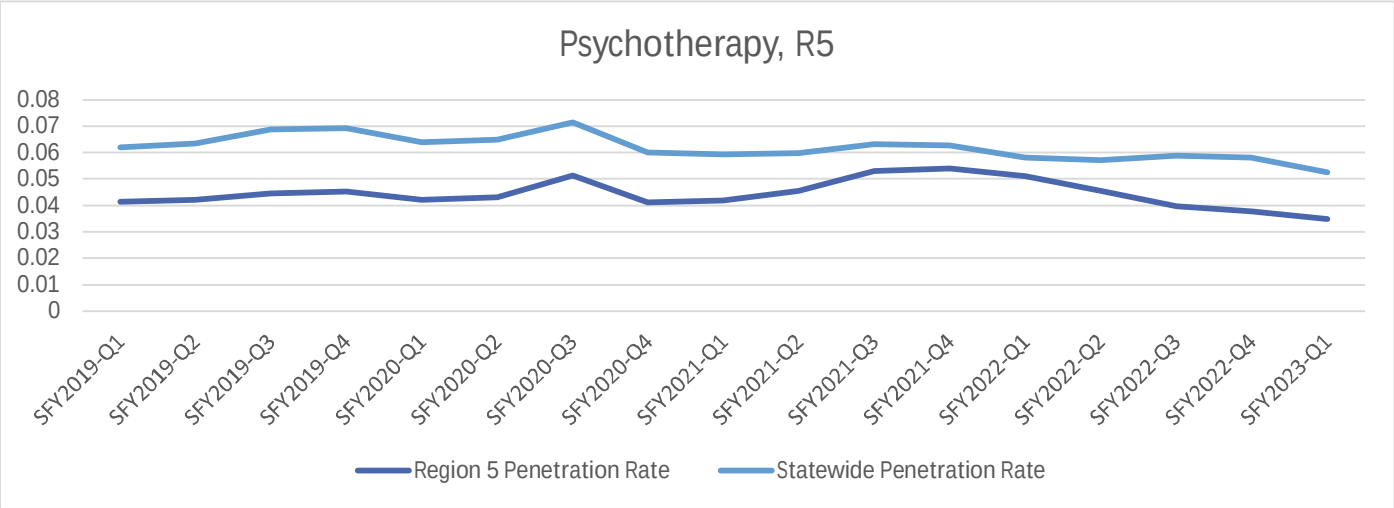
Expenditures per Medicaid Eligible Member: $42.52

Medicaid Eligible Members Receiving Any Service(s): 1,485

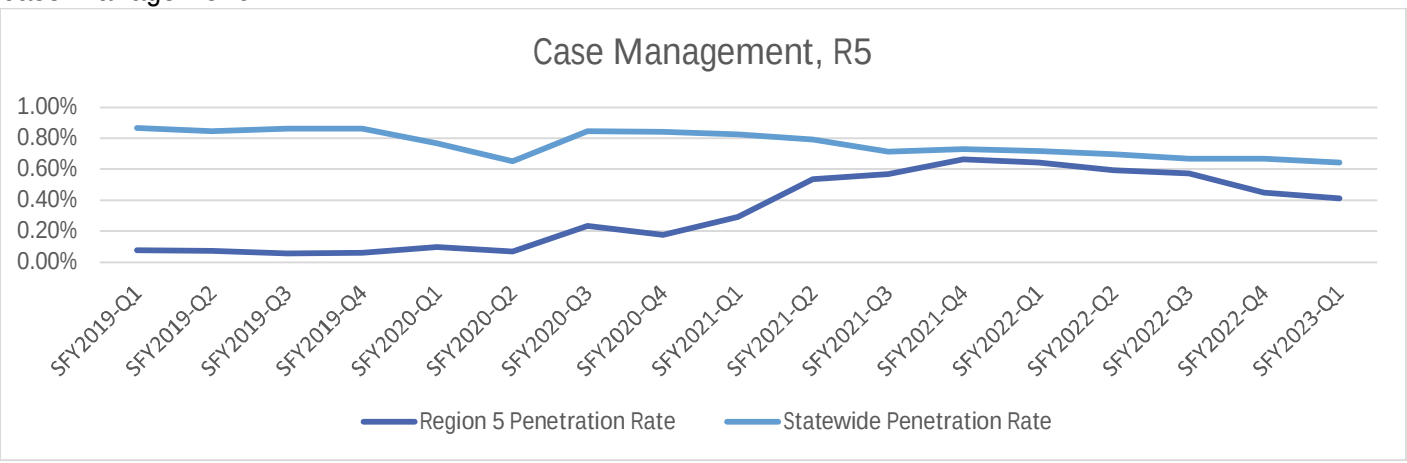
SFY 2023, Q1	Region 5			*Statewide*	
	Distinct Utilizers	% service used	Penetration Rate	*% service used*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	496	33.4%	1.7%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	40	2.7%	0.1%	*3.4%*	*0.3%*
Behavior Assessment	0	0.0%	0.0%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	992	66.8%	3.5%	*68.6%*	*5.3%*
Case Management	117	7.9%	0.4%	*8.4%*	*0.6%*
Med Management	213	14.3%	0.8%	*16.0%*	*1.2%*
Skills Building (CBRS)	58	3.9%	0.2%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	46	3.1%	0.2%	*4.8%*	*0.4%*
Substance Use Services	76	5.1%	0.3%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	26	1.8%	0.1%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	73	4.9%	1.3%	*0.8%*	*0.1%*
Behavior Modification and Consultation	1	0.1%	0.0%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	5	0.3%	0.0%	*0.5%*	*0.0%*
Crisis Psychotherapy	12	0.8%	0.0%	*0.7%*	*0.1%*
Crisis Response	1	0.1%	0.0%	*0.1%*	*0.0%*
Crisis Services	18	1.2%	0.1%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
TASSP	0	0.0%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	4	0.3%	0.0%	*0.5%*	*0.0%*
Day Treatment	12	0.8%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	1	0.1%	0.0%	*0.2%*	*0.0%*
Support services					
Respite	27	1.8%	0.1%	*3.0%*	*0.2%*
Youth Support Services	39	2.6%	0.1%	*1.7%*	*0.1%*
Family Support	7	0.5%	0.0%	*1.6%*	*0.1%*
Family Psychoeducation	20	1.3%	0.1%	*0.3%*	*0.0%*

Trends for Targeted Services-R5

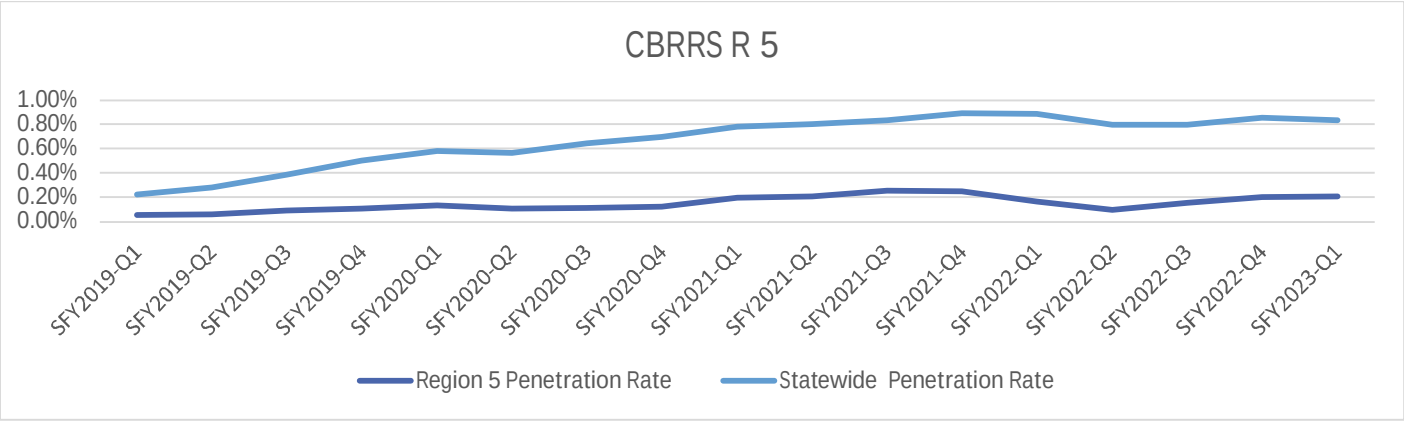
Psychotherapy



Case Management



CBRS



What is this data telling us?

Average dollars spent per eligible member in Region 5 ($43) are less than half of Region's 7 systemwide high of $94 spent per eligible member. Not surprisingly, Region 5 receives substantially less expenditures (8.6% of total state expenditures) than its statewide share of the Medicaid Eligible population (14.1%). Psychotherapy penetration rates in Region 5 are consistently below the statewide average. Case Management penetration rates in Region 5 improved dramatically in SFY 20222 and while they remain lower than the statewide average, they are not dramatically lower. However, CBRS penetration rates in Region 5 are very low and consistently lower than the statewide average.

Region 6

Bannock, Power, Caribou, Bear Lake, Franklin, and Oneida counties (Southeastern)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 15,816 (7.8% of total Medicaid eligible members statewide)

Expenditures: $934,016.05 (6.7% of total expenditures statewide)

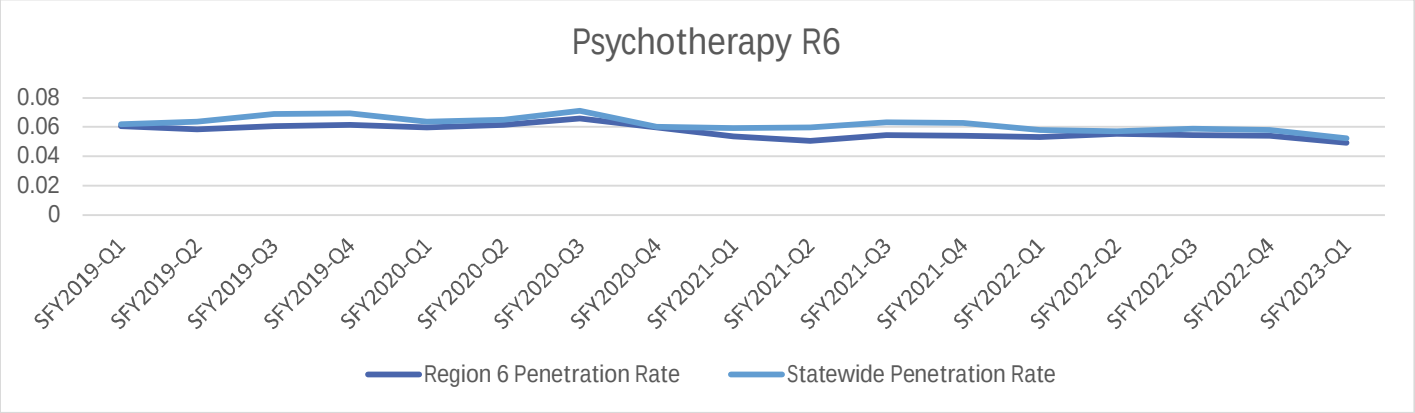
Expenditures per Medicaid Eligible Member: $56.09

Medicaid Eligible Members Receiving Any Service(s): 1,205

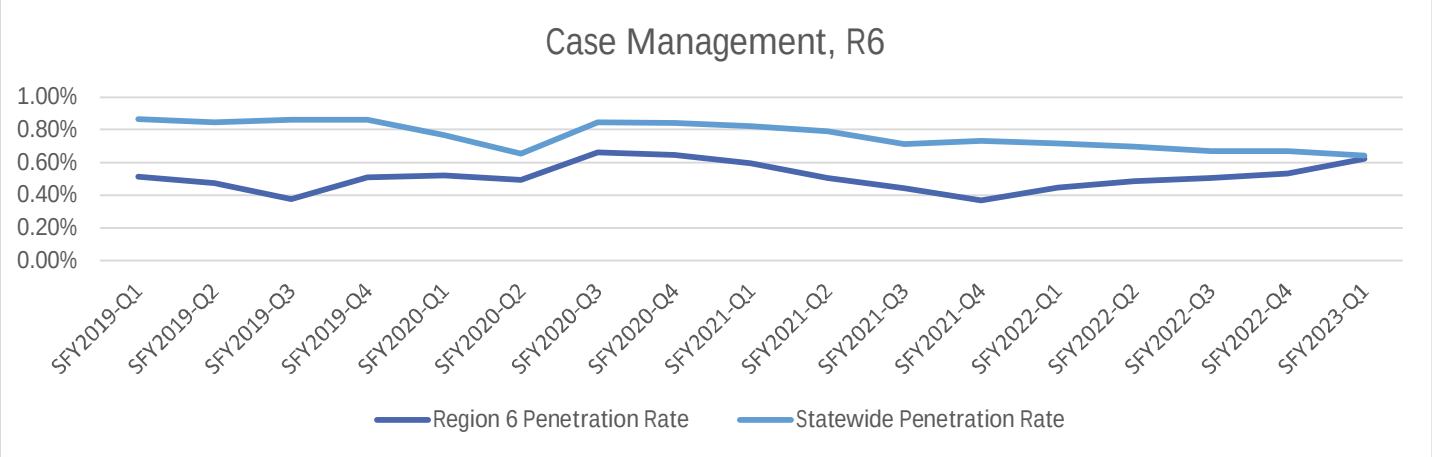
SFY 2023, Q1	Region 6			*Statewide*	
	Distinct Utilizers	% service used	Penetration Rate	*% service used*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	330	27.4%	2.1%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	84	7.0%	0.5%	*3.4%*	*0.3%*
Behavior Assessment	0	0.0%	0.0%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	780	64.7%	4.9%	*68.6%*	*5.3%*
Case Management	98	8.1%	0.6%	*8.4%*	*0.6%*
Med Management	241	20.0%	1.5%	*16.0%*	*1.2%*
Skills Building (CBRS)	121	10.0%	0.8%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	79	6.6%	0.5%	*4.8%*	*0.4%*
Substance Use Services	32	2.7%	0.2%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	9	0.7%	0.1%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	2	0.2%	0.0%	*0.8%*	*0.1%*
Behavior Modification and Consultation	0	0.0%	0.0%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	9	0.7%	0.1%	*0.5%*	*0.0%*
Crisis Psychotherapy	6	0.5%	0.0%	*0.7%*	*0.1%*
Crisis Response	2	0.2%	0.0%	*0.1%*	*0.0%*
Crisis Services	16	1.3%	0.1%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
TASSP	0	0.0%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	0	0.0%	0.0%	*0.5%*	*0.0%*
Day Treatment	1	0.1%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	16	1.3%	0.1%	*0.2%*	*0.0%*
Support services					
Respite	47	3.9%	0.3%	*3.0%*	*0.2%*
Youth Support Services	19	1.6%	0.1%	*1.7%*	*0.1%*
Family Support	7	0.6%	0.0%	*1.6%*	*0.1%*
Family Psychoeducation	0	0.0%	0.0%	*0.3%*	*0.0%*

Trends for Targeted Services-R6

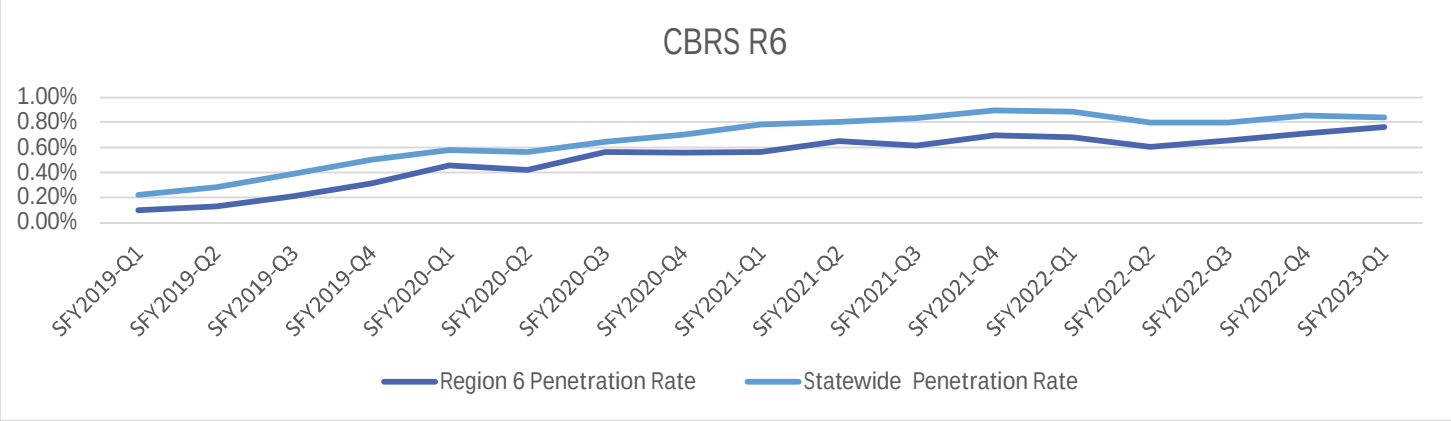
Psychotherapy



Case Management



CBRS



What is this data telling us?

Although the discrepancy is not as wide as in Regions 3 and 5, Region 6, receives less expenditures (6.7% of total state expenditures) than its statewide share of the Medicaid Eligible population (7.8%). While Psychotherapy penetration rates in Region 6 have closely mirrored statewide penetration, Case Management and CBRS penetration rates have historically lagged slightly behind the statewide rates. However, in SFY 2023 Q1, Case Management rates in Region 6 have converged indicating Region 6 has made progress in the provision of Case Management Services. Understanding the factors driving this progress maybe be illustrative for other areas in the state.

Region 7

Bingham, Lemhi, Custer, Butte, Clark, Jefferson, Fremont, Madison, Teton, and Bonneville counties (Eastern)

SFY 2023, Q1 Big Picture Overview

Total Medicaid Eligible Members: 38,996 (19.3% of total Medicaid eligible members statewide)

Expenditures: $3,665,249.01 (26.1% of total expenditures statewide)

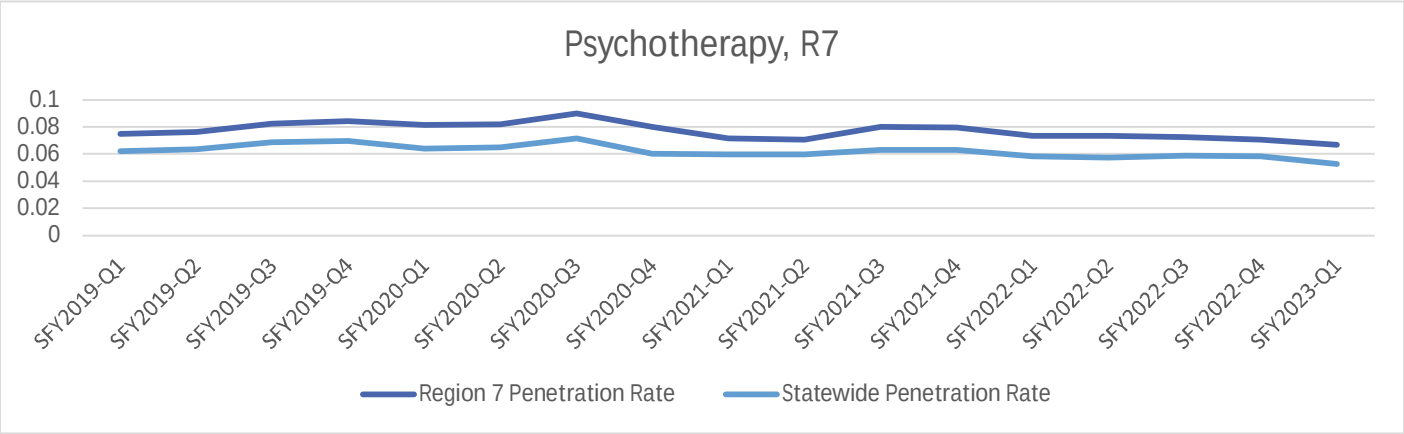
Expenditures per Medicaid Eligible Member: $93.99

Medicaid Eligible Members Receiving Any Service(s): 3,629

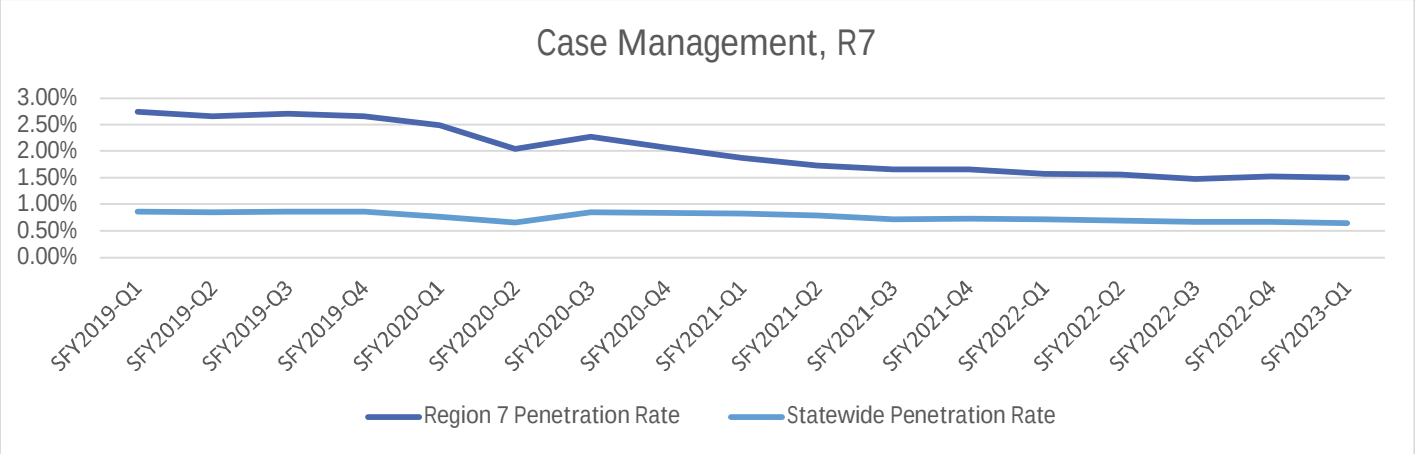
SFY 2023, Q1	Region 7			*Statewide*	
	Distinct Utilizers	% service used	Penetration Rate	*% service used*	*Penetration Rate*
Assessments					
CANS-(Billed to Medicaid)	1408	38.8%	3.6%	*36.5%*	*2.8%*
Psych and Neuropsych Testing	146	4.0%	0.4%	*3.4%*	*0.3%*
Behavior Assessment	0	0.0%	0.0%	*0.7%*	*0.1%*
Outpatient Treatment Services					
Psychotherapy	2605	71.8%	6.7%	*68.6%*	*5.3%*
Case Management	585	16.1%	1.5%	*8.4%*	*0.6%*
Med Management	388	10.7%	1.0%	*16.0%*	*1.2%*
Skills Building (CBRS)	736	20.3%	1.9%	*10.9%*	*0.8%*
Targeted Care Coordination (TCC)	335	9.2%	0.9%	*4.8%*	*0.4%*
Substance Use Services	131	3.6%	0.3%	*2.3%*	*0.2%*
Child and Family Interdisciplinary Team (CFIT)	41	1.1%	0.1%	*0.9%*	*0.1%*
Skills Training and Development (STAD)	48	1.3%	0.1%	*0.8%*	*0.1%*
Behavior Modification and Consultation	0	0.0%	0.0%	*0.8%*	*0.1%*
Crisis					
Crisis Intervention	48	1.3%	0.1%	*0.5%*	*0.0%*
Crisis Psychotherapy	45	1.2%	0.1%	*0.7%*	*0.1%*
Crisis Response	9	0.2%	0.0%	*0.1%*	*0.0%*
Crisis Services	97	2.7%	0.2%	*1.3%*	*0.1%*
Intensive Outpatient Treatment Services					
TASSP	19	0.5%	0.0%	*0.1%*	*0.0%*
Partial Hospitalization (PHP)	6	0.2%	0.0%	*0.5%*	*0.0%*
Day Treatment	9	0.2%	0.0%	*0.2%*	*0.0%*
Intensive Home and Community Based Services	5	0.1%	0.0%	*0.2%*	*0.0%*
Support services					
Respite	146	4.0%	0.4%	*3.0%*	*0.2%*
Youth Support Services	69	1.9%	0.2%	*1.7%*	*0.2%*
Family Support	190	5.2%	0.5%	*1.6%*	*0.1%*
Family Psychoeducation	2	0.1%	0.0%	*0.3%*	*0.0%*

Trends for Targeted Services-R7

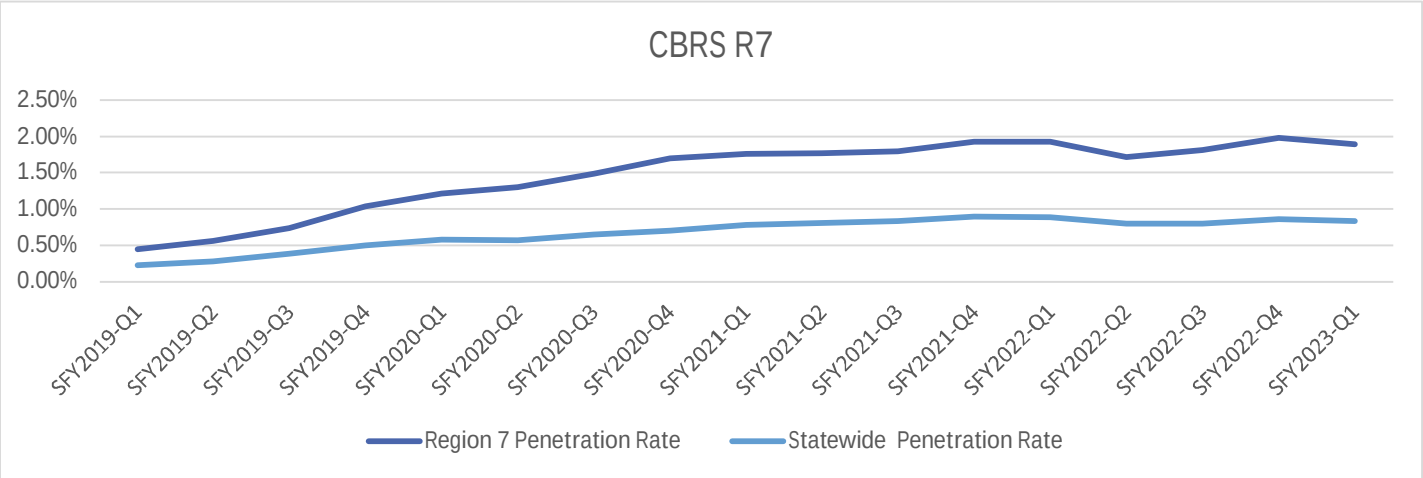
Psychotherapy



Case Management



CBRS



What is this data telling us?

Region 7 receives substantially more expenditures (26.1% of total state expenditures) than its statewide share of the Medicaid Eligible population (19.3%). Further, Region 7 has the highest average dollars spent per eligible member ($94). Like in Region 4, penetration rates trends in Region 7 for Psychotherapy, Case Management, and CBRS all follow a similar pattern of consistently exceeding average statewide penetration over time. Of note, Case Management penetration in Region 7 has fallen from nearly 3% in Q1 SFY 2019 to 1.5% in Q1 SFY 2023.

6: DBH YES Outpatient Service Utilization

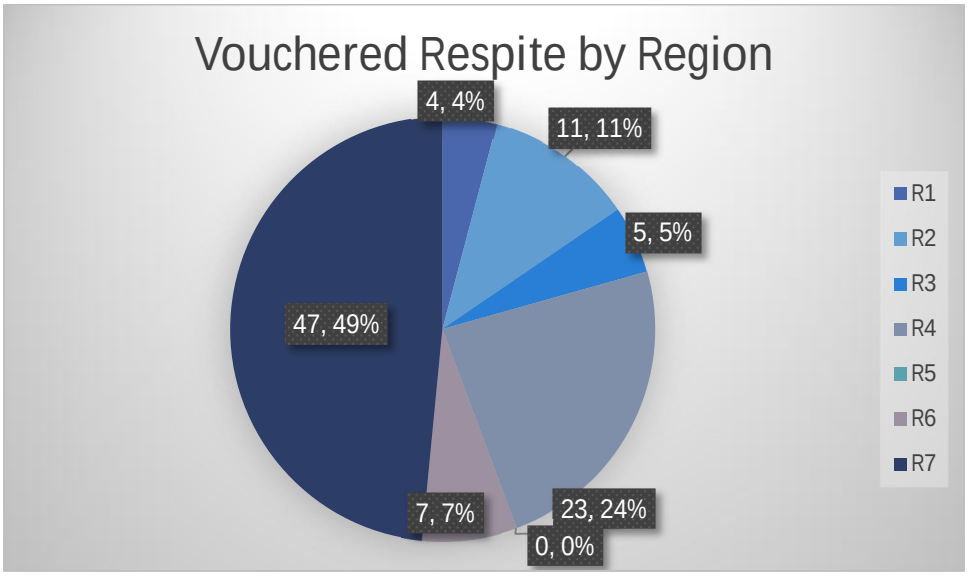
DBH Vouchered Respite

The Children's Mental Health Voucher Respite Care program is available to parents or caregivers of youth with serious emotional disturbance to provide short-term or temporary respite care by friends, family, or other individuals in the family's support system. Through the voucher program, families pay an individual directly for respite services and are then reimbursed by the division's contractor. A single voucher may be issued for up to $600 for six months per child. Two vouchers can be issued per child per year.

6a - Vouchered Respite SFY2023 Q1

Regions	1	2	3	4	5	6	7	Total
July	1	2	1	8	0	2	15	29
Aug	2	5	1	6	0	3	18	35
Sept	1	4	3	9	0	2	14	33
Q1 Total	4	11	5	23	0	7	47	97

6b



DBH Wraparound Intensive Services (WInS)

It is estimated that approximately 1,350 children and youth in Idaho may need Wraparound services. During SFY 2020, 335 children and youth received Wrapround services; 188 received Wraparound in SFY 2021; and since the initial implementation of Wrapround in Idaho, in January of 2018, 613 children and families have received WInS.

6c: WInS- SFY 2020-2022 , SFY 2023 Q1

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	Total SFY Unduplicated
SFY 2020	62	34	21	24	53	32	45	36	26	32	29	17	335
SFY 2021	19	16	34	23	24	24	19	25	27	19	24	23	188
SFY 2022	23	16	29	33	23	13	31	22	22	28	21	20	180
SFY 2023, Q1	13	8	8										29

DBH Parenting with Love and Limits (PLL)

The evidence-based practice called Parenting with Love and Limits (PLL) is offered through the regional DBH CMH clinics in regions across the state.

6d: PLL SFY 2020-2022 , SFY 2023 Q1

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	Total SFY Unduplicated
SFY 2020	16	17	13	11	8	6	18	13	9	12	3	12	137
SFY 2021	5	3	6	4	5	5	4	8	6	2	9	8	67
SFY 2022	7	8	0	6	3	1	10	3	6	14	5	5	70
SFY 2023, Q1	4	11	0										15

The number of families receiving PLL has continued to trend downward substantially.

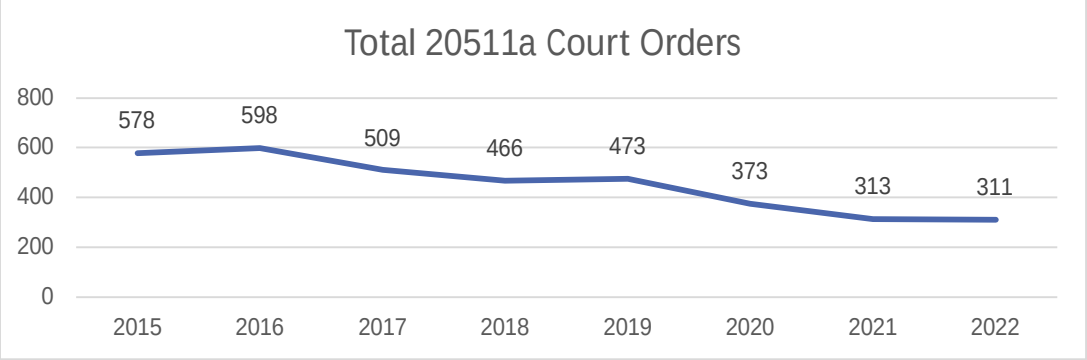
DBH 20-511A:

6e: Number of 20-511A court orders for SFY 2021 – 2022 SFY 2023 Q1.

Region	1	2	3	4	5	6	7	Total
SFY 2021	39	6	36	77	56	19	80	313
SFY 2022	35	3	41	62	67	17	86	311
SFY 2023, Q1	42							

If this rate stays the same through the remainder of the year (average of 78 per month) the number of 20-11A is projected to be approximately equal to last year.

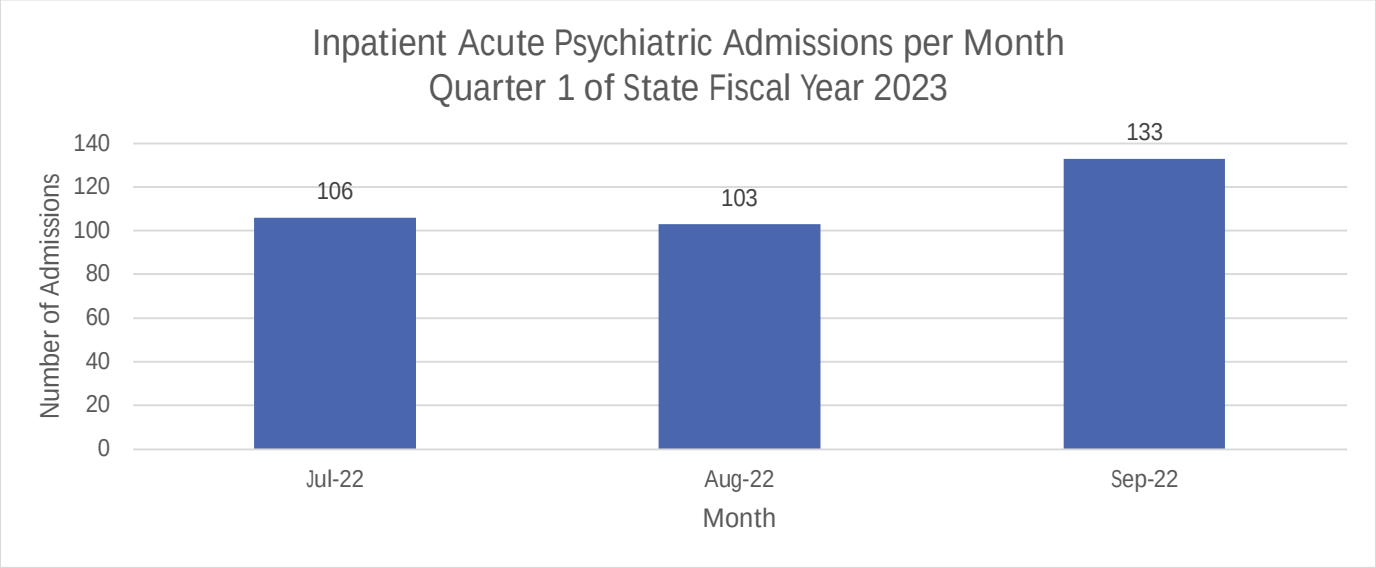
6f: Historical Annualized # of Court Ordered 20-511A, SFY 2015 - 2022



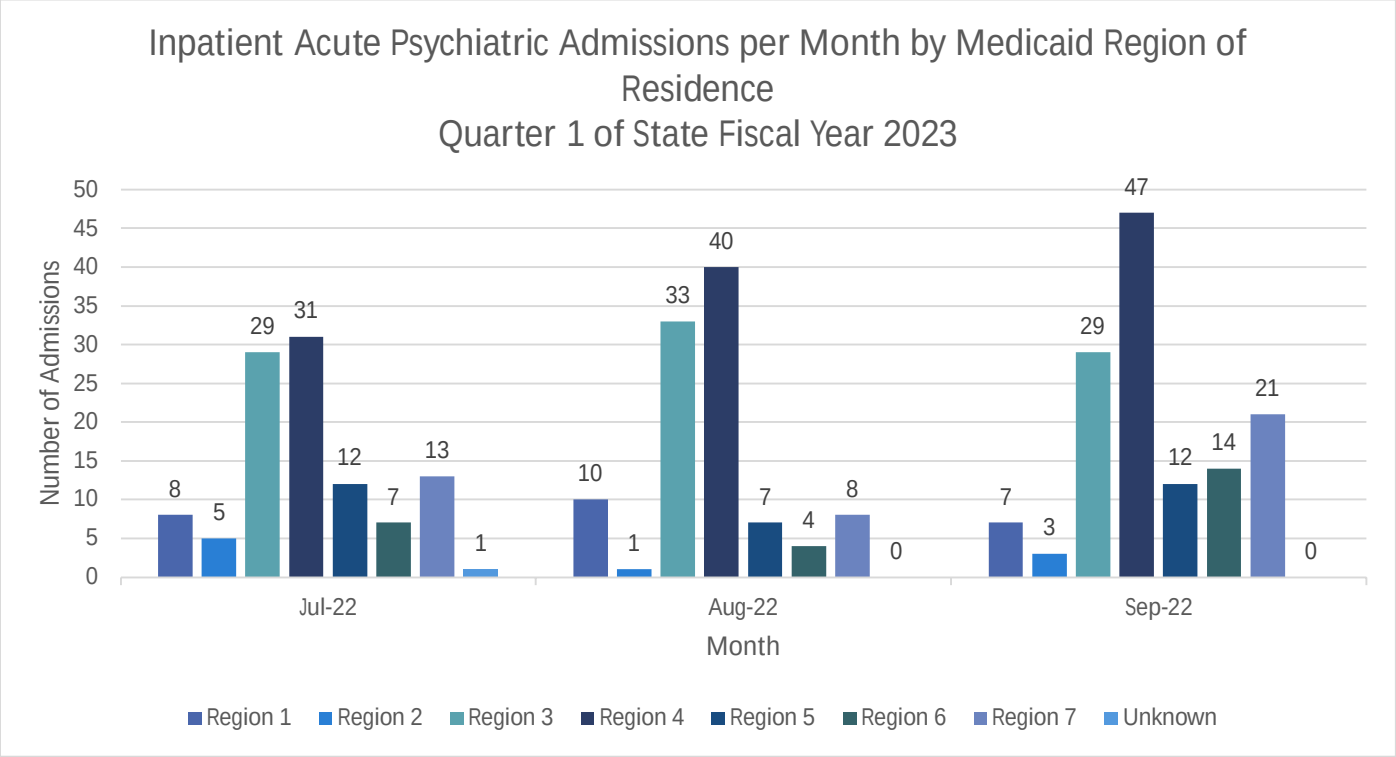
Utilization of 24-hour Services

7. Inpatient

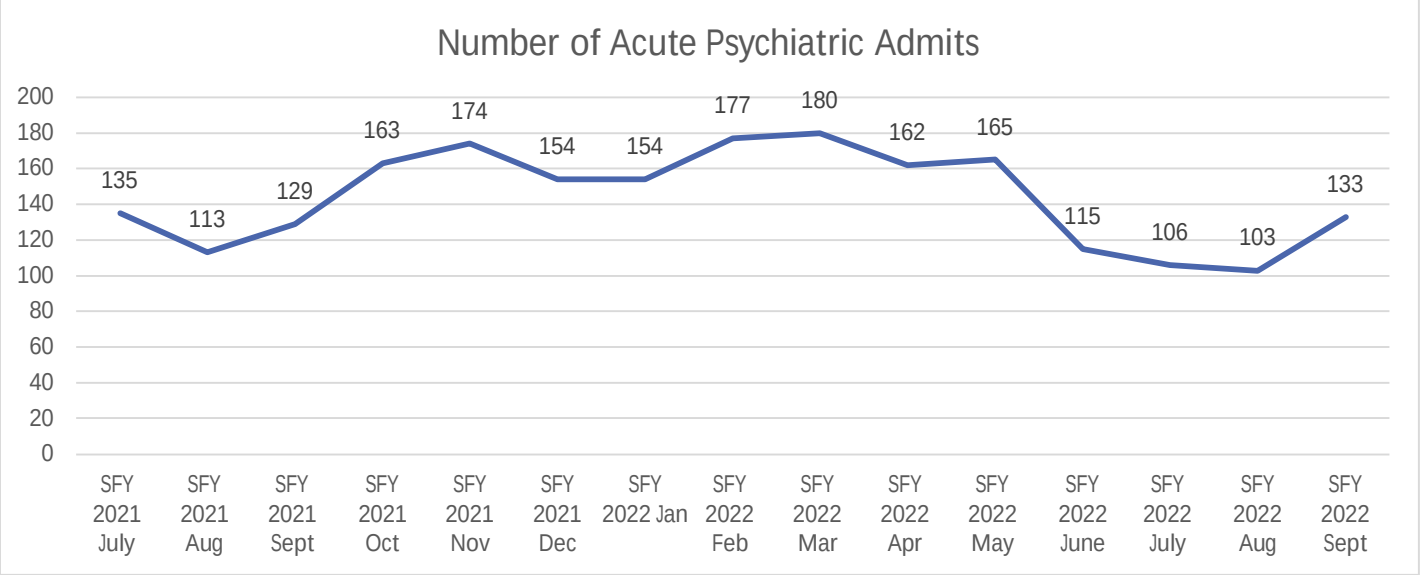
7a: Medicaid Acute Psychiatric Admissions by Month



7b: Medicaid Acute Psychiatric Admissions by Region

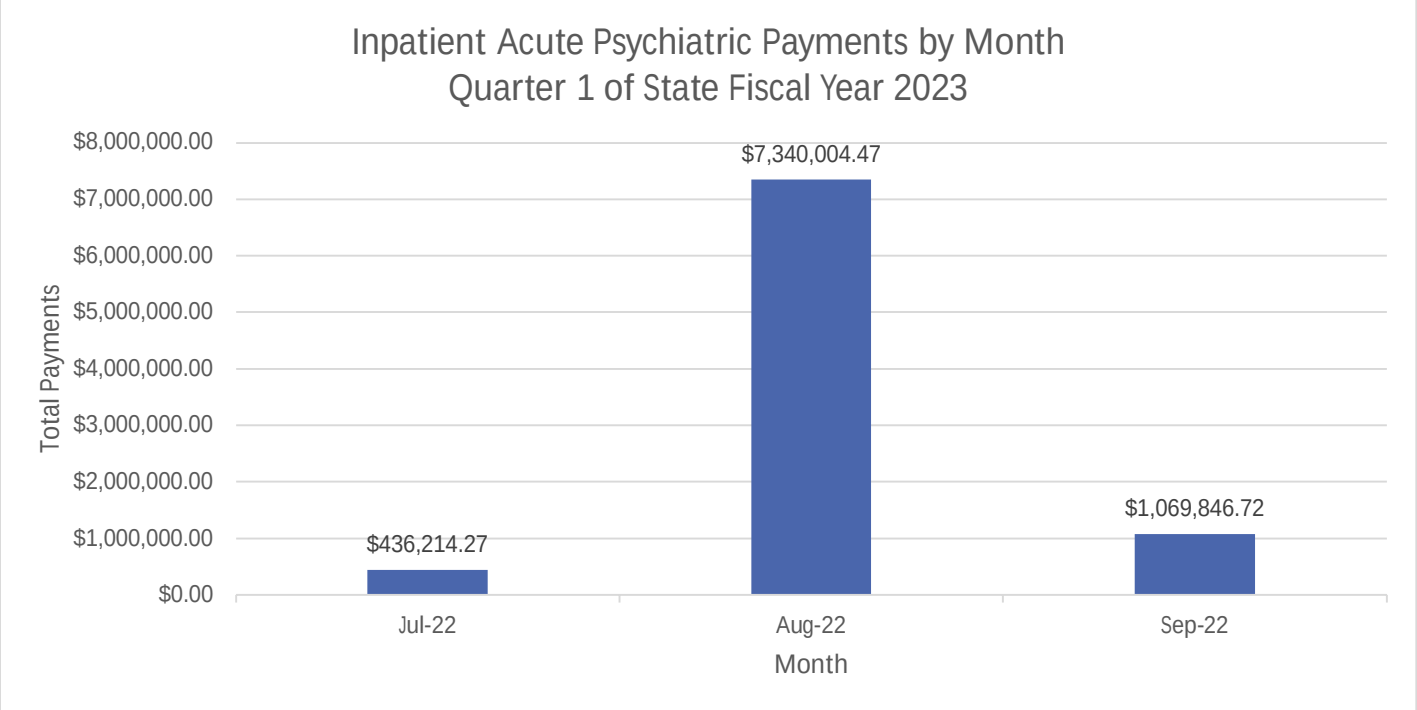


7c: Historical Trend of Medicaid Acute Admissions



Note: This data is based on provider claims data and is for admissions and is not unduplicated – a youth maybe admitted more than once. In addition, some admissions may be for the same episode, but different hospital. For example, a youth may be admitted to a general hospital and then transferred to a behavioral health-specific hospital, which are then reported as separate admissions.

7d: Expenditures



DBH State Hospital – Includes State Hospital South (SHS) Adolescent Unit through April 2021 and State Hospital West (SHW) which opened in May 2021

7e: SHS/SHW Active by month SFY 2020- 2022 , SFY 2023 Q1

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total SFY Unduplicated
SFY 2020	17	20	18	18	22	21	21	23	25	24	25	21	101
SFY 2021	28	24	30	NA	19	20	16	19	17	17	15	11	72
SFY 2022	13	14	15	12	15	14	15	13	14	13	11	13	60
SFY 2023, Q1	11	12	7										17

Note: Data for October SFY 2021 is not available as there was a change in how data was being collected

Average number per month has decreased from an average of 21 in 2020 and 2021, 13.5 in 2022. The lower number served at SHW compared to SHS is related to the number of beds available at SHW. The facility has capacity to have 16 beds, but admissions have been limited due to facility issues (e.g. nursing station) and staffing resources.

DBH SHS/SHW Readmission Incidents (not unique individuals)

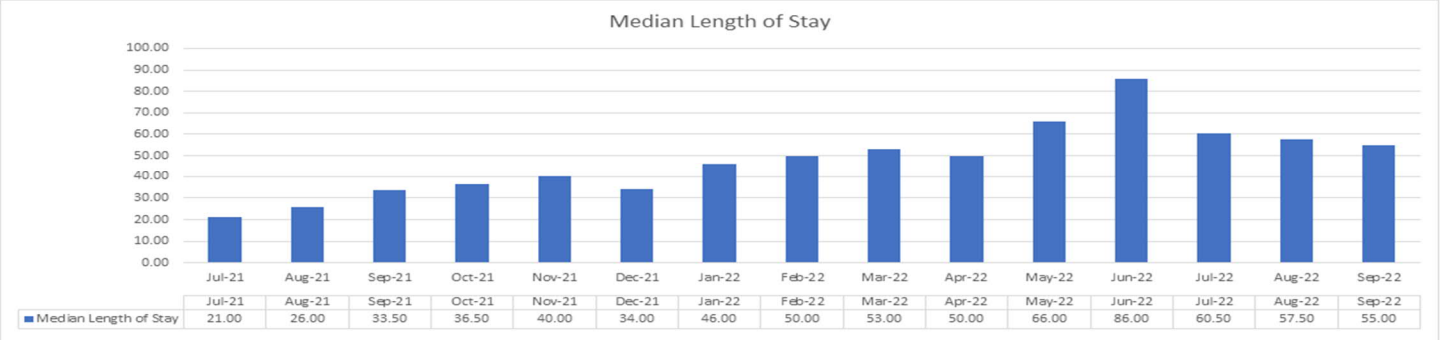
7f: SFY 2017 - 2022 , SFY 2023 Q1

Range of days to Readmission	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021**	SFY 2022 Total	SFY 2023 Q1
Re-admission 30 days or less	0	0	0	1	0	2	0
Re-admission 31 to 90 day	5	6	2	3	0	1	1
Re-admission 90 to 180 days	4	1	6	2	0	3	0
Re-admission 181 to 365 days	5	6	7	4	0	2	1
Re-admission more than 365 days	11	9	9	7	3	0	0

DBH has been tracking the trend of readmissions incidents for SHS/SHW. It is notable that the number of incidents within 30 days has been extremely low. There were 2 readmissions within 30 days in 2022 however the rate of readmission is still low 4.17 percent (2/48 = 4.17 percent).

**SHS closed its adolescent unit in April/May 2021 and State Hospital West began accepting adolescent admissions in May 2021. The QMIA-Q report began adding in State Hospital West data in Q4 SFY 2021.

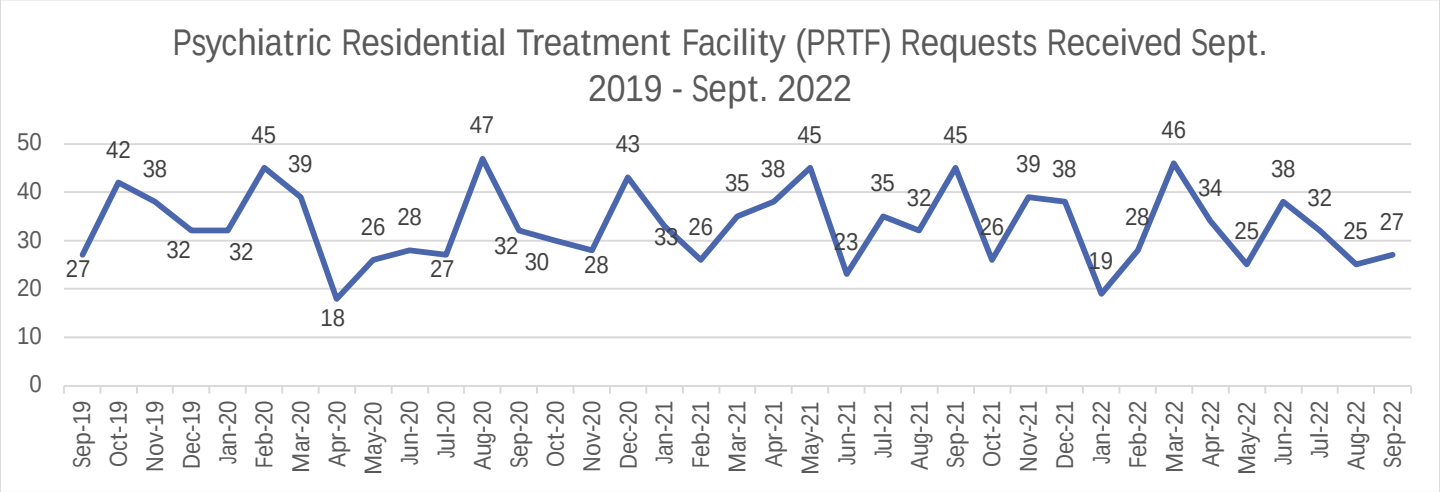
7g: SHW Length of Stay (LOS)



8. Residential

Psychiatric Residential Treatment Facility (PRTF)[6]:

8a: Number of Psychiatric Residential Treatment Facility (PRTF) Requests Monthly



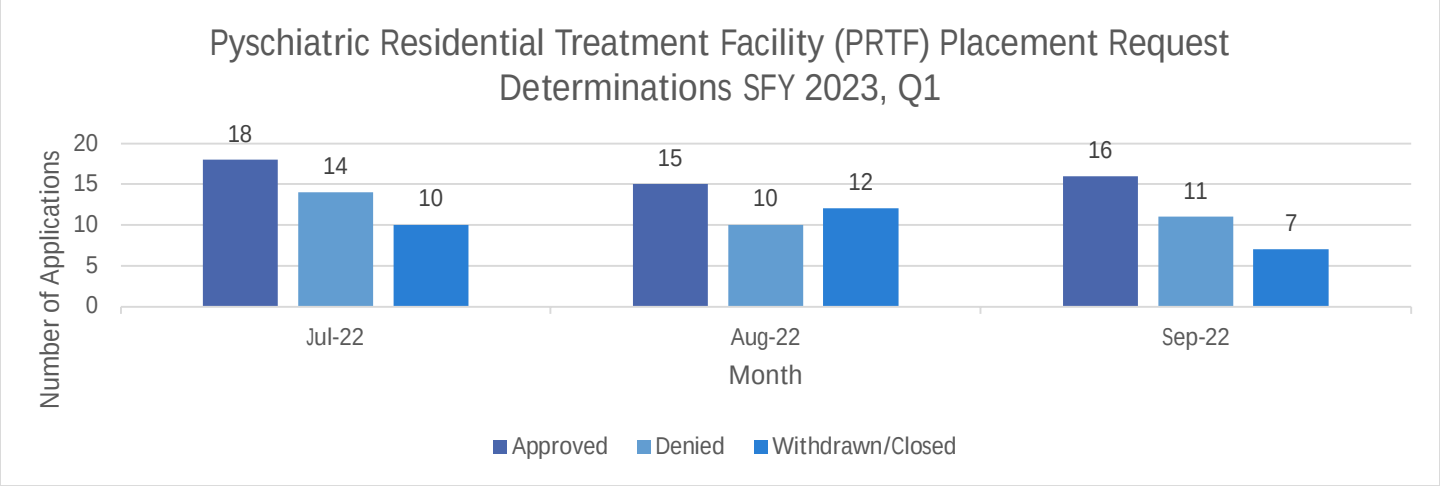
PRTF Determinations

All new Medicaid placement requests received have four potential results, including those that are approved, denied, withdrawn, or technically denied/closed.

- Approved (A) – Approved for placement in Psychiatric Residential Treatment Facility (PRTF); Medicaid works with the member's family to secure a placement in an approved PRTF.
- Denied (D)– Denied placement in PRTF; Medicaid works with the member's representatives and other entities such as Optum Idaho, DBH, or FACS to set up appropriate treatment options.
- Withdrawn (W)– Requestor, such as parent, guardian, or case worker with Children's Developmental Disability (DD), if in state custody, decided not to continue with their request (represented below as W/C).
- Technically Denied or Closed (C)– Additional information requested, but not received resulting in an inability to make a determination (represented below as W/C).

8b: PRTF Determinations SFY 2023, Q1

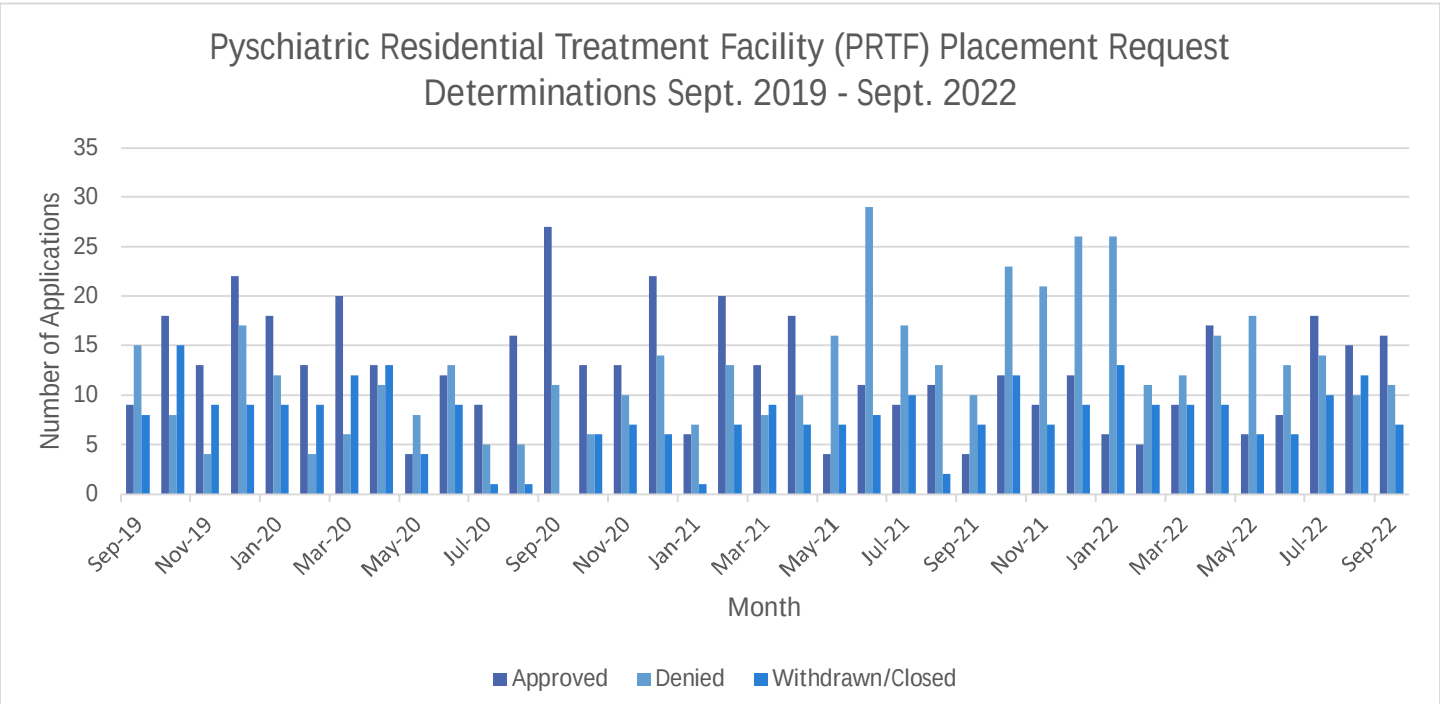
[6] Psychiatric Residential Treatment Facility (PRTF) services are as defined by 42 C.F.R. §483.352 Definitions and including a range of comprehensive services provided in a separate, stand-alone entity to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician.



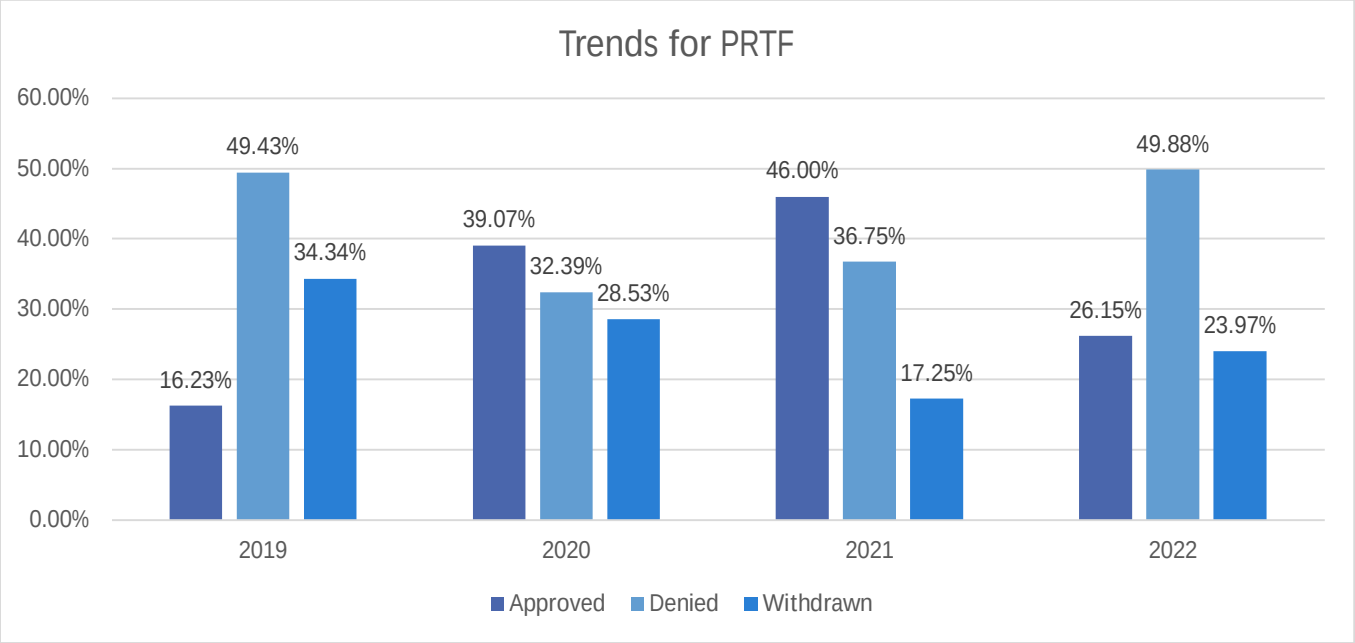
8c: Historical Trends for PRTF SFY 2019, 2020 and 2021, and 2022

SFY	*# of Placement Determinations*	*Approved*		*Denied*		*Withdrawn/Closed*	
		#	*%*	*#*	*%*	*#*	*%*
SFY 2019	265	43	16.23%	131	49.43%	91	34.34%
SFY 2020	389	152	39.07%	126	32.39%	111	28.53%
SFY 2021	400	184	46.00%	147	36.75%	69	17.25%
SFY 2022	413	108	26.15%	206	49.88%	99	23.97%
SFY 2023 Q1	113	49	43.36%	35	30.97%	29	25.66%
			34.16%		39.88%		25.66%
Avg			31.86%		42.11%		26.02%

8d: Historical Trends for PRTF SFY 2019, 2020, 2021, and 2022



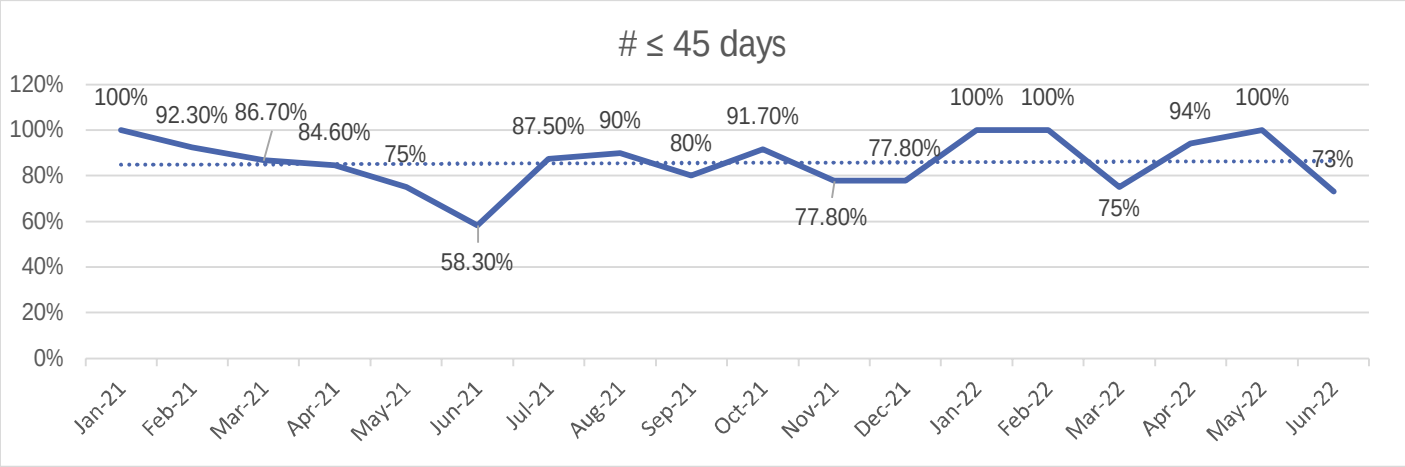
8e Trends



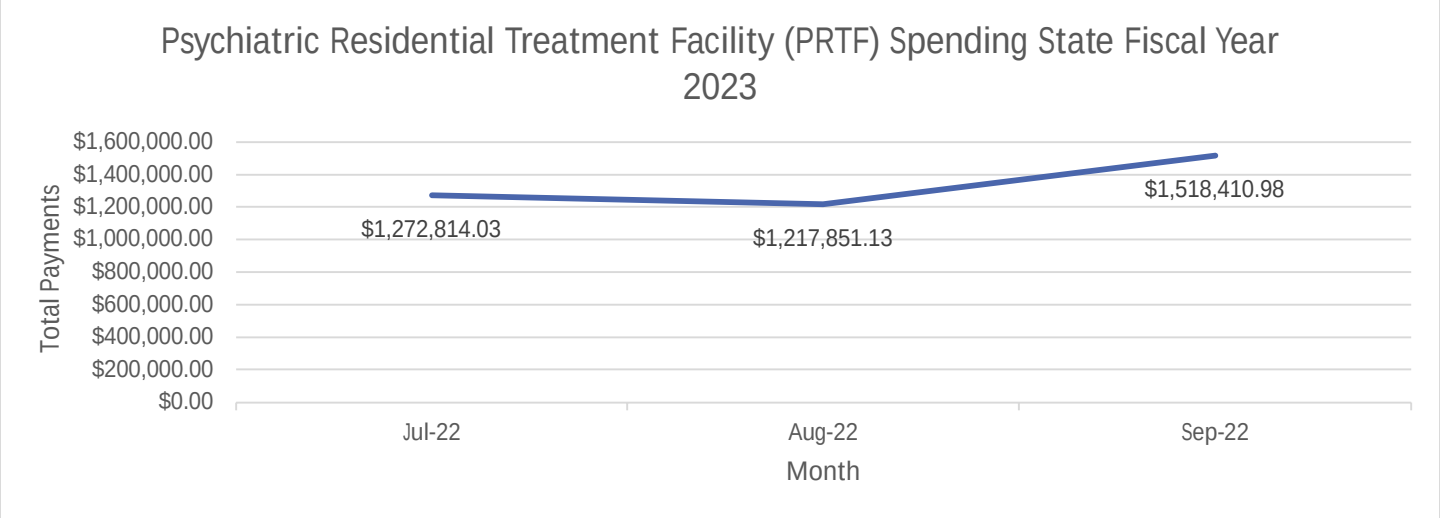
8f: Timeliness of Notice of Determination (NOD) PRTF Decisions

2021	# NOD	# ≤ 45 days	% ≤ 45	# > 45	% > 45
January	6	6	100%	0	-
February	13	12	92.3%	1	7.7%
March	15	13	86.7%	2	13.3%
April	13	11	84.6%	2	15.4%
May	4	3	75%	1	25%
June	12	7	58.3%	5	41.7%
SFY 2021	63	52	82.82%	11	17.81%
2022	# NOD	# ≤ 45 days	% ≤ 45	# > 45	% > 45
July	8	7	87.5%	1	12.5%
August	10	9	90%	1	10%
September	5	4	80%	1	20%
October	12	11	91.7%	1	8.3%
November	9	7	77.8%	2	22.2%
December	9	7	77.8%	2	22.2%
January	5	5	100%	0	-
February	6	6	100%	0	-
March	8	6	75%	2	25%
April	17	16	94%	1	6%
May	6	6	100%	0	-
June	11	8	73%	3	27%
SFY 2022	106	92	87%	14	13%
July	15	14	93%	1	7%
August	14	10	71%	4	29%
September	15	11	73%	4	27%

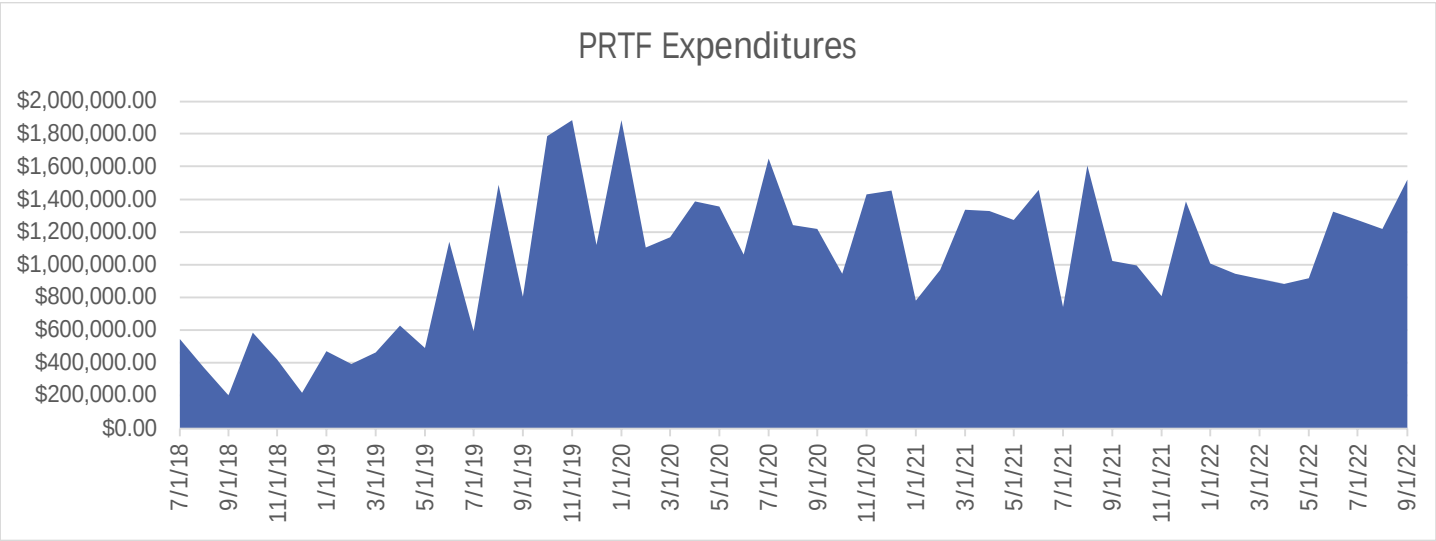
8g: Percent of determinations completed within ≤ 45 days



8h: **PRTF SFY Q1 Expenditures**



8i: PRTF Trend in Expenditures SFY 2021- SFY 2023, Q1



DBH Residential

DBH Residential placements may include children/youth who have Medicaid or who do not have Medicaid and may be placements at Psychiatric Residential Treatment Facilities (PRTF) or Residential Treatment Centers (RTCs), but the residential services are paid for by DBH. Residential numbers do not include acute hospital care.

8j: Residential Active by month SFY 2020 and 2021 and SFY 2022

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June	Total SFY Unduplicated
SFY 2020	8	3	4	3	2	2	4	4	6	6	6	8	18
SFY 2021	9	9	14	NA	13	14	15	12	10	9	10	12	24
SFY 2022	12	17	16	16	18	17	17	16	17	23	24	23	37
SFY 2023, Q1	23	20	23										26

Note: Data for October SFY 2021 is not available as there was a change in how data was being collected.

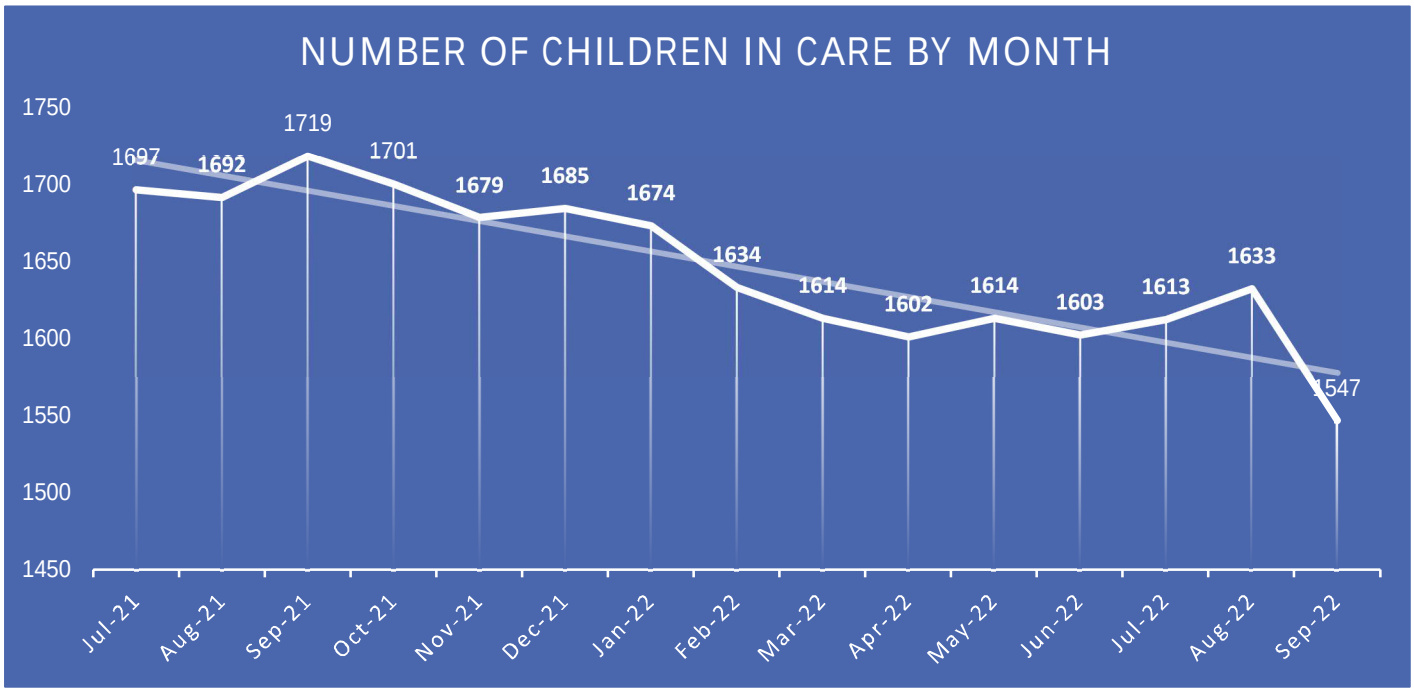
DBH has an increased number of residential placements SFY 2022 vs. SFY 2020 and 2021.

9. YES Partners Information

Family and Community Services (FACS):

DBH and FACS are working together to develop data related to children and youth with SED (?) who are in foster care in future QMIA-Q reports. The Divisions will be collaborating on data that will allow us to assess children in foster care who have had a CANS. The data is delayed this quarter based on some changes in the Division of FACS but will be included in future QMIA-Q reports.

9a: SFY 2022 Number of Children active in Foster Care by month



Note: Counts in the above chart have been updated to reflect point-in-time data pulled from the new FACS data system. Variances in counts from prior reports are due to a combination of system and methodology changes for FACS data collection and reporting, and ongoing data entry in the system. And the chart above reflects total numbers of children in foster care, not children in foster care with SED.

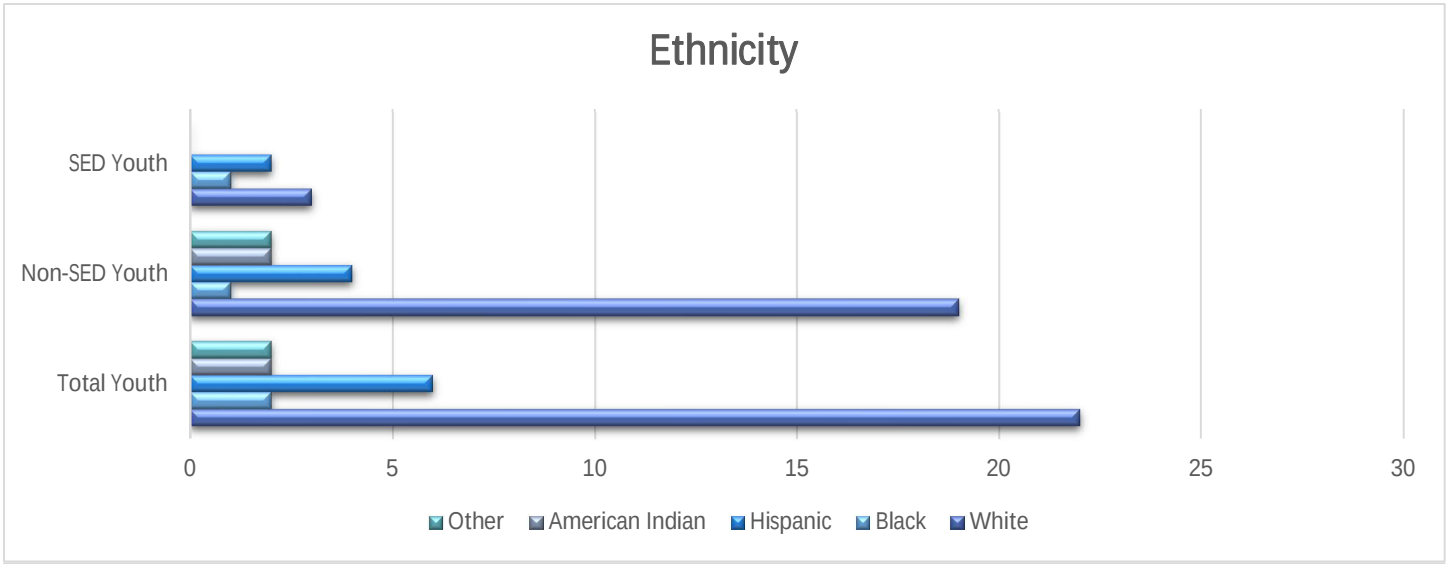
Idaho Department of Juvenile Corrections

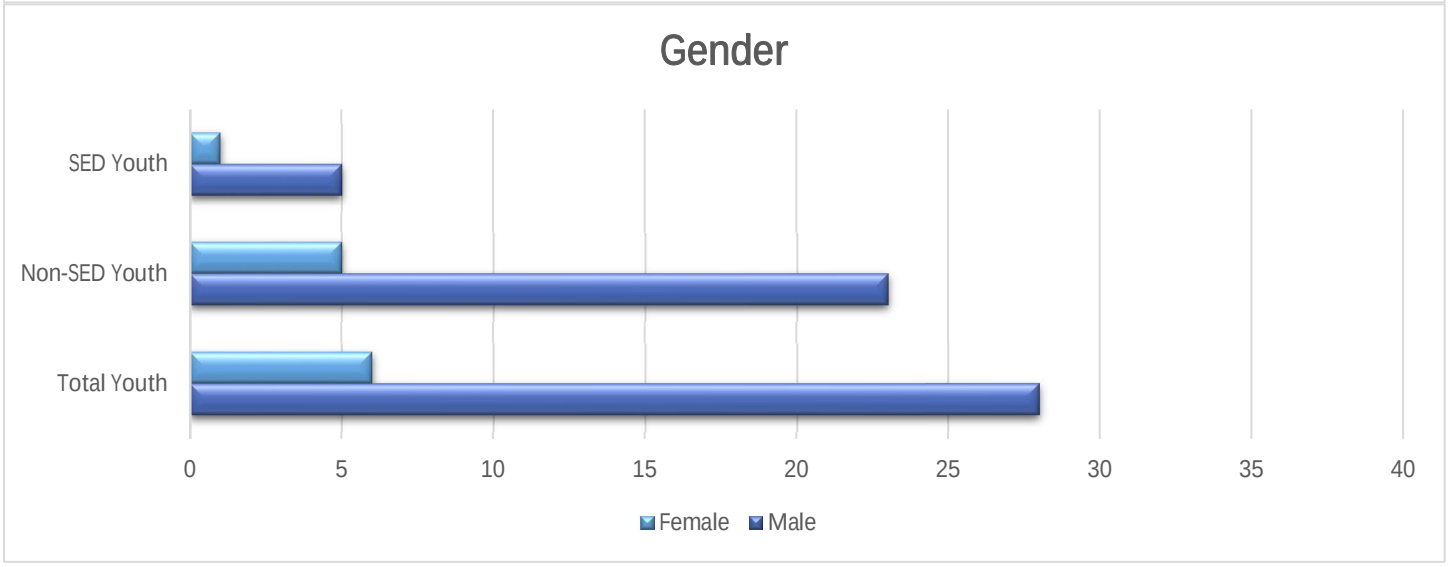
When a youth is committed to IDJC, they are thoroughly assessed in the Observation and Assessment (O&A) units during the initial duration of their time in commitment. During O&A, best practice assessments (including determining SED status via documentation provided from system partners) determine the risks and needs of juveniles in order to determine the most suitable program placement to meet the individual and unique needs of each youth. Youth may be placed at a state juvenile corrections center or a licensed contract facility to address criminogenic risk and needs. Criminogenic needs are those conditions that contribute to the juvenile's delinquency most directly.

IDJC provides services to meet the needs of youth defined in individualized assessments and treatment plans. Specialized programs are used for juveniles with sex offending behavior, serious substance use disorders, mental health disorders, and female offenders. All programs focus on youth's strengths and target reducing criminal behavior and thinking, in addition to decreasing the juvenile's risk to reoffend using a cognitive behavioral approach. The programs are evaluated by nationally accepted and recognized standards for the treatment of juvenile offenders. Other IDJC services include professional medical care, counseling, and education/vocational programs.

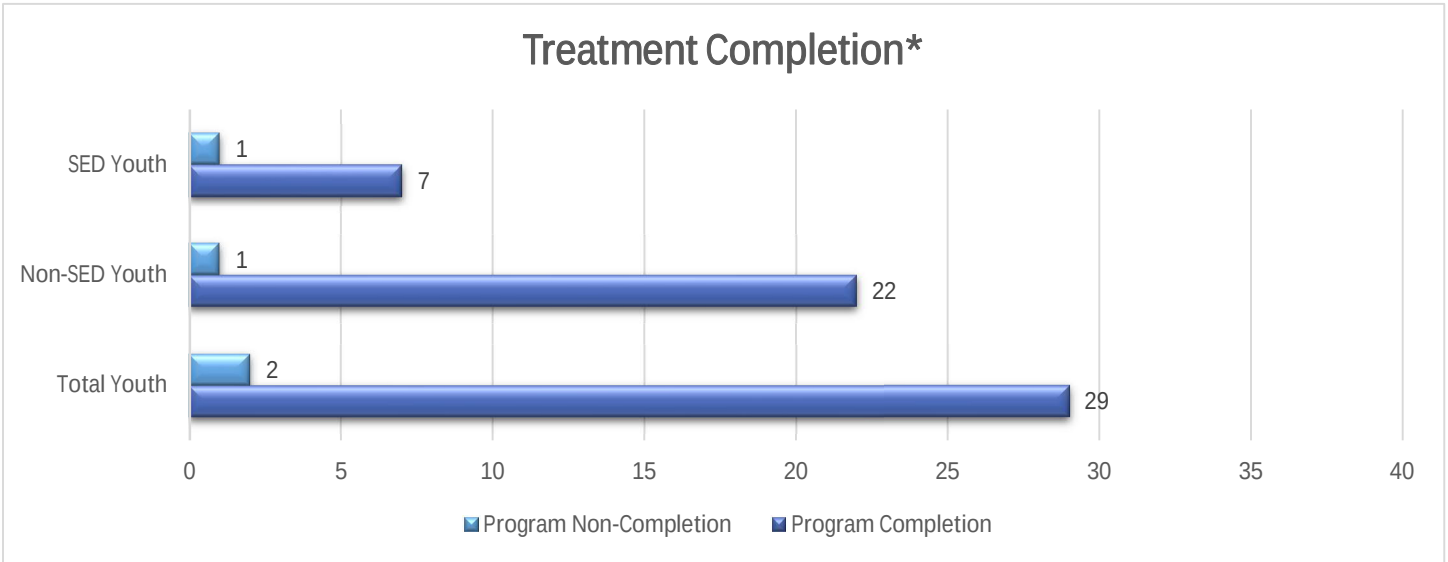
Once a youth has completed treatment and the risk to the community has been reduced, the juvenile is most likely to return to county probation. Each juvenile's return to the community is associated with a plan for reintegration that requires the juvenile and family to draw upon support and services from providers at the community level. Making this link back to the community is critical to the ultimate success of youth leaving state custody.

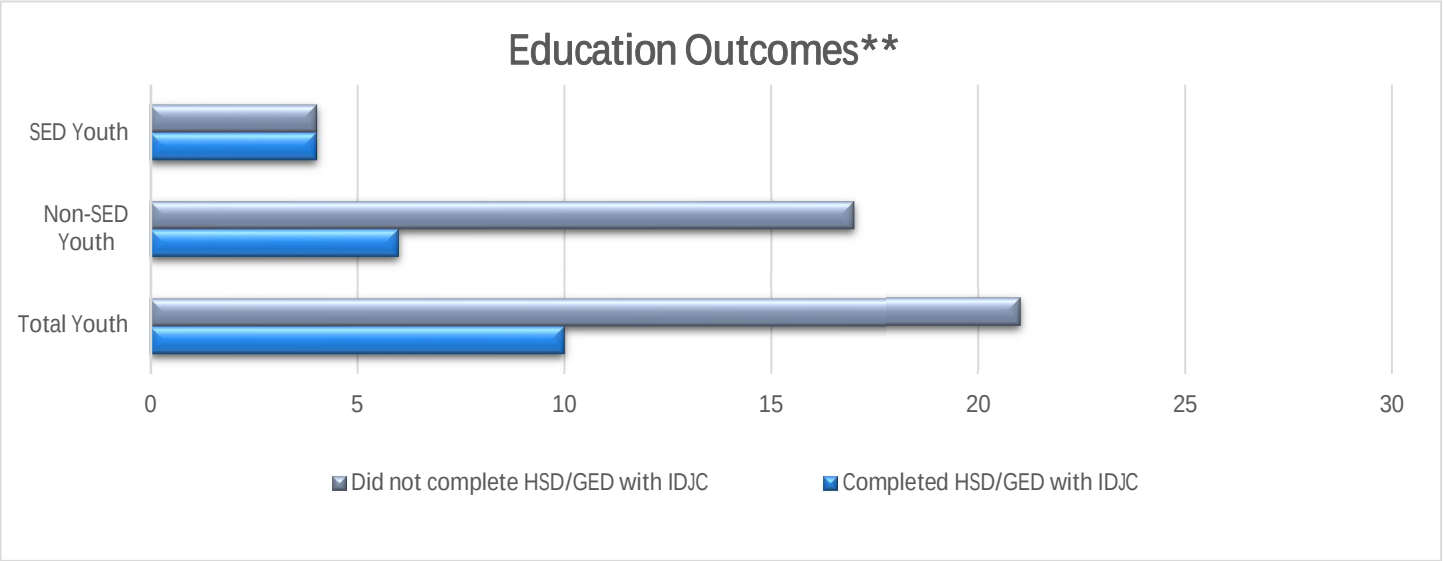
The graphs below compare ethnicity and gender between all youth committed to IDJC and SED youth committed to IDJC from July 1 – September 30.





The graphs below compare positive youth outcomes between all youth released from IDJC and SED youth released from IDJC between July 1 – September 30.





**Defined as reduced risk to a 2 or a 1 (5-1 scale) on the Progress Assessment / Reclassification (PA/R) instrument.*
***Eligible juveniles are under 18 that did not complete their High School Diploma (HSD) or General Education Development (GED) while attending the accredited school at IDJC.*

State Department of Education (SDE)

SFY 2021-2022 Complaints, Mediation, Due Process, Expedited Due Process

Item description	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Total number of written signed complaints filed.	28	41	29	30	30	37
Complaints with reports issued.	22	35	23	27	24	34
Reports with findings of noncompliance.	16	20	16	22	21	29
Reports within timelines.	22	35	23	27	24	34
Reports within extended timelines.	0	0	0	0	0	0
Complaints pending.	0	0	0	0	0	0
Complaints pending a due process hearing.	0	0	0	0	0	0
Complaints withdrawn or dismissed.	6	6	6	3	6	3

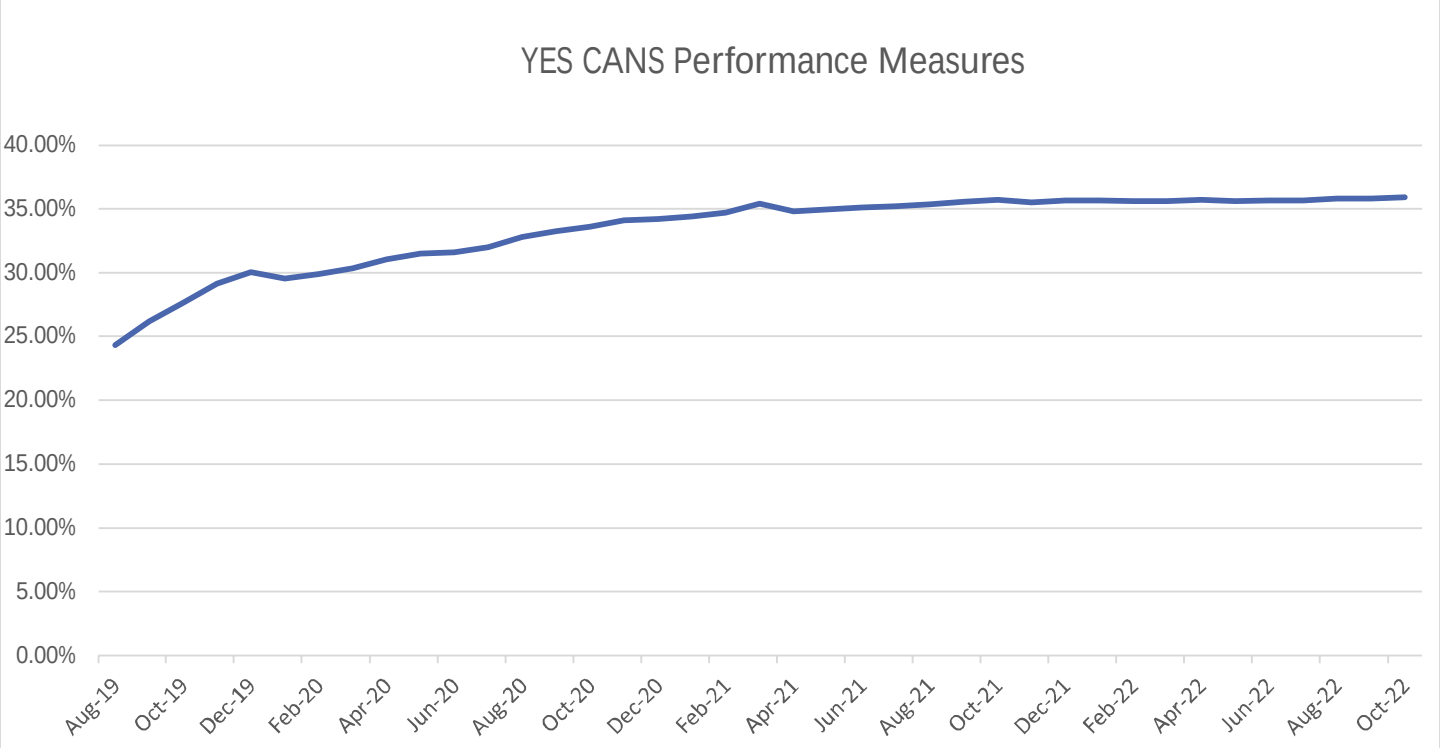
Item description	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Total number of mediation requests received through all dispute resolution processes.	19	18	9	14	20	12
Mediations held.	9	13	2	14	15	9
Mediations held related to due process complaints.	1	1	0	1	5	4
Mediation agreements related to due process complaints.	1	1	0	1	4	1

Mediations held not related to due process complaints.	8	12	0	13	10	5
Mediation agreements not related to due process complaints.	6	12	2	13	8	5
Mediations pending.	0	0	0	0	0	0
Mediations withdrawn or not held.	10	5	7	0	5	3
Item description	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Total number of due process complaints filed.	5	3	5	5	7	4
Resolution meetings.	4	3	2	2	0	0
Written settlement agreements reached through resolution meetings.	2	2	0	2	0	0
Hearings fully adjudicated.	2	1	2	1	3	0
Decisions within timeline (include expedited).	0	0	1	1	0	0
Decisions within extended timeline.	2	1	1	0	3	0
Due process complaints pending.	0	0	3	0	0	1
Due process complaints withdrawn or dismissed (including resolved without a hearing).	3	2	0	4	4	3
Item description	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Total number of expedited due process complaints filed.	1	1	0	2	0	1
Expedited resolution meetings.	0	1	0	1	0	0
Expedited written settlement agreements.	0	1	0	1	0	0
Expedited hearings fully adjudicated.	0	0	0	0	0	0
Change of placement ordered.	0	0	0	0	0	0
Expedited due process complaints pending.	0	0	0	0	0	0
Expedited due process complaints withdrawn or dismissed.	1	1	0	2	0	1

10. YES Service Outcomes

YES services are leading to improved outcomes. In SFY 2023, Q1 the percent of children and youth whose overall rating improved at least one level (e.g., from a 3 to a 2, or a 2 to 1) remained approximately stable at 35.94%.

10a: YES CANS ratings continue to demonstrate improvement in outcomes.



Note: Outcomes data includes all children who received outpatient services but does not exclude children who received other services in addition to outpatient.

Detailed Outcomes data:

The detailed outcomes data information presented below is just a small sample of the systemwide information available on the Idaho TCOM Institute website. The Idaho TCOM Institute website is home to the IDHW System Dashboard which includes CANS-based reports meant to gauge how the overall YES system-of-care is functioning. The System Dashboard is updated quarterly with assistance from the Praed Foundation and includes six key reports as well as the ability to download specific system-wide data for further analysis. The remainder of this section highlights examples of how the dashboard can be used to assess the overall YES system of care. The full dashboard can be accessed assessed by visiting the IDHW DBH Idaho TCOM website at: https://healthandwelfare.idaho.gov/providers/behavioral-health-providers/idaho-transformational-collaborative-outcomes-management-tcom.

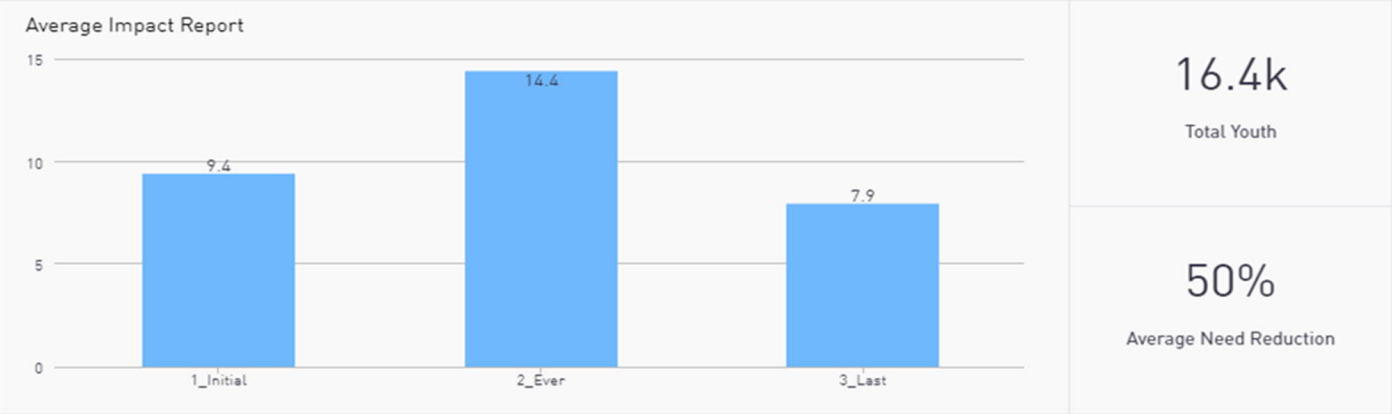
10b: Average Impact Report (January 1, 2018 – March 31, 2022)

Average Impact

Purpose: This chart provides an overview of need reduction over time and can be used to assess the average impact the system of care is having on the individuals it serves.

Data Notes:

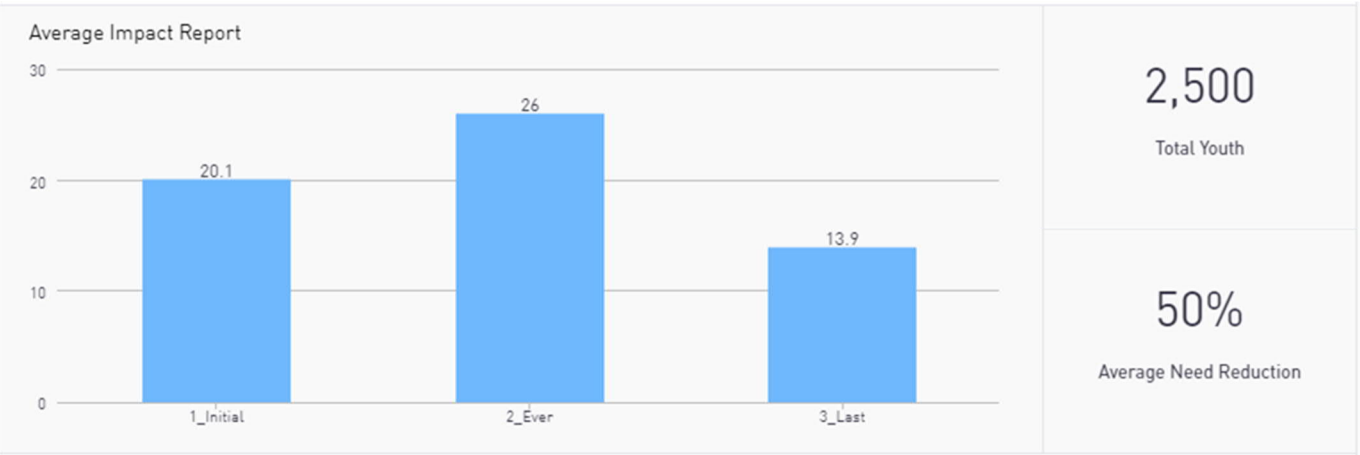
- This chart only includes individuals that had a first CANS any time on or after 18 months prior to the end of the current reporting quarter. In addition, Individuals on this chart must have received at least 3 CANS and the time difference between the first and last CANS must be greater than 90 days.
- The Average Need Reduction is calculated based on Ever to Last using the formula: (Ever-Last)/Ever.
- This chart only includes the Behavioral, Caregiver, Culture, Life Functioning and Risk Behaviors domains.



What is this data telling us?

When considering all youth in the system of care who have received at least three CANS assessments, there has been an average need reduction of 50%. A question this data might lead to is: Do we see similar findings for youth in the system with the highest needs (i.e., overall CANS of 3)?

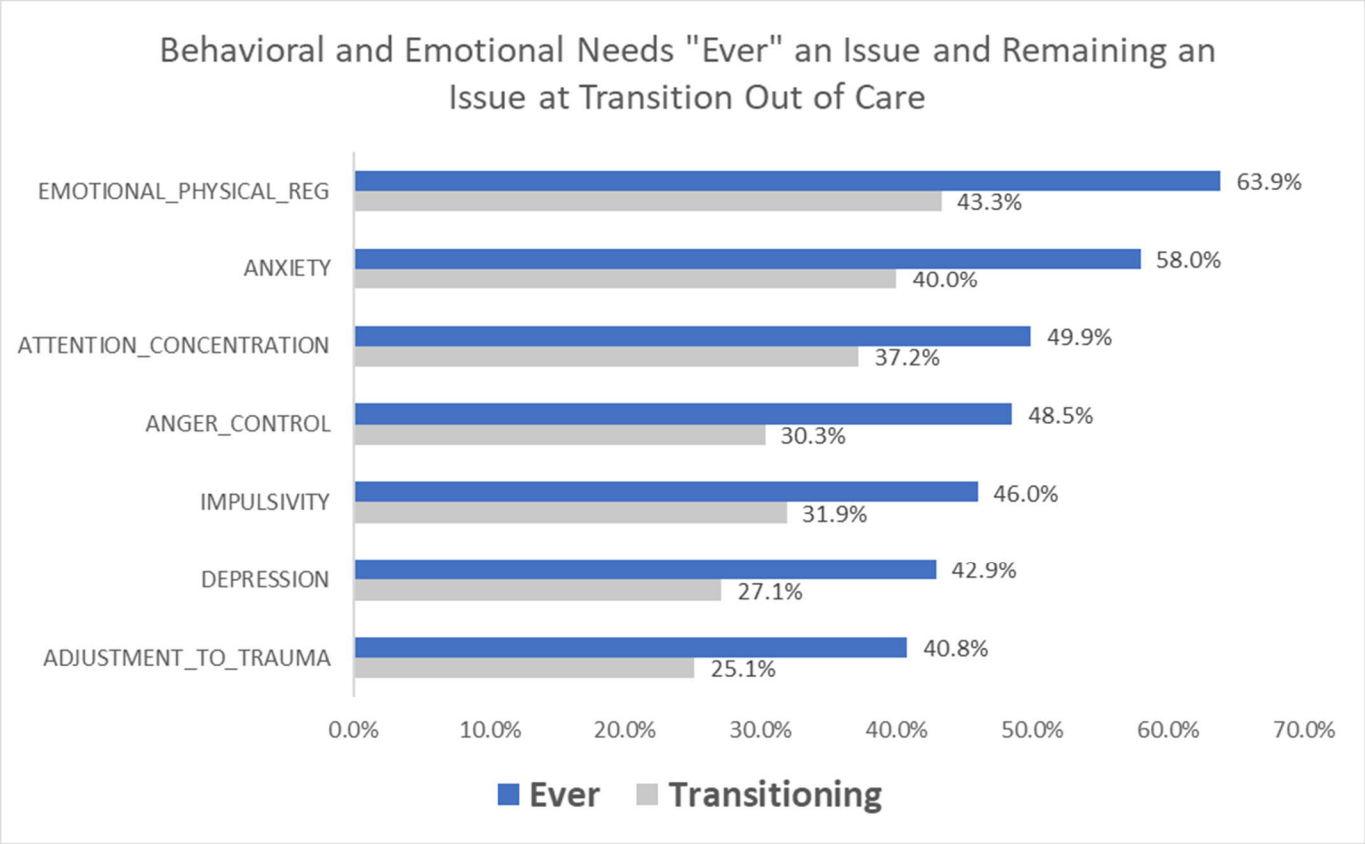
10c: Average Impact Report – Filtered by Overall CANS of 3 (January 1, 2018 – March 31, 2022)



What is this data telling us?

Because dashboard reports can be filtered by CANS scores (0 to 3), it is possible to assess how the system of care is functioning when different levels of care are warranted (e.g., CANS of 3 versus CANS of 0). As the report indicates and as would be expected, youth with an overall CANS of 3, had substantially more actionable needs as compared to all youth in the system of care. However, average need reduction for the 2,500 youth with an overall of CANS of 3 was also 50%, indicating the overall system is making substantial progress in need reduction for those youth with the highest need.

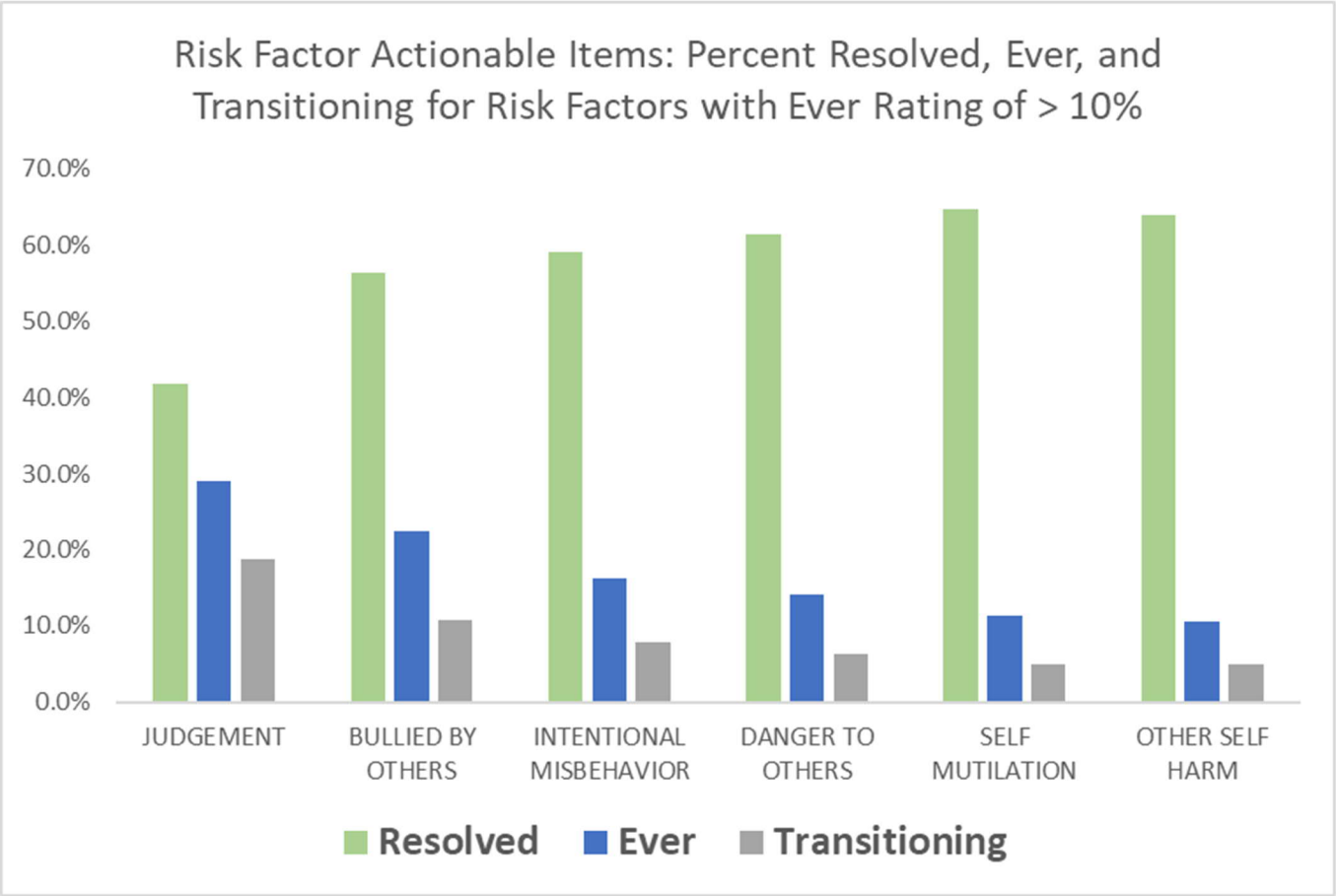
10d: Behavioral and Emotional Needs Impact Report: Downloaded Data Example – Persistent Needs (January 1, 2018 – March 31, 2022)



What is this data telling us?

The focus of this examination of downloaded dashboard data is Behavioral and Emotional needs categorized as persistent based on 25% or more of youth transitioning out of care with an actionable rating in the area which, not surprisingly, coincides with areas of high need reflected by substantial percentages of youth Ever having an actionable rating. Emotional and physical regulation, anxiety, and attention/concentration are areas of high and persistent need with 50% or more of youth Ever having the need and a high percentage of youth (37% to 43%) transitioning out of care with an actionable need in these areas suggesting efforts to address these areas could improve youth outcomes.

10e: Risk Factor Impact Report: Downloaded Data Example – Top Actionable Needs (January 1, 2018 – March 31, 2022)



What is this data telling us?

This downloaded data example includes Risk Factors with an "Ever" actionable rating of 10% or more. Systemwide, impressive progress was made in the areas of being bullied by others, intentional misbehavior, danger to others, self-mutilation, and other type of self-harm with over 56% to 65% of youth "Resolved" (i.e., actionable at any assessment no longer actionable to the latest reassessment). The data also suggested the risk factor "Judgement" may be fruitful for intervention efforts because nearly 19% of youth were actionable in this area when they transitioned out of care. Further, nearly 30% of youth were Ever actionable in area of Judgement and, as compared to other risk factors, there was less resolution in the area of Judgement.

11. Quality Monitoring Processes

The QMIA Family Advisory Subcommittee (Q-FAS)

The QMIA Family Advisory Subcommittee (Q-FAS) presents an opportunity for YES partners to gather information and learn from current issues that families often have to deal with in accessing the children's mental health system of care. Q-FAS solicits input from family members and family advocates on families' experiences accessing and using YES services. The feedback received about successes, challenges, and barriers to care is used to identify areas that need increased focus and to prioritize quality improvement projects. This subcommittee helps to guide YES partners work, providing children, youth, and families in Idaho access to appropriate and effective mental health care.

The QFAS maintains a list of barriers to care that are discussed in the QFAS which have been identified over the past years. Barriers that are noted may be experienced by one or more families, and may not include all barriers, or specifically address gaps in services as noted in the prevalence data. The establishment of the priorities for quality improvement project recommendation for SFY 2023 are in progress in the QFAS. A priority brought forth for consideration for SFY 2023, Q1 is opportunities for QFAS learn directly from families through having families come to the meeting to tell their stories. The QFAS is currently developing this process.

11a: QFAS List of Barriers to Care

Area	Noted issues
Access to care	Services not available within reasonable distance Services not coordinated between mental health and DD- DHW Waitlist for Respite and Family Support Partners Respite process through Medicaid too demanding due to need for updated CANS Wait times for services can be several months
Clinical care	Repeating the CANS with multiple providers is traumatic Diagnosis often not accurate Therapist not knowledgeable of de-escalation techniques Stigmatization and blaming attitudes towards families Families need more information about services is (e.g., Case Management)
Outpatient services	No service providers in the area where family needs care Services needed were not available, so families are referred to the services that are available Not enough expertise in services for high-needs kids (TBRI, Family Preservation) Some services only available through other systems: DD, Judicial Families having to find services themselves based on just a list of providers - and even the lists at times being too old to be useful
Crisis services	Access to immediate care had to go through detention Safety Plans not developed with family or not effective
24-hour services: Hospitals/Residential	Not enough local beds Length of time for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) determination Families getting verbal "denial" but no Notice of Determination/appeal info until after "re-applying" for EPSDT (raised at Due Process meeting) Support needed by families during the EPSDT process, and after while waiting for placement Medication changes without input from family Family not involved in discharge planning Family threatened with charges of abandonment or neglect Children with high needs and repeat admissions may be denied access Child not in hospital long enough for meds to take effect Care in local residential facilities does not provide specialized care that is needed
Step-down or Diversion Services	Lack of Step-down services Services being offered are not appropriate (telehealth, not available, not accessible) Workforce shortage Distance Amount of services (3 hours CBRS)
School issues	Too long to get an Individualized Education Plan (IEP) School makes choices that don't match needs of the child

	Safety Plans from schools not developed with family input
Stigma and Blaming	Families being blamed if discharge is not successful Lack of collaboration and partnership with discharge planning No understanding of how language is shaming in emails or other explanations (highlighting family "non-compliance")
Other family concerns	Families required to get Release of Information (ROIs) and documents-often wo enough notice Lack of transparency about paperwork and other requirements Lack of empathy for other family crisis/situations Too many appointments and other children with needs Appointments scheduled quickly that may conflict with family availability Need one case manager/TCC type person Information on how to access care not available Transportation not available Gas vouchers only at specific gas stations

YES Complaints

Tracking and responding to complaints about the YES system. A total of 92 YES complaints were received in SFY 2022 and 33 for SFY 2023, Q1.

11b: YES Complaints (full report published on YES Website) https://yes.idaho.gov/wp-content/uploads/2022/10/YES-Rights-and-Resolutions-Q4-SFY-2022-Final-2.pdf

	YES	DBH	Optum	EPSDT	MTM	Liberty	IDJC	FACS	SDE*	Total
SFY 2022	22	1	27	-	25	1	16	0	-	92
SFY 2023 Q1	8	0	16	0	3	6	0	0	-	33

YES Quality Review (QR)

The purpose of the 2022 YES Quality Review was to:

- Objectively assess and improve clinical practice and program effectiveness systemwide
- Identify YES program strengths and needs
- Develop actionable information based on specific clinical practice (why things happen)
- Identify targeted areas of clinical practice for system improvement

The QR process included interviews with youth and families, record reviews, and interviews with clinical staff and supervisors involved in treatment.

In order for the 2022 Quality Review to focus on better identifying **clinical** root causes of shortages of high-quality intensive community treatment services specific questions were answered such as:

1. What are the youth and caregivers' experience of barriers to accessing and engaging in and maintaining 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? Why are or aren't they providing 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? Capacity vs capability - do they have the ability to provide the services (example Wraparound) and capacity issues as well.
4. What state-level barriers and supports impact the expansion of intensive community-based treatment?

Results of the 2022 QR will be published on the YES Website by January 31, 2023

12. YES Quality Monitoring Results

In Spring of SFY 2022, QMIA utilized three types of quality review processes to assess the quality of services being delivered and evaluated the integration of the YES Principles of Care into the system of care: 1) All Key Quality Performance Measures, 2) Family Experience Survey https://yes.idaho.gov/youth-empowerment-services/about-yes/yes-history/?target=8, 3) Provider Survey https://yes.idaho.gov/youth-empowerment-services/about-yes/yes-history/?target=8

The following table is a list of the quality measures that the QMIA Council determined would be the YES Key Quality Performance Measures (KQPMs) . Results in the last column indicate the current status of this measure:

Needs Improvement= Red

Emerging = orange

Evolving = blue

Established = green

Quality targets were developed by the Council and may change over time but are provided here to give YES partners and stakeholders an initial way to analyze results. Based on the targets there are four (4) items that need improvement, nine (9) that are emerging, ten (10) that are evolving, and six (6) that are established. There are seven (7) items identified by the QMIA Council for which the data are not yet available and are being developed

Performance Metric	Measure	Frequency	Quality Targets for YES Practice			SFY 2022	Status
			Emerging	Evolving	Established	Results	
Are children who need services being identified?	CANS Assessments- % of 0, 1, 2, and 3 s- maintain current average of 30% =0, 70% = 1,2 and 3	Quarterly	55%-64%	65%-69%	70%+	69%	Evolving
Are children getting access to care?	Expected % of Medicaid members accessing Psychotherapy	Annually	55%-64%	65%-69%	70%+	78%	Established
Are services available timely?	Family can easily access the services child needs	Annual	65% - 74%	75% - 84%	85% +	69%	Emerging
	Meetings occur at times and locations that are convenient	Annual	65% - 74%	75% - 84%	85% +	83%	Evolving
For Children and Youth with scores of 2 or 3 on the CANS	Assessments are completed within 30 days of first contact[7]	Annual	55%-64%	65%-69%	70%+	58%	Emerging
	Treatment planning is completed within 10 days of first treatment contact (QR)	Annual	55%-64%	65%-69%	70%+	58%	Emerging
	Psychiatric supports consultation is provided within 30 days of first treatment contact (QR)	Annual	55%-64%	65%-69%	70%+	50%	Needs Improvement
Are Children getting Access to care in the scope, duration and intensity needed	Provider makes suggestions about what services might benefit child/youth	Annual	65% - 74%	75% - 84%	85% +	77%	Evolving
	Provider suggests changes when things aren't going well	Annual	65% - 74%	75% - 84%	85% +	75%	Evolving
	Provider leads discussion of how to make things better when services are not working	Annual	65% - 74%	75% - 84%	85% +	68%	Emerging
	Provider helped make a safety/crisis plan	Annual	65% - 74%	75% - 84%	85% +	61%	Needs improvement

[7] Measure was assessed during the Quality Review process. Number of records analyzed was very small and is assumed to be representative of the whole YES system, but further evaluation is needed to verify.

	I feel confident that child/youth's safety/crisis plan will be useful	Annual	65% - 74%	75% - 84%	85% +	61%	Needs Improvement
For children and youth with scores of 2 or 3 on the CANS	Practice standards of scope, intensity and duration are met by initial care effectiveness (QR)	Annual	55%-64%	65%-69%	70%+	32%	Needs Improvement
Are services being delivered in accordance care plans?	Children with SED in IDJC care complete mental health treatment	Quarterly	65%-74%	75%-84%,	85% +	87.5%	Established
Are services provided with fidelity to POCPM?	Provider encourages me to share what I know about my child/youth	Annual	65% - 74%	75% - 84%	85% +	85%	Established
	The goals we are working on are the ones I believe are most important	Annual	65% - 74%	75% - 84%	85% +	87%	Established
	My child and I are the main decision makers	Annual	65% - 74%	75% - 84%	85% +	83%	Evolving
	Provider respects me as an expert on my child/youth	Annual	65% - 74%	75% - 84%	85% +	85%	Established
	The assessment completed by the provider accurately represents my child/youth	Annual	65% - 74%	75% - 84%	85% +	81%	Evolving
	My youth/child is an active participant in planning services	Annual	65% - 74%	75% - 84%	85% +	71%	Emerging
	My child/youth has the opportunity to share his/her own ideas when decisions are made	Annual	65% - 74%	75% - 84%	85% +	82%	Evolving
	I know who to contact if I have a concern or complaint about my provider	Annual	65% - 74%	75% - 84%	85% +	68%	Emerging
	Services focus on what my child/youth is good at, not just problems	Annual	65% - 74%	75% - 84%	85% +	84%	Evolving
	Provider discusses how to use things we are good at to overcome problems	Annual	65% - 74%	75% - 84%	85% +	76%	Evolving
	Collaborative/Team -Based Care	Annual	65% - 74%	75% - 84%	85% +	74%	Emerging
	Care is outcome based	Annual	65% - 74%	75% - 84%	85% +	73%	Emerging
Are services provided through Child and Family Teaming	Families were able to participate in child's mental health services as much as they want	Annual	65% - 74%	75% - 84%	85% +	83%	Evolving
	The provider communicates as much as needed with others involved in my child's care	Annual	65% - 74%	75% - 84%	85% +	73%	Emerging
Are YES Complaints and appeals addressed and tracked	Number, type and disposition of all complaints and grievances	Quarterly	Yes	Yes	Yes	Yes	Established

KQPMs that are still being developed

Performance Metric	*Measure*	*Frequency*	*Quality Targets for*			*Results*
Are services available timely?	Follow-up outpatient services for Medicaid and Non-Medicaid YES Eligible within 7 days of hospitalization (national 48%- Current Idaho range is 6%-89%-See Nate W study)	Quarterly	38%	48%-57%	58%+	NA
Are services available in urban, rural and frontier areas across the state?	Utilization of services by county	Quarterly	65%-74%	75%-84%	85% +	NA
Are services proportionately available to culturally diverse populations ?	Utilization of services - by race ethnicity by region -	Quarterly	65%-74%	75%-84%	85% +	NA
Are Children getting Access to care in the scope, duration and intensity needed?	YES eligible children receive a minimum of 8 Psychotherapy sessions (scope, intensity, duration) (potential to add variation by Level of Care rating on the CANS)	Quarterly	65%-74%	75%-84%	85% +	NA

	Children have skill building interventions in 50% of psychotherapy sessions	Annual	65%-74%	75%-84%	85% +	?
	Children have caregivers/supporters involved in 50% of psychotherapy sessions	Annual	65%-74%	75%-84%	85% +	?
Are services being delivered in accordance care plans?	Services listed in Care plans are provided	Annual	65%-74%	75%-84%	85% +	NA

12b: Family Experience Survey

The SFY 2022 YES family survey included 45 questions that asked about families experiences of care in five areas (1) the extent to which youth and families care adheres to the Idaho YES principles of care and practice model, (2) the adequacy of crisis safety planning, (3) the extent to which the CANS Assessment process followed guidelines, (4) select services the youth participated in (e.g., Wraparound, psychiatric hospitalization) , and (5) caregiver's perceptions of service outcomes such as improvement in youth overall mental health and day-to-day functioning at home, school and in the community. Research has shown these questions are valid and reliable indicators of families experiences of care and the variation in participants responses predicts variation in the extent to which youth benefit from care (Williams et al., 2021) .

The survey was fielded via postal mail from February 2022 to April 2022. The sample included 5,999 caregivers of youth who participated in YES mental health services during 2021. Caregivers were randomly sampled with proportional allocation across Idaho's' seven behavioral health regions to ensure adequate representation across the State. Following an evidence-based process the survey entailed a pre-survey letter, survey with postage paid return envelope, reminder card, and final survey with postage paid return envelope. The survey asked specifically about 1 identified child within the household. A total of 1,048 caregiver's responded (20.4% response rate after excluding returned mail).

The full report is available at https://yes.idaho.gov/wp-content/uploads/2022/10/2022IdahoYESFamilySurveyResults.pdf

12b1. Trends over the last three years:

Questions	2020 Result	2021 Result	2022 Result
Family Centered Care			
Provider encourages me to share what I know about my child/youth	85%	85%	85%
The goals we are working on are the ones I believe are most important	88%	88%	87%
My child and I are the main decision makers	79%	83%	83%
Family and Youth Voice and Choice			
Provider respects me as an expert on my child/youth	82%	85%	85%
The assessment completed by the provider accurately represents my child/youth	78%	81%	81%
My youth/child is an active participant in planning services	58%	67%	71%
My child/youth has the opportunity to share his/her own ideas when decisions are made	72%	83%	82%
I know who to contact if I have a concern or complaint about my provider	62%	68%	68%
New- I was able to participate in my child/youth's mental health services as much as I want	-	-	83%
Strengths-Based Care			
Services focus on what my child/youth is good at, not just problems	78%	84%	84%
Provider discusses how to use things we are good at to overcome problems	70%	77%	76%
Individualized Care			
Provider makes suggestions about what services might benefit my child/youth	75%	76%	77%
Provider suggests changes when things aren't going well	69%	74%	75%
Provider leads discussion of how to make things better when services are not working	62%	69%	68%
Access to Community-Based Service array			
My family can easily access the services my child needs	61%	71%	69%
Meetings occur at times and locations that are convenient for me	79%	83%	83%
New- We are able to access all the mental health services recommended by the provider.	-	-	70%
Collaborative/Team -Based Care			
The provider makes sure everyone involved on my child's treatment team is working together in a coordinated way.	65%	73%	74%

New-The provider communicates as much as needed with others involved in my child/youth's care-	-	-	73%
Culturally Competent Care	92%	93%	93%
Outcome-Based Care	73%	75%	73%
Adequacy of Safety/Crisis Planning			
Provider helped make a safety/crisis plan	48%	60%	61%
I feel confident that my child/youth's safety/crisis plan will be useful	54%	61%	61%
Total	70.2%	75.8%	75.8%

12c: YES Provider Survey

The central questions for SFY 2022's Provider Survey were based on the results of the Quality Review conducted in 2021. The findings form 2021 indicated that youth with intensive needs experienced delays in access to care, infrequent treatment sessions, care coordination that did not engage partners, disparities in care and outcomes for persons identified as culturally diverse.

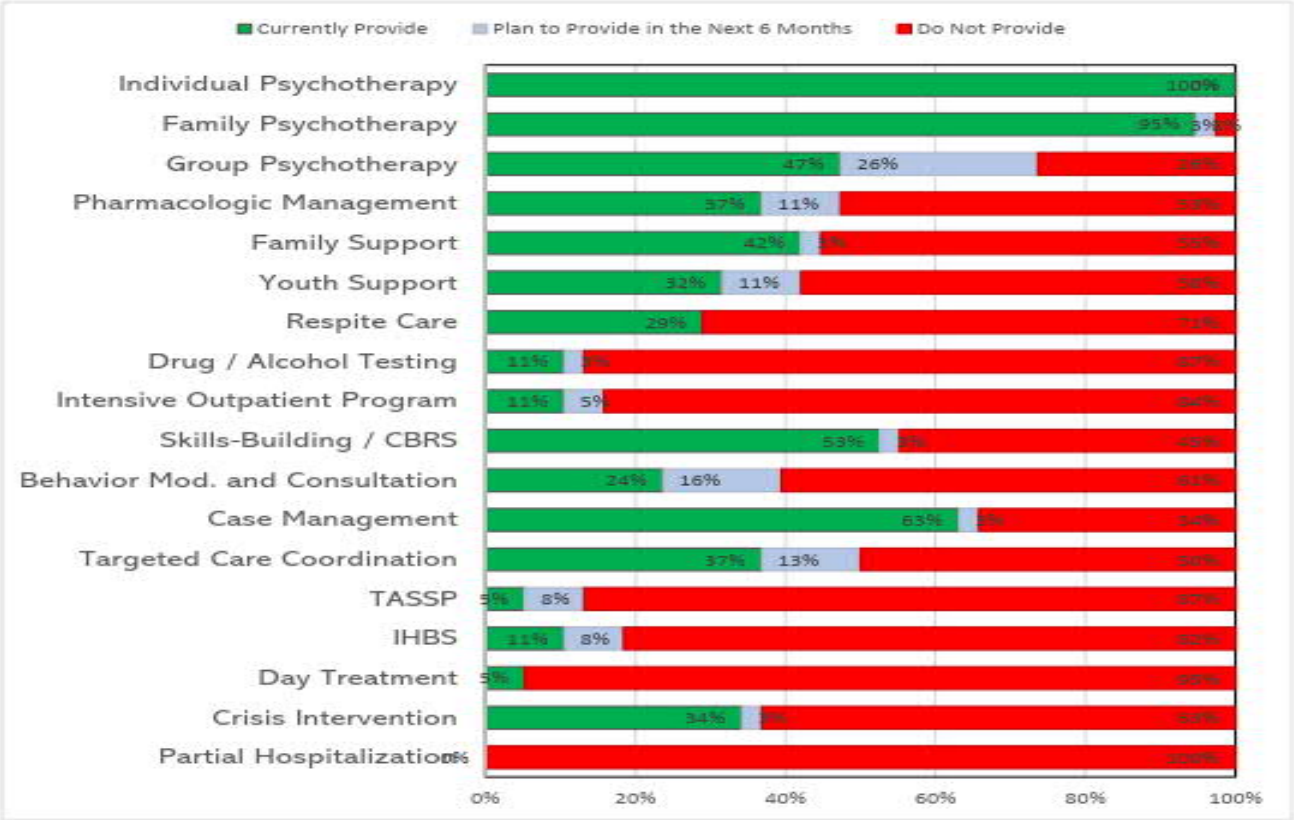
The Provider Survey was designed to answer two primary questions:

1) What capacity do providers currently have for intensive community-based treatment?
2) What state-level barriers and supports impact the expansion of intensive community-based treatment?

Findings of the survey indicate that:

a) Individual providers, as a group, do not provide intensive, community-based treatment services
b) Very few provider agencies (5-10%) currently offer intensive, community-based services (see 11c1)
c) The current service array is contracting rather than expanding
d) Barriers and supports impacting the expansion of community based treatment services were readily and consistently identified by providers included: reimbursement rate, administrative burdens, lack of qualified and willing workforce, high cost of training staff.

12c1: YES Provider Agencies Current and Planned Services

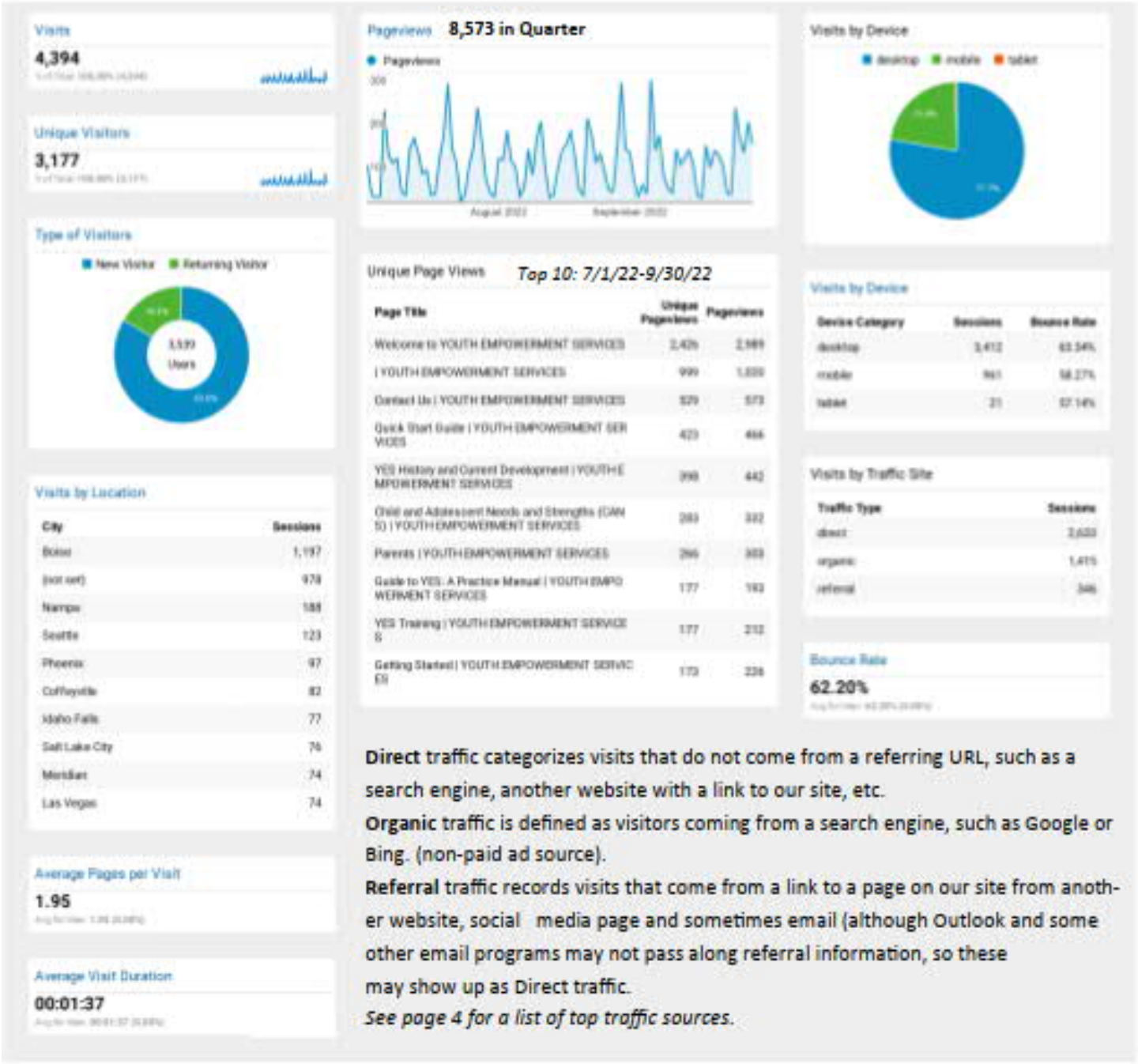


13 YES Communications :

YES WEBSITE ANALYTICS

Reporting Period: July 1, 2022 – September 30, 2022

VISITORS AND PAGES



Direct traffic categorizes visits that do not come from a referring URL, such as a search engine, another website with a link to our site, etc.

Organic traffic is defined as visitors coming from a search engine, such as Google or Bing. (non-paid ad source).

Referral traffic records visits that come from a link to a page on our site from another website, social media page and sometimes email (although Outlook and some other email programs may not pass along referral information, so these may show up as Direct traffic.

See page 4 for a list of top traffic sources.

YES WEBSITE ANALYTICS

Trends since site launch: June 21, 2022 – September 30, 2022

VISITORS AND PAGES

Pageviews **43,656 total since June 21, 2021 launch**

Visits

20,904

Unique Visitors

13,794

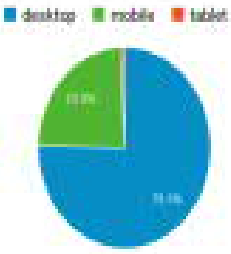
Average Pages per Visit

2.09

Average Visit Duration

00:02:16

Visits by Device



Type of Visitors

Visits by Location

City	Sessions
Boise	5,858
(not set)	2,548
Nampa	1,350
Seattle	715
Meridian	672
Coeur d'Alene	616
Idaho Falls	601
Salt Lake City	497
Pocatello	446
Twin Falls	397

Unique Page Views *Top 10: 6/21/21-9/30/22*

Page Title	Unique Pageviews	Pageviews
Welcome to YOUTH EMPOWERMENT SERVICES	12,583	16,125
| YOUTH EMPOWERMENT SERVICES	8,433	8,660
Contact Us | YOUTH EMPOWERMENT SERVICES	2,738	2,989
Quick Start Guide | YOUTH EMPOWERMENT SERVICES	2,427	2,721
YES History and Current Development | YOUTH EMPOWERMENT SERVICES	1,711	1,951
Powers | YOUTH EMPOWERMENT SERVICES	1,430	1,675
Guide to YES: A Practice Manual | YOUTH EMPOWERMENT SERVICES	1,263	1,442
Getting Started | YOUTH EMPOWERMENT SERVICES	1,089	1,248
Child and Adolescent Needs and Strengths (CANS) | YOUTH EMPOWERMENT SERVICES	979	1,155
YES Overview | YOUTH EMPOWERMENT SERVICES	847	905

Visits by Device

Device Category	Sessions	Bounce Rate
desktop	15,751	52.00%
mobile	4,994	55.49%
tablet	159	44.03%

Visits by Traffic Site

Traffic Type	Sessions
direct	11,966
organic	7,268
referral	1,670

Bounce Rate

52.77%

YES WEBSITE ANALYTICS

Reporting Period: July 1, 2022 – September 30, 2022

NOTE: Document downloads and external links were not tracked this quarter due to a reporting error.

Where do visitors enter the YES site?

Page Title	Entrances	Pages / Session
Welcome to YOUTH EMPOWERMENT SERVICES	2,352	1.27
| YOUTH EMPOWERMENT SERVICES	957	1.07
Child and Adolescent Needs and Strengths (CANS) | YOUTH EMPOWERMENT SERVICES	215	1.54
YES History and Current Development | YOUTH EMPOWERMENT SERVICES	137	3.23
Contact Us | YOUTH EMPOWERMENT SERVICES	114	5.03
Wraparound Intensive Services | YOUTH EMPOWERMENT SERVICES	94	1.63
Parents | YOUTH EMPOWERMENT SERVICES	65	4.66
Quick Start Guide | YOUTH EMPOWERMENT SERVICES	61	7.64
Guide to YES: A Practice Manual | YOUTH EMPOWERMENT SERVICES	51	3.78
YES Training | YOUTH EMPOWERMENT SERVICES	46	4.61

What pages do visitors leave the YES site from?

Page Title	Exits	% Exit
Welcome to YOUTH EMPOWERMENT SERVICES	1,202	40.21%
| YOUTH EMPOWERMENT SERVICES	942	92.35%
Contact Us | YOUTH EMPOWERMENT SERVICES	370	64.57%
YES History and Current Development | YOUTH EMPOWERMENT SERVICES	304	68.78%
Quick Start Guide | YOUTH EMPOWERMENT SERVICES	267	57.30%
Child and Adolescent Needs and Strengths (CANS) | YOUTH EMPOWERMENT SERVICES	219	65.96%
Parents | YOUTH EMPOWERMENT SERVICES	124	40.92%
Guide to YES: A Practice Manual | YOUTH EMPOWERMENT SERVICES	116	60.10%
YES Training | YOUTH EMPOWERMENT SERVICES	113	53.30%
Wraparound Intensive Services | YOUTH EMPOWERMENT SERVICES	82	53.59%

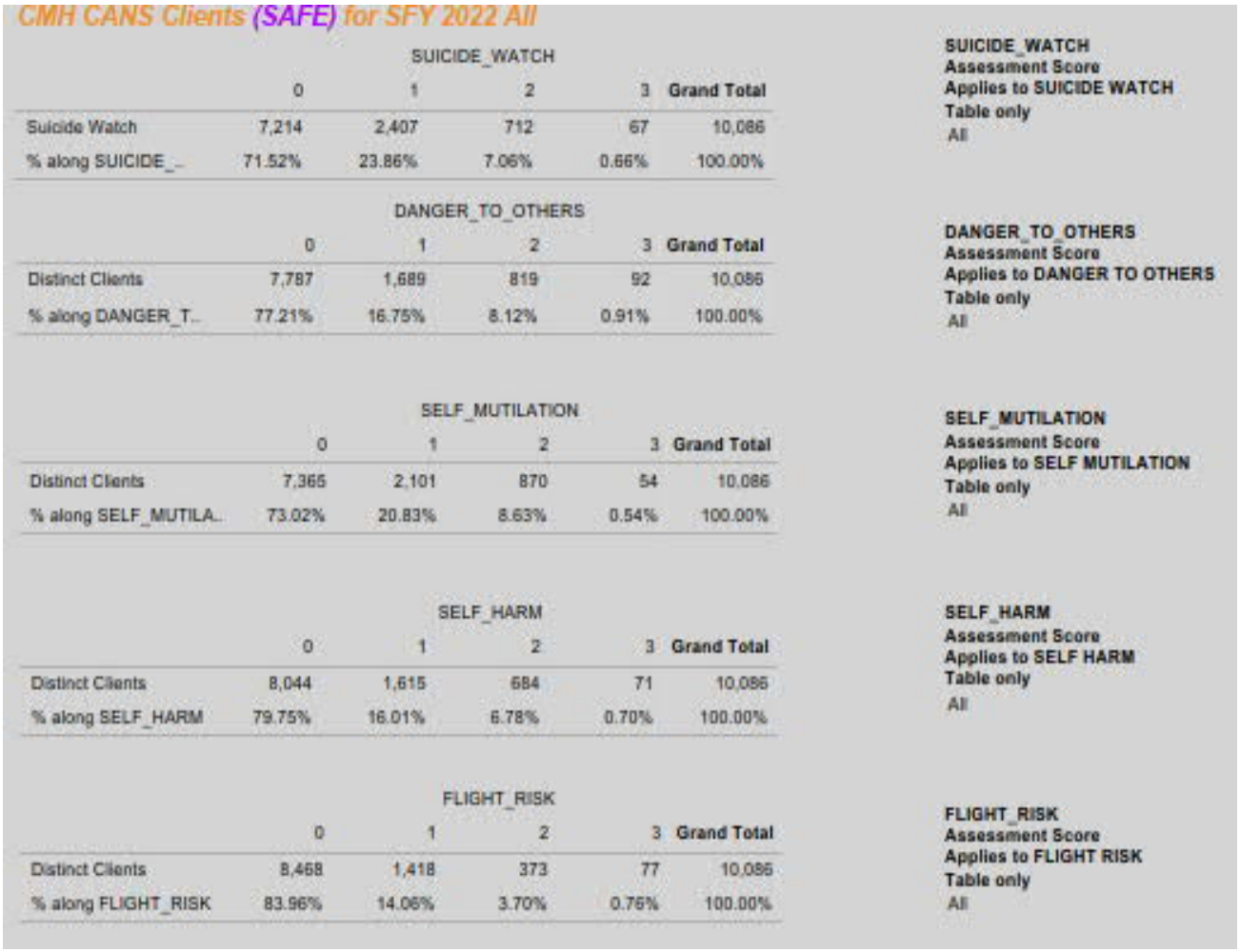
14 Supplemental CANS info: Are kids Safe, in School and Out of Trouble

This section of the QMIA Report is includes status at initial CANS, regarding safety, school, and legal issues.

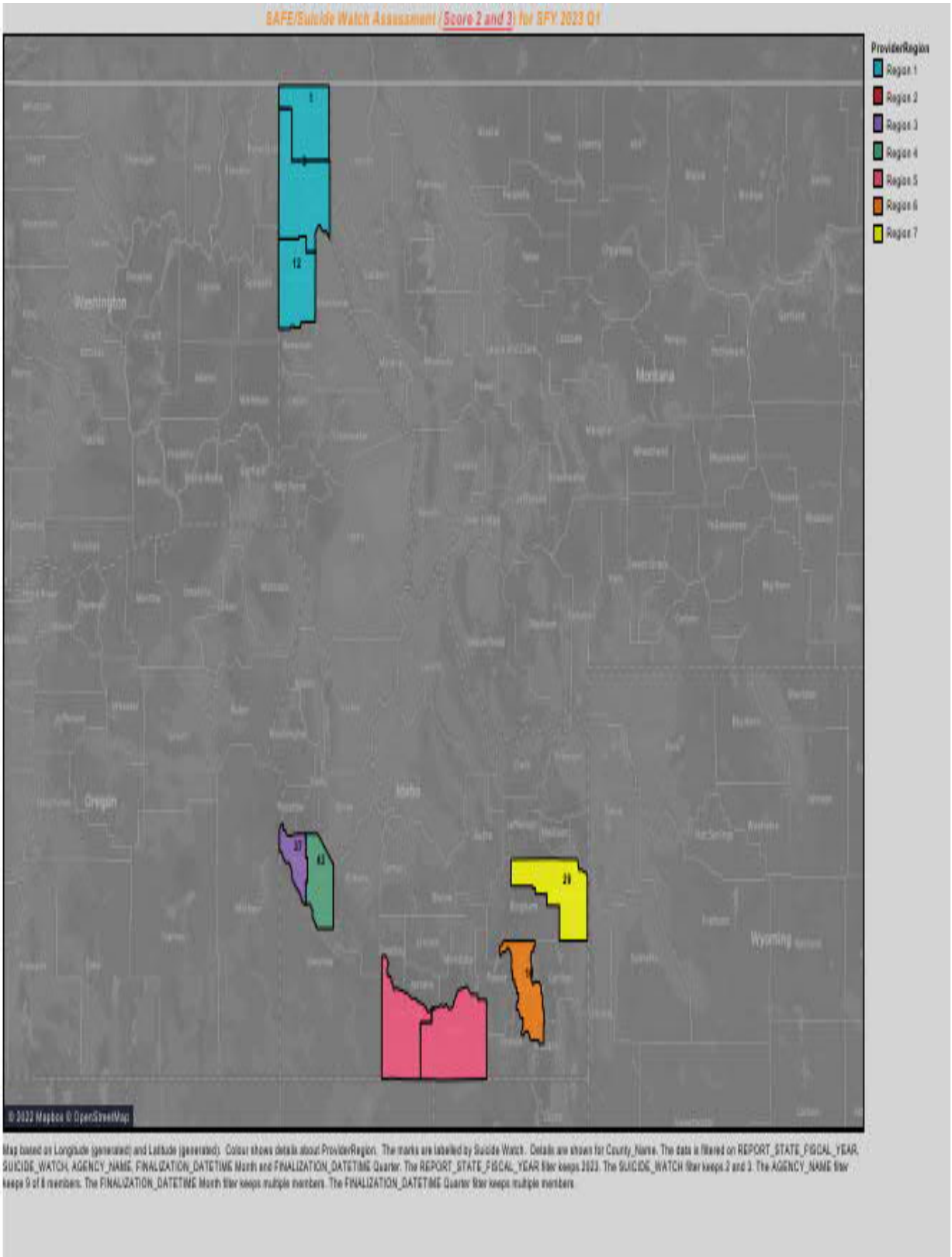
Safe

Based on the results of the initial CANS, the following are the ratings on Suicide Watch, Danger to others, Self-Mutilation, Self-Harm, Flight Risk. For SFY 2023 Q1, approximately

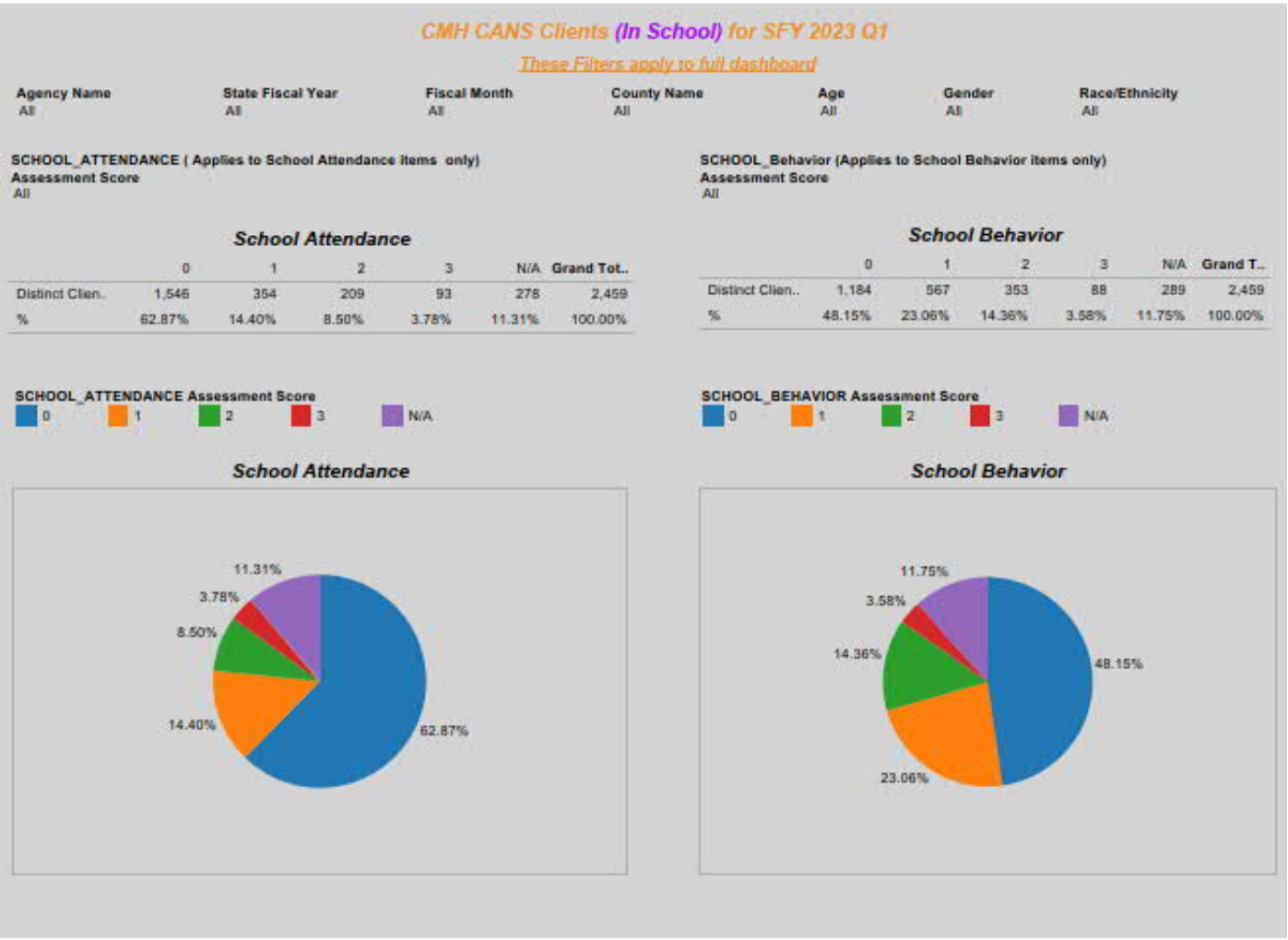
- 76% on average have no evidence of safety issues (score of zero on the CANS),
- 17% percent have some safety concerns noted (Score of 1 on the CANS),
- 7% percent have safety issues that are interfering with their functioning (Score of 2 on the CANS) , and
- 1% percent are having severe problems with safety issues (Score of 3 on the CANS).



Locations of children and youth with higher risk of safety issues by county for SFY 2023; Q1:



In School – SFY 2023-Q1



What is School Behavior?

This item on the CANS rates the behavior of the individual in school or school-like settings (e.g., Head Start, pre-school). A rating of '3' would indicate an individual who is still having problems after special efforts have been made (e.g., problems in a special education class).

Questions to Consider

- How is the individual behaving in school?
- Has the individual had any detentions or suspensions?
- Has the individual needed to go to an alternative placement?
- What do these behaviors look like?
- Is it consistent among all subjects/classes?
- How long has it been going on?
- How long has the individual been in the school?

Out of trouble: SFY 2023, Q1

Appendix A: Glossary- updated Sept. 2022

Child and Adolescent Needs and Strengths (CANS)	A tool used in the assessment process that provides a measure of a child's or youth's needs and strengths.
Class Member	Idaho residents with serious emotional disturbance (SED) who are under the age of 18, have a diagnosable mental health condition, and have a substantial functional impairment.
Distinct Number of Clients	Child or youth is counted once within the column or row but may not be unduplicated across the regions or entities in the table.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment (EPSDT), which is now referred to as Children's Medicaid, provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services. (National website Medicaid.gov).
IEP	The Individualized Education Plan (IEP) is a written document that spells out a child or youth's learning needs, the services the school will provide, and how progress will be measured.
Intensive Care Coordination (ICC)	A case management service that provides a consistent single point of management, coordination, and oversight for ensuring that children who need this level of care are provided access to medically necessary services and that such services are coordinated and delivered consistent with the Principles of Care and Practice Model.
Jeff D. Class Action Lawsuit Settlement Agreement	The Settlement Agreement that ultimately will lead to a public children's mental health system of care (SoC) that is community-based, easily accessed and family-driven and operates other features consistent with the System of Care Values and Principles.
QMIA	A quality management, improvement, and accountability program.
Serious Emotional Disturbance (SED)	The mental, behavioral, or emotional disorder that causes functional impairment and limits the child's functioning in family, school, or community activities. This impairment interferes with how the youth or child needs to grow and change on the path to adulthood, including the ability to achieve or maintain age-appropriate social, behavioral, cognitive, or communication skills.
SFY	The acronym for State Fiscal Year, which is July 1 to June 30 of each year.
SFYTD	The acronym for State Fiscal Year to Date.
System of Care	An organizational philosophy and framework that involves collaboration across agencies, families, and youth for improving services and access, and expanding the array of coordinated community-based, culturally, and linguistically competent services and supports for children.
TCOM	The Transformational Collaborative Outcomes Management (TCOM) approach is grounded in the concept that the different agencies that serve children all have their own perspectives, and these different perspectives create conflicts. The tensions that result from these conflicts are best managed by keeping a focus on common objectives — a shared vision. In human service enterprises, the shared vision is the person (or people served). In health care, the shared vision is the patient; in the child serving system, it is the child and family, and so forth. By creating systems that all return to this shared vision, it is easier to create and manage effective and equitable systems.
Unduplicated Number of Clients	Child or youth is counted only once in the column or row
Youth Empowerment Services (YES)	The name chosen by youth groups in Idaho for the new System of Care that will result from the Children's Mental Health Reform Project.
Other YES Definitions	System of Care terms to know: https://yes.idaho.gov/youth-empowerment-services/resources/terms-to-know/yes-system-of-care-terms-to-know/ YES Project Terms to know: https://yes.idaho.gov/youth-empowerment-services/resources/terms-to-know/yes-project-terms-to-know/

Appendix B –Annual Estimation 2022

Annual Estimated Number of Potential Class Members Dec, 2022

	Type of insurance				
	Employer	Non-Group	Medicaid	Uninsured	Total
Insured rate based on 2020 Estimated Census	50.70%	5%	34.90%	7.10%	
Population	246,000	25,000	170,000	35,000	
Estimated prevalence	6%	6%	8%	11.90%	
Estimated need	14,760	1,500	13,600	4,165	
Expected Utilization Lower Estimate 15%	2215	225	13,600	4,165	20,205
Expected Utilization Higher Estimate 18%	2655	270	13,600	4,165	20,690

**Note: Census data did not add up to 100%, however the choice was to use the percentage values recommended in the report rather than try to adjust based on assumptions.*

Definitions of Insurance:

Employer: Includes those covered by employer-sponsored coverage either through their own job or as a dependent in the same household.

Non-Group: Includes individuals and families that purchased or are covered as a dependent by non-group insurance.

Medicaid: Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

Uninsured: Includes those without health insurance and those who have coverage under the Indian Health Service only

Estimated range:

YES Eligible lower (15% Employer, Non-Group, Medicaid, Uninsured) = 2215+225+13,600 +4,165 = 20,205

YES Eligible higher (18% Employer, Non-Group, Medicaid, Uninsured) = 12655+270+13,600+ 4,165 = 20,690

Resources for data;

Population numbers:

https://www.kff.org/other/state-indicator/health-insurance-coverage-of-children-0-18-cps/?dataView=1&currentTimeframe=0&selectedRows=%7B"states":%7B"idaho":%7B%7D%7D%7D&sortModel=%7B"colId":"Location","sort":"asc"%7D

Prevalence rates:

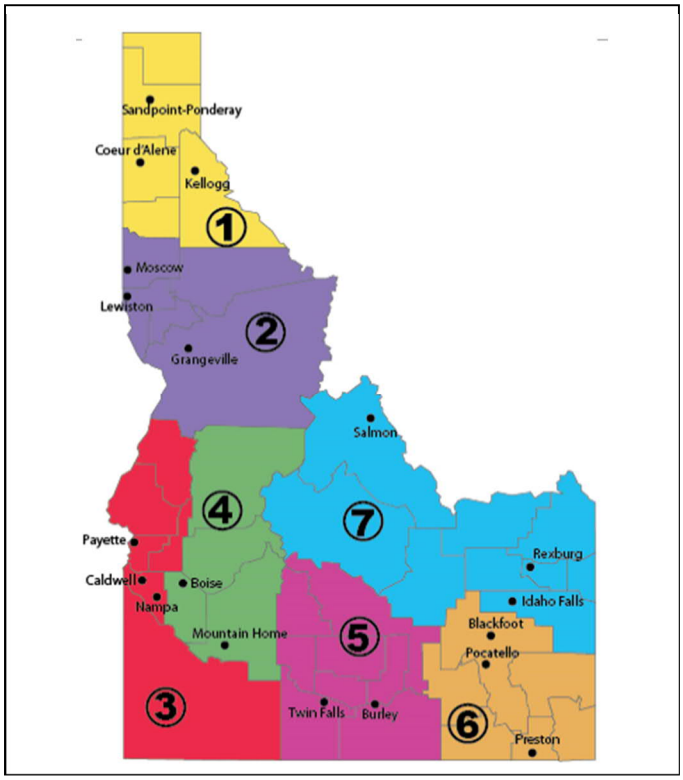
Medicaid : https://yes.idaho.gov/youth-empowerment-services/about-yes/yes-history/?target=7

Poverty prevalence: http://www.nccp.org/profiles/ID_profile_6.html

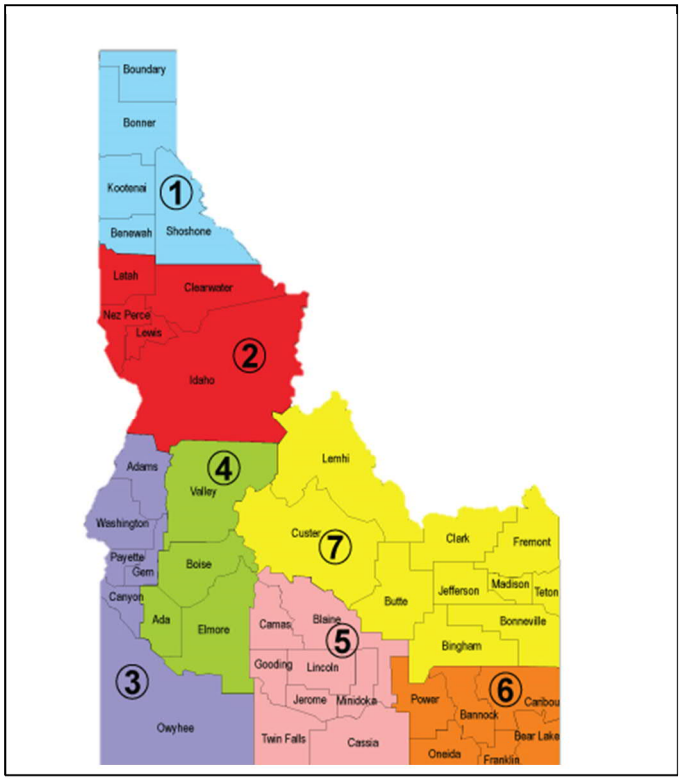
Private insurance:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2805472/

Appendix C- Regional Maps

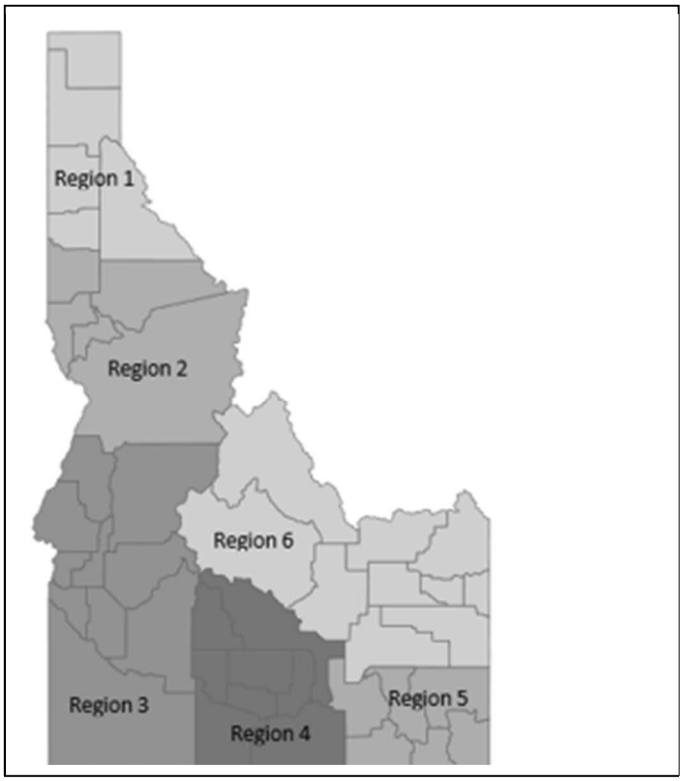
Idaho Department of Health and Welfare: Medicaid,



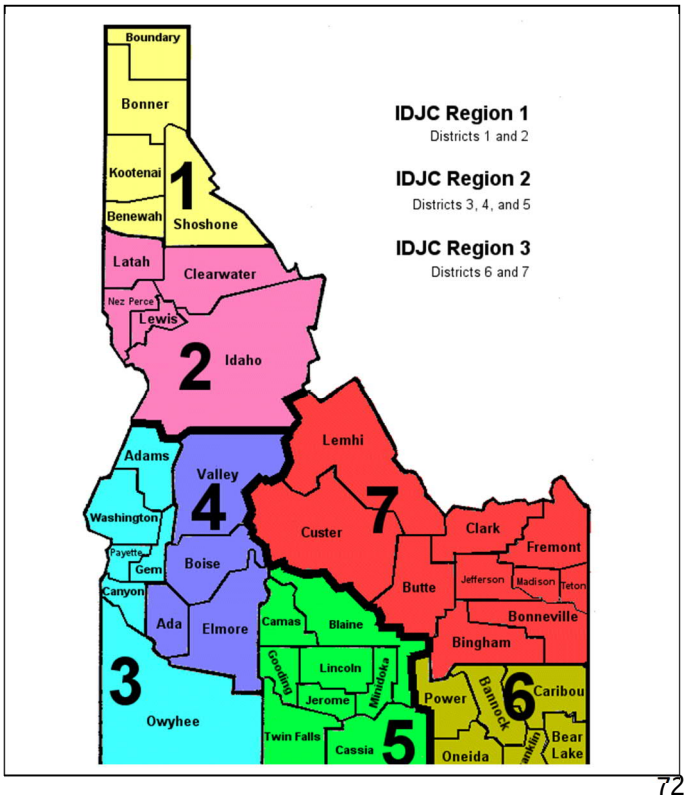
Idaho Department of Health and Welfare: DBH



Idaho State Department of Education



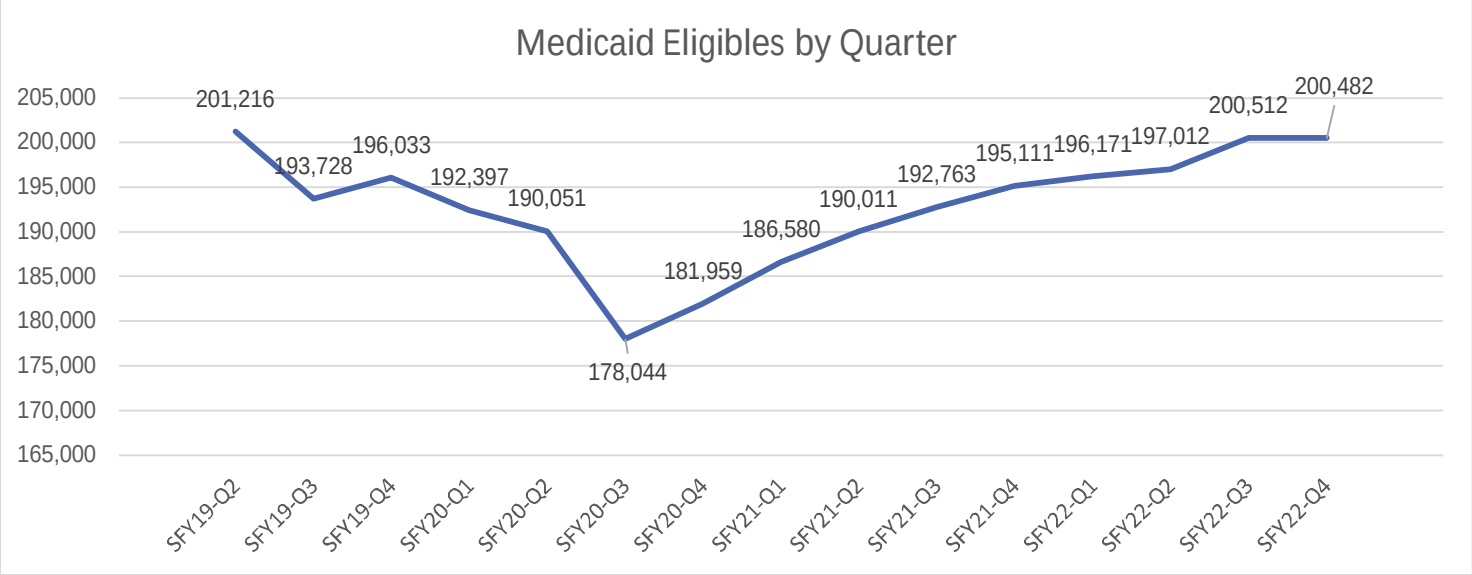
Idaho Department of Juvenile Corrections



Appendix D –Medicaid Eligible Members and rate of Utilization of Services

Medicaid eligible members, ages 0 - 17

Region	SFY19-Q1	SFY19-Q2	SFY19-Q3	SFY19-Q4	SFY20-Q1	SFY20-Q2	SFY20-Q3	SFY20-Q4	SFY21-Q1	SFY21-Q2	SFY21-Q3	SFY21-Q4	SFY22-Q1	SFY22-Q2	SFY22-Q3	SFY22-Q4	SFY23-Q1
Region 1	22,899	23,204	22,400	22,699	22,331	22,037	20,609	21,178	21,789	22,358	22,794	23,146	23,266	23,717	23,906	23,926	24,245
Region 2	7,859	7,910	7,690	7,755	7,681	7,606	7,161	7,335	7,551	7,746	7,832	7,972	8,068	8,193	8,317	8,350	8,517
Region 3	43,046	43,436	41,528	42,046	40,973	40,603	37,855	38,722	39,626	40,479	41,054	41,567	41,848	42,148	42,681	42,777	43,124
Region 4	39,509	39,911	38,364	38,773	38,133	37,568	35,158	35,989	36,874	37,705	38,241	38,625	38,996	39,449	39,814	40,057	40,520
Region 5	27,270	27,562	26,628	27,026	26,496	26,319	24,603	25,181	25,860	26,485	26,884	27,181	27,369	27,695	27,960	28,115	28,360
Region 6	14,699	14,863	14,387	14,516	14,246	14,264	13,399	13,775	14,171	14,451	14,682	14,850	15,057	15,275	15,474	15,630	15,816
Region 7	36,153	36,500	35,195	35,759	35,243	35,042	32,811	33,402	34,429	35,163	35,796	36,480	37,027	37,594	38,045	38,460	38,996
OOS	8,607	7,830	7,536	7,459	7,294	6,612	6,448	6,377	6,280	5,624	5,480	5,290	4,540	2,941	4,315	3,167	2,121
Total	200,042	201,216	193,728	196,033	192,397	190,051	178,044	181,959	186,580	190,011	192,763	195,111	196,171	197,012	200,512	200,482	201,699



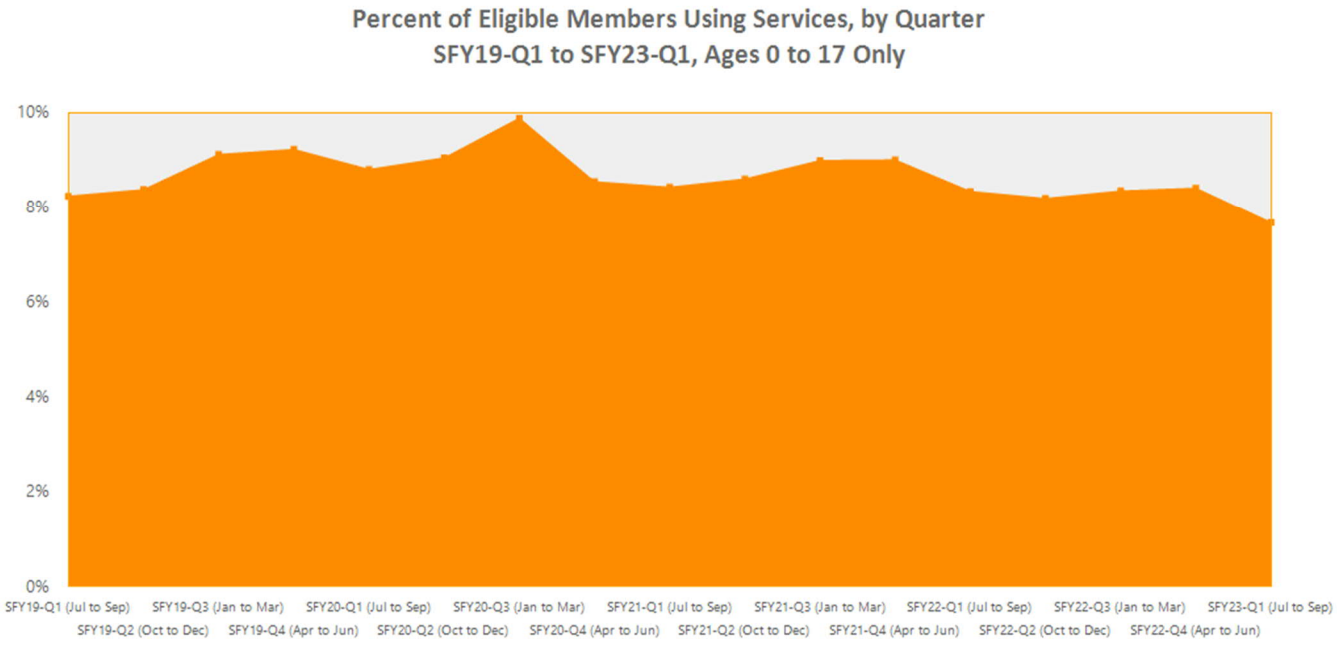
Utilization Rate - Percentage of Eligible Members Using Services

Percent Utilization: While data reveals variation in total members 0-17 eligible and also utilizing services over the report time period (SFY19-Q1 to SFY23-Q1), the percentage of members utilizing services remains relatively steady by quarter varying from 7.7% to 9.9%. It should also be noted that variation can be attributed to seasonality consistent with previous plan experience similar for each year.

QoQ (SFY22-Q4 to SFY23-Q1): -8.8%
YoY (SFY22-Q1 to SFY23-Q1): -8%

Utilization Rate by Quarter - Ages 0 to 17 Only
Description: This table displays the number of service utilizers compared to number of Eligible members, by quarter, between 7/1/2018 to 9/30/2022 for utilizers/members between the ages of 0 to 17. Data as of 11/7/2022

Qtr	Total Utilizers per Quarter	Total Distinct Members per Quarter	Pct Utilizers	Rate per Thousand	QoQ Change	YoY Change
SFY2019-Q1	16,513	200,042	8.25%	83		
SFY2019-Q2	16,886	201,216	8.39%	84	1.7%	
SFY2019-Q3	17,691	193,728	9.13%	91	8.8%	
SFY2019-Q4	18,106	196,033	9.24%	92	1.1%	
SFY2020-Q1	16,962	192,397	8.82%	88	-4.5%	6.8%
SFY2020-Q2	17,218	190,051	9.06%	91	2.8%	8.0%
SFY2020-Q3	17,616	178,044	9.89%	99	9.2%	8.3%
SFY2020-Q4	15,575	181,959	8.56%	86	-13.5%	-7.3%
SFY2021-Q1	15,751	186,580	8.44%	84	-1.4%	-4.2%
SFY2021-Q2	16,371	190,011	8.62%	86	2.1%	-4.9%
SFY2021-Q3	17,358	192,763	9.00%	90	4.5%	-9.0%
SFY2021-Q4	17,594	195,111	9.02%	90	0.1%	5.3%
SFY2022-Q1	16,390	196,171	8.35%	84	-7.3%	-1.0%
SFY2022-Q2	16,167	197,012	8.21%	82	-1.8%	-4.8%
SFY2022-Q3	16,770	200,512	8.36%	84	1.9%	-7.1%
SFY2022-Q4	16,888	200,482	8.42%	84	0.7%	-6.6%
SFY2023-Q1	15,501	201,699	7.69%	77	-8.8%	-8.0%


Percent of Eligible Members Using Services, by Quarter
SFY19-Q1 to SFY23-Q1, Ages 0 to 17 Only
10%
8%
6%
4%
2%
0%
SFY19-Q1 (Jul to Sep)
SFY19-Q2 (Oct to Dec)
SFY19-Q3 (Jan to Mar)
SFY19-Q4 (Apr to Jun)
SFY20-Q1 (Jul to Sep)
SFY20-Q2 (Oct to Dec)
SFY20-Q3 (Jan to Mar)
SFY20-Q4 (Apr to Jun)
SFY21-Q1 (Jul to Sep)
SFY21-Q2 (Oct to Dec)
SFY21-Q3 (Jan to Mar)
SFY21-Q4 (Apr to Jun)
SFY22-Q1 (Jul to Sep)
SFY22-Q2 (Oct to Dec)
SFY22-Q3 (Jan to Mar)
SFY22-Q4 (Apr to Jun)
SFY23-Q1 (Jul to Sep)

FIFTH YOUTH EMPOWERMENT SERVICESIMPLEMENTATION PROGRESS REPORT

Appendix B:

Final Report

of the

Youth Empowerment Services

Quality Review (SFY 2022)

Fall 2022

Final Report

of the

Youth Empowerment Services (YES)

Quality Review (SFY 2022)

Provided by:

Union Point Group, LLC

for the

Idaho Department of Health and Welfare

Division of Behavioral Health *and* Division of Medicaid

Fall, 2022

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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.

A special thanks goes out to the committed Quality Program staff at the Idaho Department of Health and Welfare (IDHW). They facilitate and execute this process each year, while managing a series of other, ongoing complex quality assurance and improvement processes. A special thank-you to Candace Falsetti for putting this vision into action, to Michelle Schildhauer for her continued diligence in executing each iteration of this Review process, and to the dedicated reviewers who do this work reliably, conscientiously, and with humility each year: Britt Miller, Debra Stance, Don Caagbay, and Michelle Schildhauer. They are a testimony to the importance of committed people working together for all of Idaho's children and families.

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.

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

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?

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.

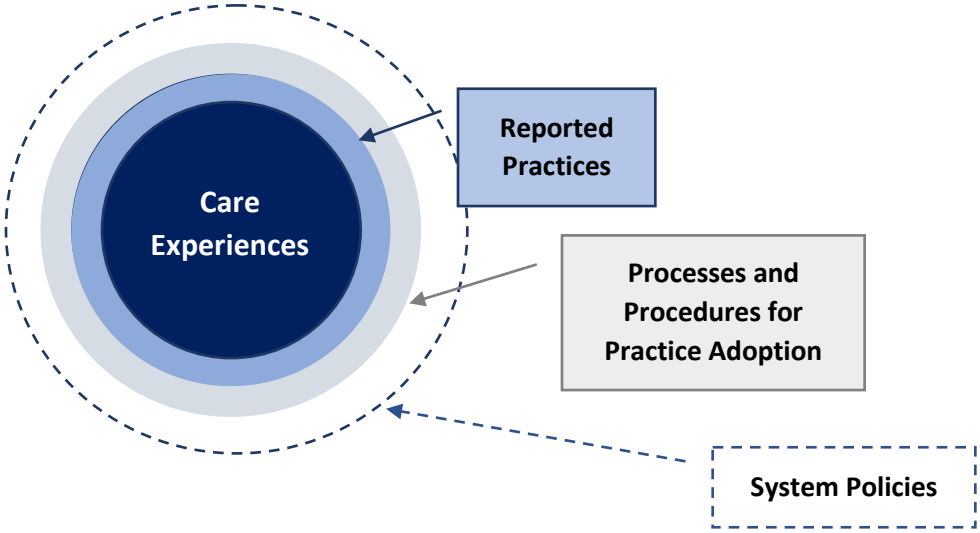
Methodology in Brief

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.

[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

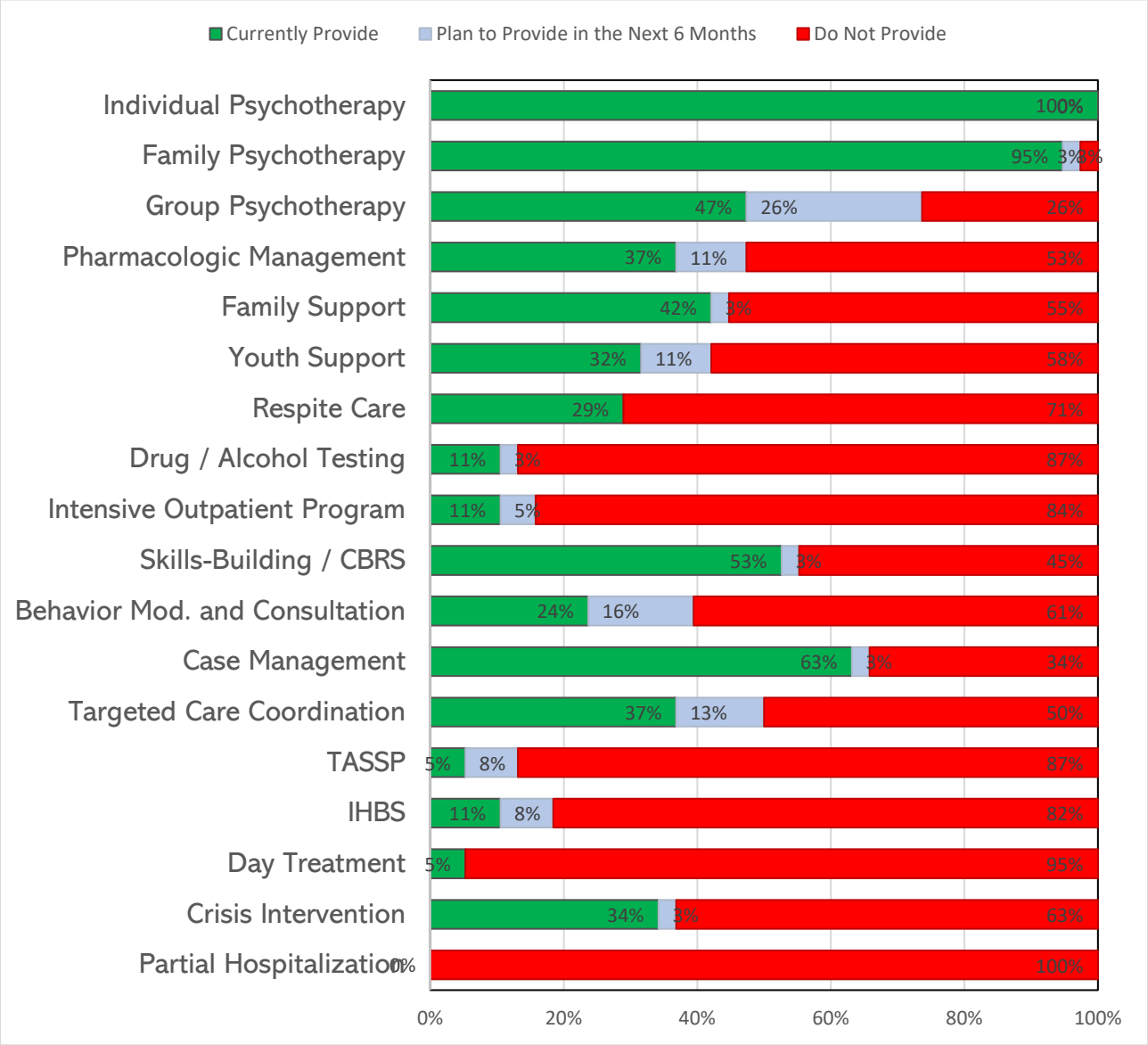
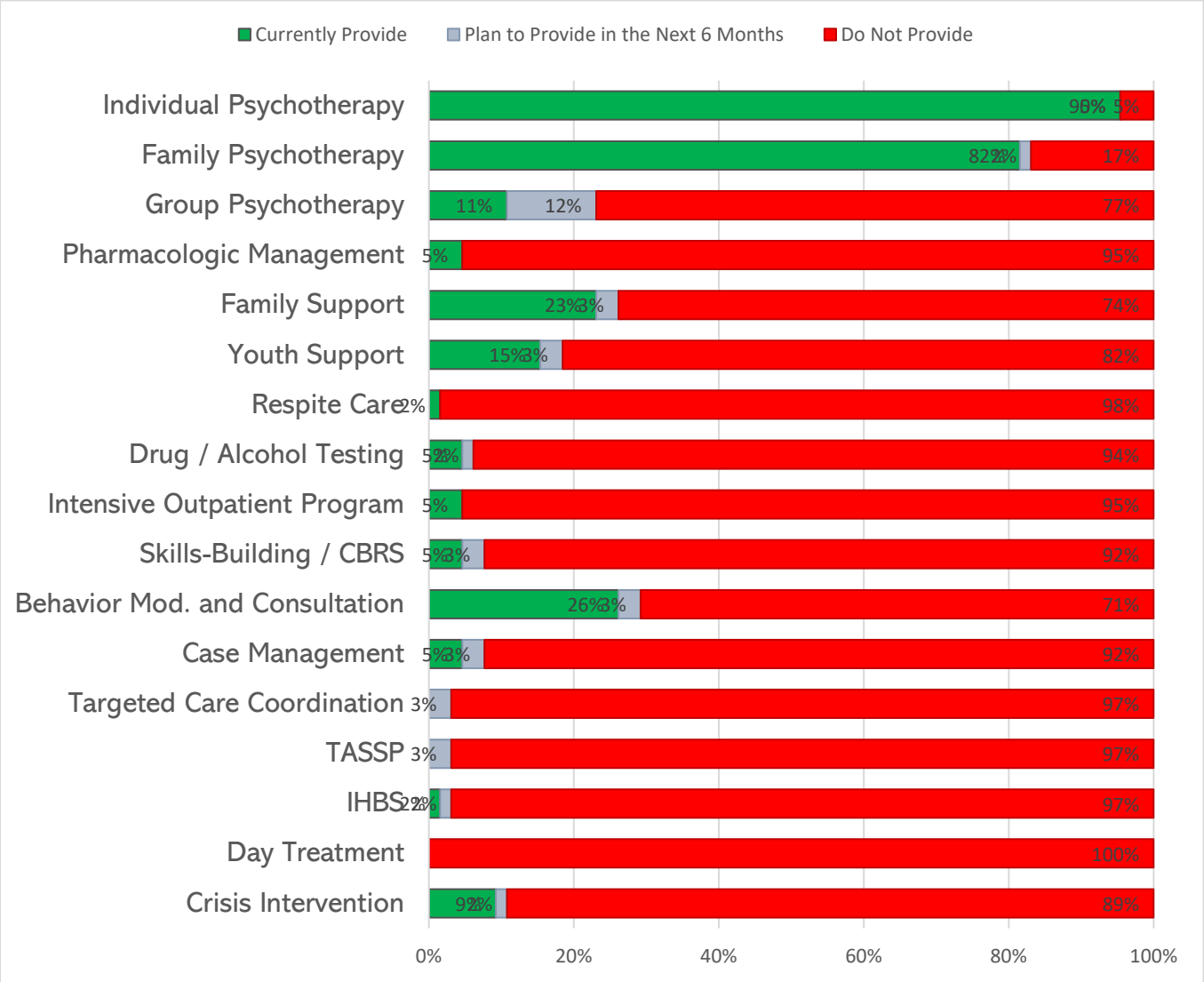


Chart 2 (below) identifies individual practitioners' self-reported service array. Response percentages are based on survey responses from 65 child-serving practitioners who participated in the Summer 2022 survey.

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.

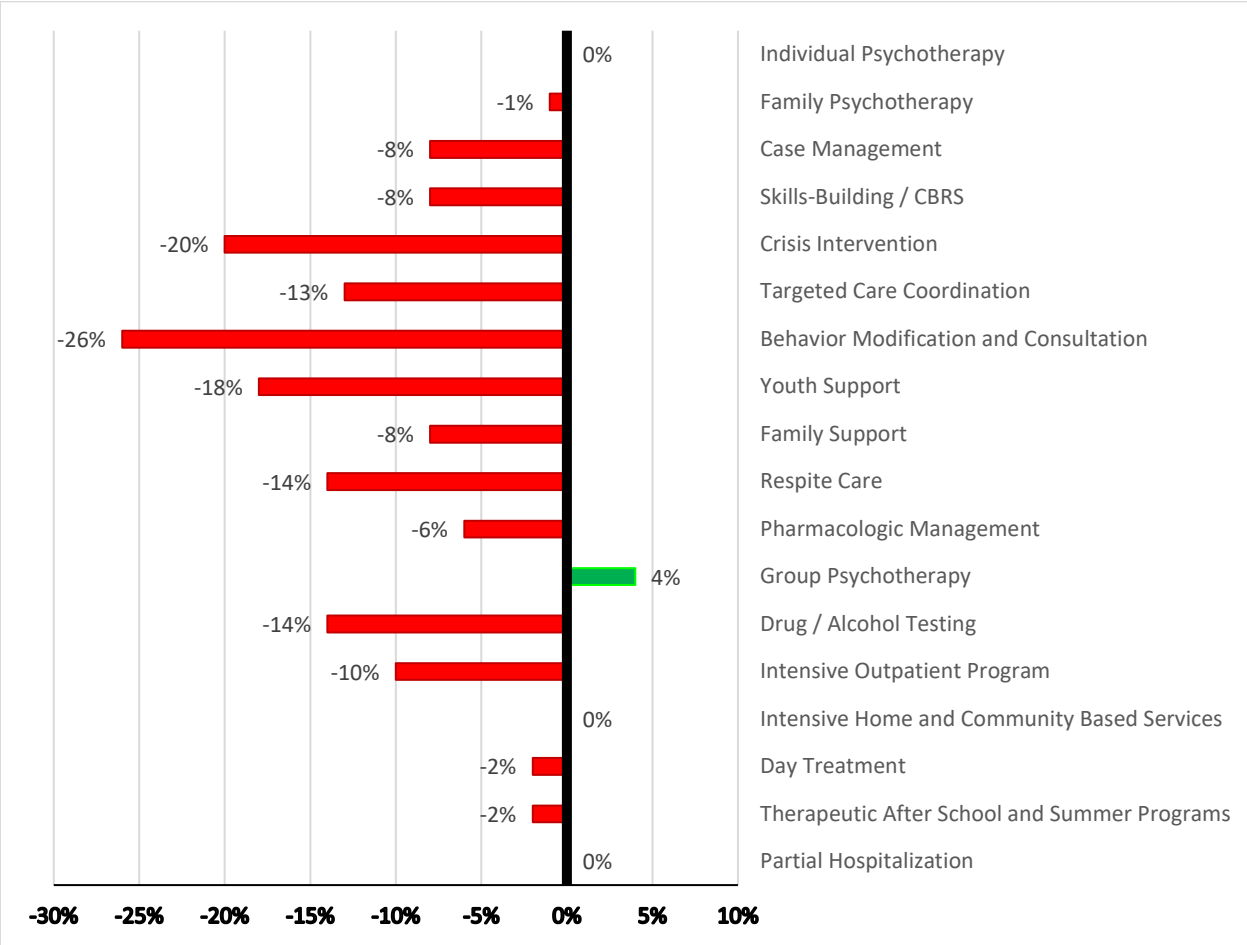
Across multiple service types, provider agencies are also unlikely to provide the intensive treatment options best suited for youth with severe or complex needs. Only about 10% of agencies indicate that they provide Intensive Outpatient Programs, Intensive Home and Community-Based Services, or Drug and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

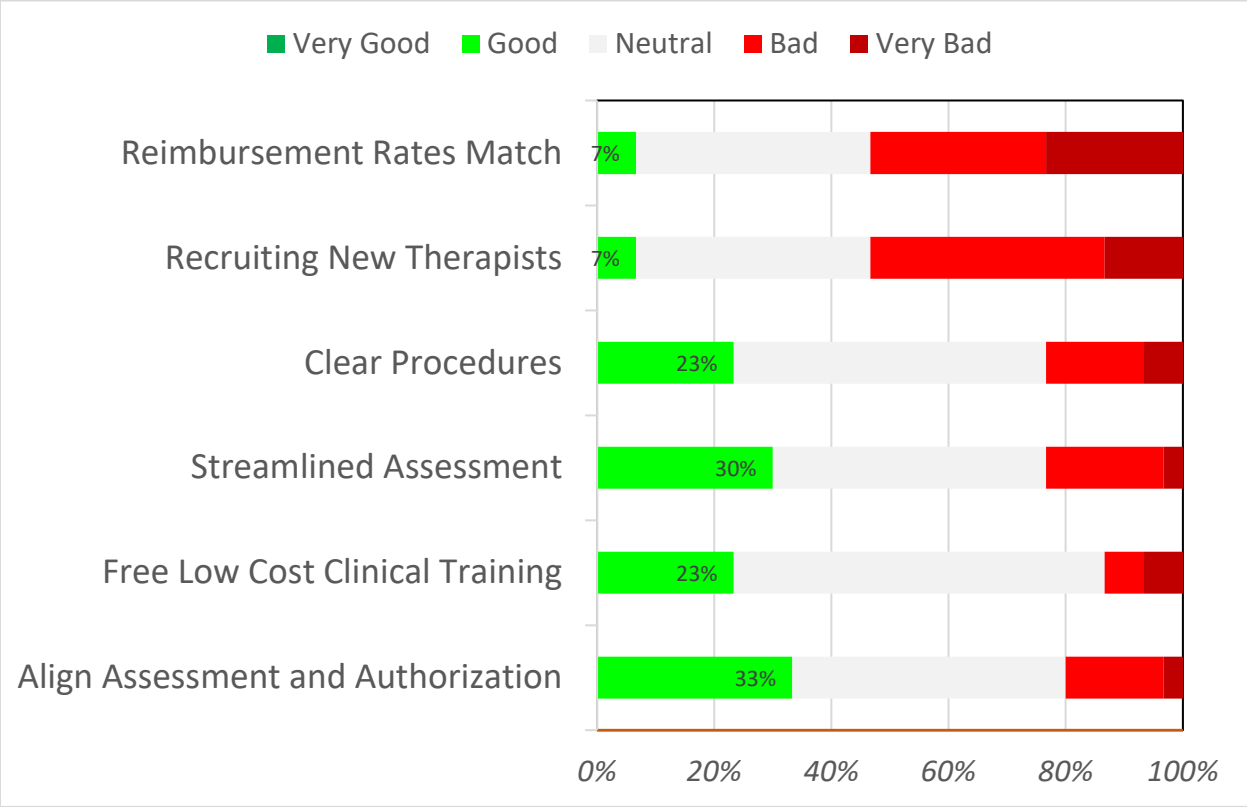
We also asked if providers had initiated a new service in the past year. Twenty-three percent of agency respondents indicated that they had initiated a new service in the past year; only 4% of individual practitioners indicated that they had initiated a new service in the past year. For both agency respondents 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).

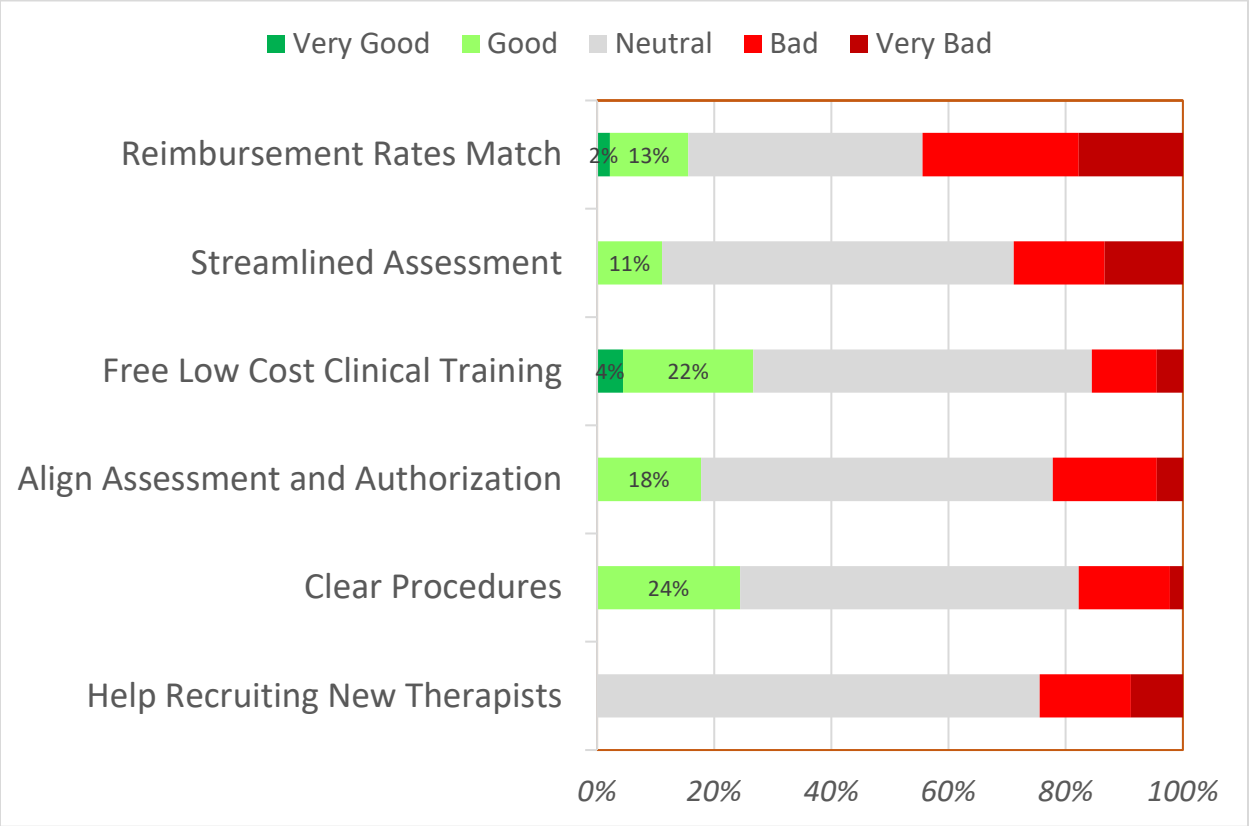
Chart 4. Agency Respondents' Satisfaction with Supports for Service Expansion



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.

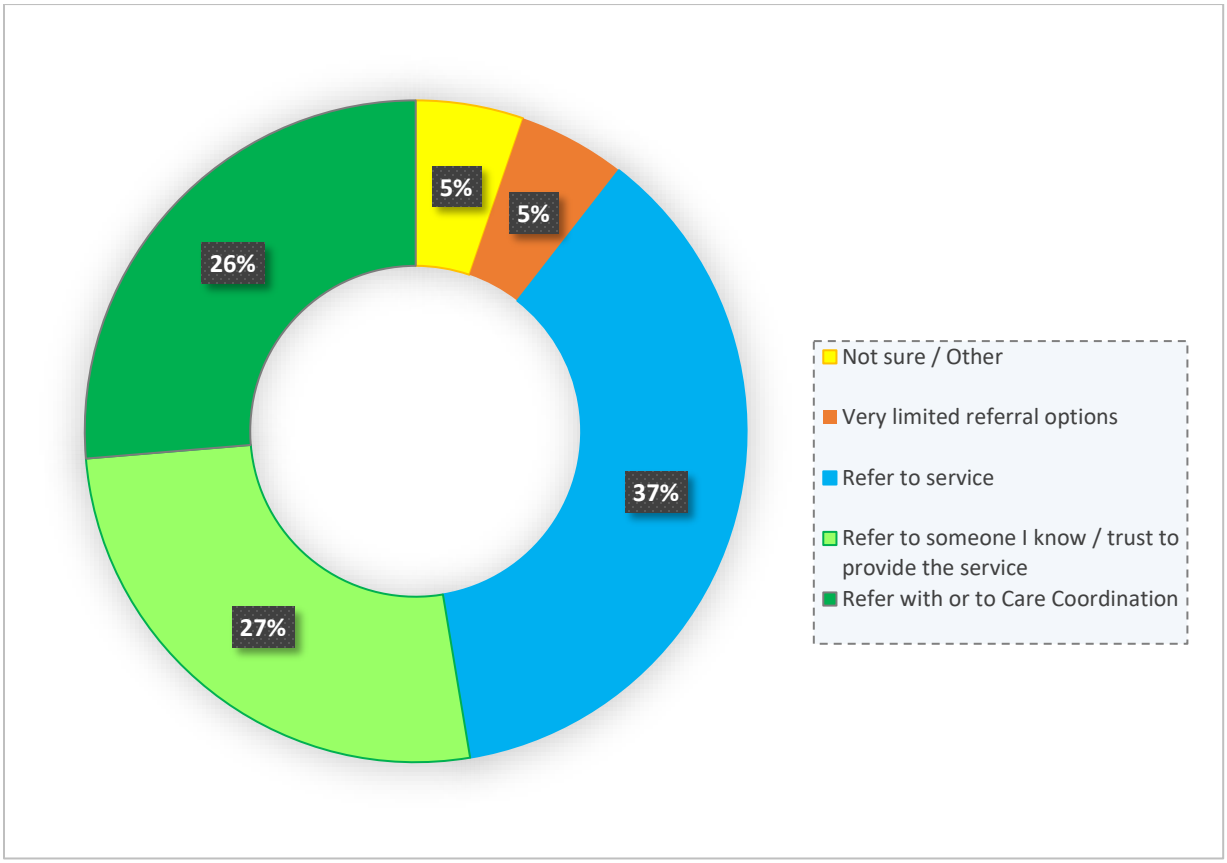
Second, one new variation on a theme did emerge in this year's responses. Several times, respondents alluded to or explicitly described the importance of having access to knowledgeable, personalized help in working to initiate services or address regulations.

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.

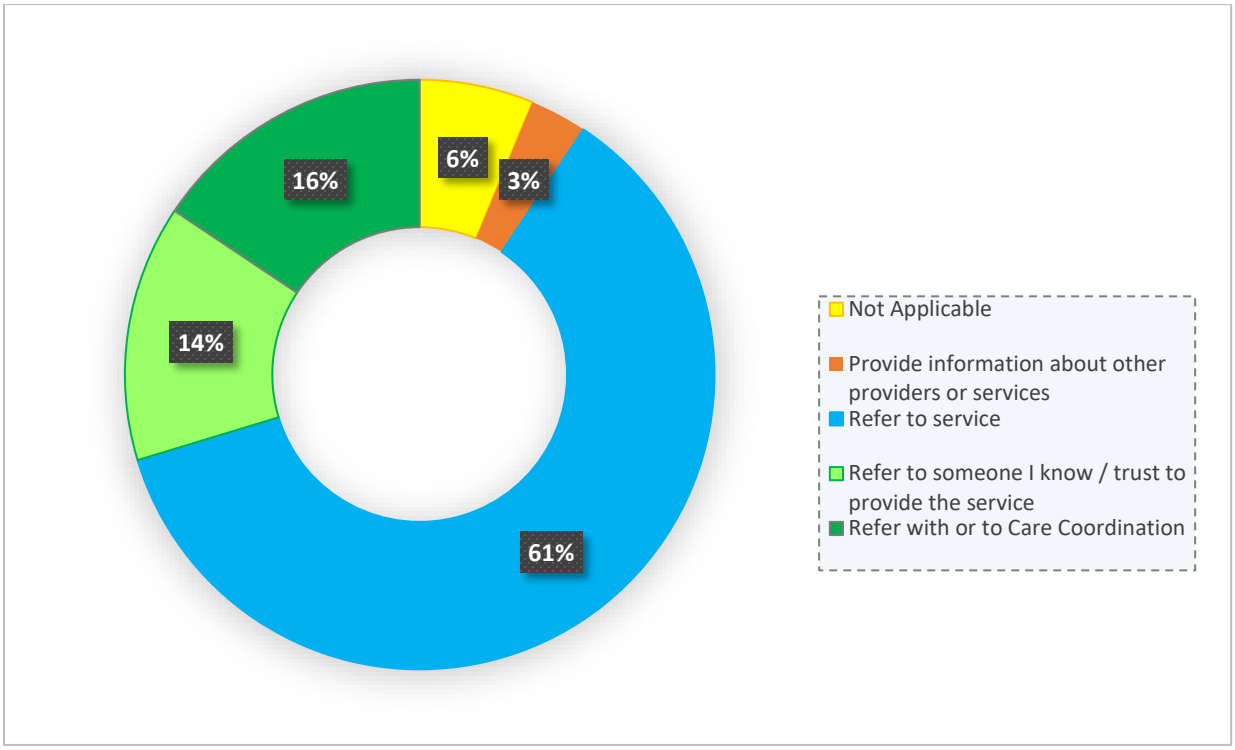
Chart 6. Agency Respondents' Processes for Connecting Youth Needing Other Services



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

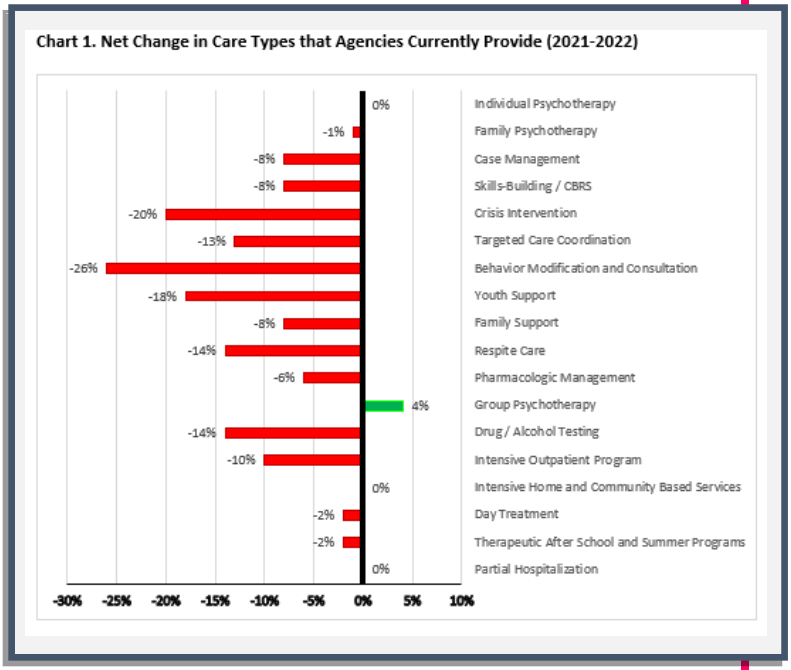
Provider survey data indicate 13% fewer providers are offering Targeted Care Coordination in 2022 than in 2021. Data from the SFY 2022 Q3 QMIA Quarterly Report indicates that that "there is a trend toward fewer children accessing Case Management" (p. 13). Similarly, use of Targeted Care Coordination 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.



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%

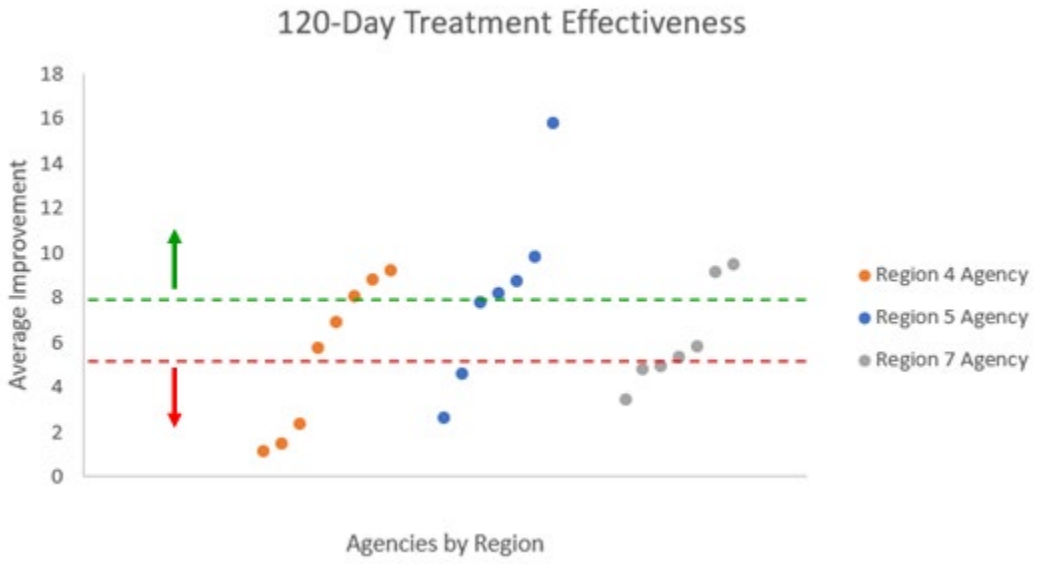
Choosing Agencies to Maximize Practice Variation

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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