

Final Report

of the

Youth Empowerment Services (YES)

Quality Review (SFY 2023-2024)

Provided by:

Union Point Group, LLC

for the

Idaho Department of Health and Welfare

Division of Behavioral Health

Winter, 2024

Table of Contents

Acknowledgements..... 3

Executive Summary: Key Findings 4

Methodology in Brief 14

Question #1. What supports and barriers exist to standardizing the referral process?..... 17

Question #2. How are service plans individualized to provide appropriate care while addressing current service access barriers? 31

Question #3. How are care coordination services prioritized and accessed in the first 30 days post-assessment?..... 38

Question #4. What change has there been in the provider network’s capacity for intensive community-based treatment? 48

Question #5. Do network providers perceive any change in the state-level barriers and supports that impact the expansion of intensive community-based treatment? 52

Question #6. What efforts are the IDHW Division of Behavioral Health and Medicaid undertaking to grow the network of specialized community-based treatment providers?..... 57

Summary 64

References 67

Appendix A: Service List and Descriptions 69

Appendix B: Full Methodology 73

Acknowledgements

This effort requires the collaboration of administrators, managers, providers, practitioners, caregivers and youth. We appreciate the commitment to quality and willingness to honestly express concerns that we have encountered across so many people involved in children's public behavioral healthcare in Idaho.

We extend a special thanks to the administrators and staff of Quality Management, Improvement and Accountability within the Department of Behavioral Health at the Idaho Department of Health and Welfare (IDHW). Candace Falsetti has shepherded this work since its inception and has capably delegated much of the current year's management and implementation to Douglas Klingler. He dedicated long hours and exceptional effort to ensuring that the information herein was collected and provided, ready for analysis.

Executive Summary: Key Findings

The vision of the IDHW Department of Behavioral Health is that, “People receive the behavioral health services they need when they need them.” Consistent with this, in the fall of 2023 the Idaho Department of Health and Welfare’s Quality Program implemented a Quality Review (QR) **to better understand referral and initial service receipt practices**. The review focused on youth with **high intensity needs**, given that service timeliness and appropriateness are even more consequential for these youth than for youth with less intensive or complex needs. Previous Quality Reviews and the most recent statewide Family Survey also indicate that referral and connection to appropriate services is particularly challenging for this group of youth.

This Executive Summary provides:

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

IDHW can eliminate substantial family distress and provider burden by making three modest changes to current referral and connection processes. These three changes also position IDHW for compliance with recent changes in Federal regulations regarding provider networks. They are to:

- **create a uniform referral form and protocol statewide, allowing referrals to be tracked, routed and acted on in a timely fashion;**
- **prevent escalation in youth needs by creating simple, public rules for service priority;**
- **develop a network of specialized treatment providers for a defined group of youth with complex needs.**

Each recommendation’s evidence and series of implementation action steps is summarized on the following pages.

Recommendation #1. Create a uniform referral form and protocol statewide.

IDHW is to be commended for moving towards a 'One Department' approach for addressing the needs of Idaho's children. Movement towards a System of Care reduces the likelihood that children with the most serious needs will continue to experience being shifted from system to system without state-level accountability.

In order to realize this promise of accountability, IDHW must have a statewide system for tracking all children and youth referred for behavioral health treatment. This currently does not exist, despite repeated recommendations and efforts.

Current referral protocols are routinely disregarded because they do not address the circumstances of nearly half of all families seeking intensive treatment for their child.

Current State of Referral and Connection Protocols. Families described tremendous frustration with the process of referral and connection to care. Fifty-three percent of families indicated that their experience of accessing care was primarily negative. Caregivers described either having to use personal connections in order to access care, or engaging in a time-consuming process of trying to ascertain where appropriate care could be accessed. Once referred, forty percent of interviewed families described wait times in excess of ten business days. Yet it does not have to be this way. One family described a referral and connection experience that should be experienced by all youth with complex or intensive needs:

“It was a very stressful time but there was a lot of support from a lot of different agencies.... All of the agencies worked together to get her the help she needed as quickly as possible.”

With few exceptions, current referral protocols are developed at the level of the contracted agency. The clinicians we interviewed indicated that these referral protocols are routinely disregarded (approximately half of the time) because they do not encompass the particular circumstances of youth and families being referred.

Clinicians pointed to referral from another agency, pressing clinical needs, previous experience with the client as reasons for disregarding the referral protocol.

Effective Protocols among States Exiting Federal Settlement Agreements. Summary. We looked at referral and connection infrastructures and protocols at three states which have experienced successful exit from a Federal Settlement Agreement involving their children's behavioral health system. The three states are: Massachusetts, Hawai'i and Washington. We found a series of common elements across these protocols, as well as a set of standout features in specific state infrastructure and protocols.

Common elements that we found across these states include:

- single, statewide form for all referrals;
- electronic submission and tracking of referrals;
- clear standards for when contact must be made and services offered;
- state-level responsibility for tracking and acting on referral response timeliness;
- ongoing state-level efforts to reduce and eliminate barriers to connection to appropriate services.

Standout features we encountered included:

- integration of Crisis Line and Help Line to create single point of access (1 system);
- ability to make real-time screening and routing decisions (2 systems);
- assignment of a Care Coordinator at the point of referral (1 system);
- explicit follow-up across Crisis and Outpatient referrals to ensure connection to care (1 system);
- public posting of referral rates, acceptance rates, and care dosages received (1 system).

Actions to Consider.

- Standardize the development of an electronic referral form for use statewide.
- Develop a referral protocol with clear timelines for communication post-receipt of referral as well as for connection to services post-receipt of referral. Make explicit what must be provided to youth and families when specific, appropriate services are not currently available.
- Widely publicize the protocol among partner agencies and the public. Provide online and in-person education regarding how to use it and how it operates.
- Empower a state-level committee to review and act on referrals based on the intensity of need identified, and the delay in receiving access to appropriate care.

Recommendation #2. Prevent escalation in youth needs by creating simple, public rules for service priority.

At the core of the Settlement Agreement is the need for IDHW to make available substantially more intensive community-based treatment services. The development of a statewide referral and tracking system will likely further highlight the importance of connecting children and youth with high-intensity or complex service needs to appropriate services in a timely fashion. IDHW's move to a 'One Department' philosophy will also highlight the importance of accountability for serving youth, particularly those with cross-sector involvement. Together, the combination of limited treatment resources and clearer information about service needs and cross-sector involvement point to the need for IDHW to develop and implement simple, public rules for service priority.

Current Processes for Addressing Service Waits. Our multi-year assessment of the continuum of care available to Idaho's children with behavioral health needs indicates that intensive community-based treatment services have shrunk in availability, though that shrinkage may have plateaued. Currently, nearly half of all families of youth with intensive needs indicate that they cannot access services in a timely fashion, or in their local community. Clinicians whom we interviewed for this Quality Review indicated that they use their own judgment of risk and need when considering taking new youth into care. Per our Provider Survey, individual practitioners and agencies appear to be less likely now than in previous years to access personal networks of specialists or to provide families with access to care coordination. It is getting harder, not easier, for families to access intensive community based treatment services.

All of these data indicate that families and providers would benefit from having clarity regarding how to manage the process of service provision when all appropriate services are not available.

"Asking for help and admitting you need help is hard. It is discouraging that once you finally recognize the need, it takes so long to finally get your kid in for help."

-Parent of Youth in YES

Actions to Consider.

- Create a clear, clinically justified hierarchy of treatment priority by service type. For instance, Wraparound services may always be offered to and prioritized for individuals with a Mobile Crisis encounter or hospital exit in the past thirty days.
- Pre-test the protocol with a small, well-defined set of youth and providers in order to ensure its viability. Update and expand testing of the protocol to encompass additional youth and providers.
- Publicize the protocol across the provider network, family advocacy organizations, and public agencies involving children and youth. Make education on the protocol available online to lower barriers to access.
- Track the effectiveness of the protocol in addressing early dropout from treatment, reduction in crisis episodes and treatment effectiveness.
- Adjust the protocol as intensive community-based treatment capacity increases. The expectation is that as capacity increases, the need for prioritization rules will become less pressing.

Recommendation #3. Develop a network of specialized treatment providers for a defined group of youth with complex needs.

IDHW has completed execution of a multi-year contract with a managed care entity, Magellan Healthcare, to administer the IBHP. That notwithstanding, IDHW is ultimately responsible to the Centers for Medicare and Medicaid Services and to the District Court for providing the full array of appropriate behavioral health treatment and coordination services to Idaho's children and youth. Only a collaborative effort across the Division of Medicaid, Children's Behavioral Health Program and Magellan Healthcare will grow the network of providers and their capacity sufficient to exit the Settlement Agreement and guarantee appropriate care for children in need.

Evidence Summary. This survey took place as Optum Idaho's contract was finishing and before Magellan Healthcare assumed the role of the IBHP administrator.

Providers who participated in our survey voiced a general distrust of the IDHW, and dissatisfaction with the depth, timeliness, and consistency of actions taken to meet the needs of the network. During the transition to the current IBHP administrator, Magellan Healthcare, providers voiced frustration with the lack of clarity and written documentation regarding how to become a network provider, and the conditions associated with being a network provider. Looking at multi-year capacity trends, services for which reimbursement increased saw a modest increase in capacity. This indicates the primacy of financial concerns among providers.

At the same time, in multiple QRs to date, parents have voiced frustration at the lack of providers available to address complex challenges experienced by their youth. In the current QR, parents described a series of actions that they have taken to address the lack of coordinated, specialized care available to their children.

"[It]...seems that systemic changes aren't happening as they need to."

- YES Network Provider

A parent with a child involved in Juvenile Justice indicated that, "I was mostly just hoping that someone would get through to her [daughter]. Her criminal charges were stacking up and her behaviors were not being tolerated." A parent with a child with developmental needs indicated that they are "...still not able to access ABA....the DD services are slow."

Instead, we want parents to have the experience described by one caregiver whose child was referred to behavioral health treatment after a CPS incident, stating that, "All of the agencies worked together to get her the help she needed as quickly as possible." Given the current system-level focus on addressing the cross-cutting needs of children and youth involved in the foster care system, we recommend that developing the competencies and capacity of this specialty provider network serves as a priority for the next year.

Actions to Consider.

- Use CANS data to identify significant unmet treatment needs of children and youth involved in the foster care and public behavioral health systems;
- Assess the current capacity for effectively treating these youth, and the estimated gap between the current capacity and the needed capacity;
- Identify the training and treatment protocols associated with effectively treating these needs in this population;
- Prioritize development of internal capacity for training therapists on these interventions, via the Center of Excellence or similar mechanisms;
- Provide initial and ongoing value-based incentives to providers certified to provide these treatments.

Questions this Quality Review Answers

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

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

Each year, that purpose is applied to a central, clinical question. The central question addressed by this year's QR is: How is IDHW supporting referral and connection to engaging, high quality care within the first 30 days of treatment?

The central question of this year's QR originates from the first recommendation of last year's QR. In last year's QR, we recommended that IDHW **'focus the system on providing engaging, high-quality care during the first 30 days of treatment.'**

We listed a series of potential follow-up actions to address this identified need. They included that IDHW:

- Standardize the documentation and tracking of the referral process;
- Standardize and require assessment for barriers to accessing treatment as part of the intake process;
- Monitor the use of, and satisfaction with, non-emergency medical transportation and any other system-provided supports to address access barriers;
- Provide specialized assistance to therapists working with youth with co-occurring disorders and complex needs.

How is IDHW supporting referral and connection to engaging, high quality care within the first 30 days of treatment?

These follow-up actions have informed the specific questions that this Quality Review seeks to answer. We identified six specific questions originating from these findings and recommendations.

Six related questions that we seek to answer in this Quality Review are:

- (1) What supports and barriers exist to standardizing the referral process?
- (2) How are service plans individualized to provide appropriate care while addressing current service access barriers?
- (3) How are care coordination services prioritized and accessed in the first 30 days post-assessment?
- (4) What change has there been in the provider network's capacity for intensive community-based treatment?
- (5) Do network providers perceive any change in the state-level barriers and supports that impact the expansion of intensive community-based treatment?
- (6) What efforts are the Divisions of Behavioral Health and Medicaid undertaking to grow the network of specialized community-based treatment providers?

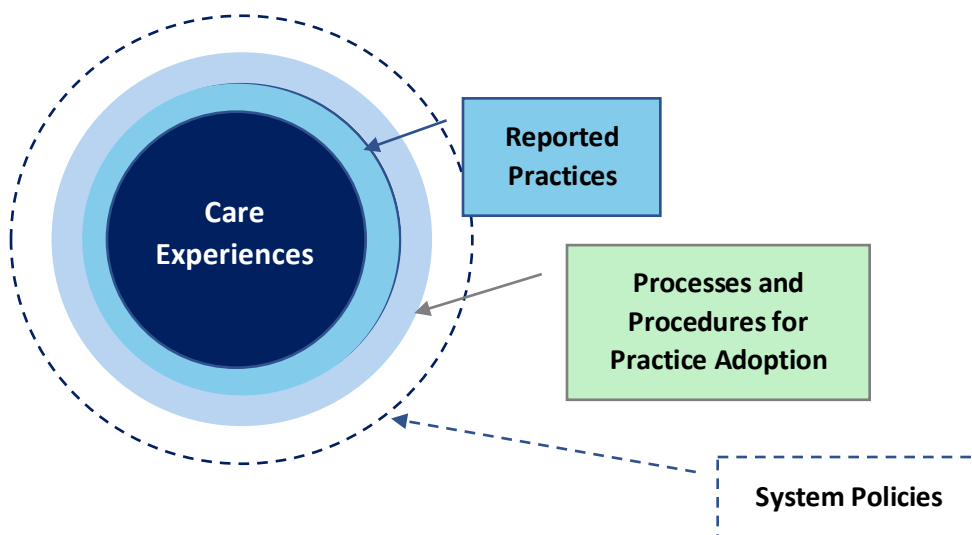
This report presents the data from the QR process used to answer these six questions and generate recommendations for system improvement.

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 that result in youth having better care experiences and outcomes.

Purpose. The QR we used this year focused on understanding the process of referral to, and initial receipt of, appropriate services for youth with intensive treatment needs. Our interviews and file reviews protocols were tailored for this purpose. Functionally, we defined the review period as the time from referral to 30 days post-assessment (with the Child and Adolescent Needs and Strengths (CANS) tool). Clinically, assessment should drive treatment planning and service provision. Looking for 30 days post-assessment allows us to identify the extent to which referral results in an initial connection to appropriate services. In this review appropriateness is functionally defined as a match between the intensity of assessed needs and the services provided. We looked at the match between services identified for provision in the Treatment Plan (clinician perspective), as well as services identified by youth or their caregiver as important (youth / family perspective).

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



Measures. In order to do this the QR includes data collection from multiple stakeholders, across levels of the system. Per Figure 1, the QR begins with interviews with families and youth about their experiences of care. This is the core of what we need to understand: how well practices work for youth and their families. This is followed by a review of care documentation (reported practices) and clinician interviews. We then survey all contracted providers statewide regarding their services and how IDHW supports their work. In this year's QR we also looked for examples of a particular practice (referral submission and tracking) across other public behavioral health systems. This search focused on behavioral health systems which have successfully exited a federal Settlement Agreement.

Staff Training. This year's Quality Review began with the training of six IDHW staff. Having multiple staff conduct file reviews and interviews can reduce bias introduced by any single interviewer. Four of the six staff completed reliability training on the file review protocol. These staff had excellent reliability scores. On average, in test protocols, they demonstrated agreement with expert ratings more than 80% of the time. This provides us with confidence that the file review ratings are accurate and consistent across raters.

Sampling. Because provider availability often varies with population density, we sampled youth in communities across the state. We also worked to sample across providers with different levels of effectiveness (per the Child and Adolescent Needs and Strengths functional assessment). This allows us to identify variation in referral and connection practices, and to sample from youth who have both positive and negative experiences of care.

This review includes file review data from 21 youth, interviews with caregivers of nineteen of those youth, four youth interviews, and interviews with the clinicians treating eight of these youth. In completing the file reviews, IDHW staff reviewed all clinical documentation provided to us by their primary treatment provider. This included assessments, plans of care, encounter notes, crisis plans, transition plans and any other practice documentation. We rated care in terms of its documented timeliness, appropriateness and degree of collaboration.

Results in Full:

Quality Review 2023-2024

Question #1. What supports and barriers exist to standardizing the referral process?

Across Quality Reviews we have identified a lack of accessible intensive community-based treatment services for youth in YES. This leads to treatment wait times which consistently exceed standards for timely access required of contracted providers. Given limited treatment resources, triaging is the most commonly accepted form of resource management for health care services. Idaho's referral process is idiosyncratic to Region, level of care, and even provider. Standardizing and tracking referral and connection to appropriate services offers a way to ethically manage limited intensive treatment resources and plan for the deployment of additional intensive treatment resources.

In order to develop an appropriate referral and tracking system, we have worked to identify: (1) how the current referral and service connection process functions; (2) what information is useful to clinicians receiving a referral for treatment services; (3) referral and service connection processes used by public children's behavioral health systems which have successfully exited Settlement Agreements which are substantially similar to Idaho's Settlement Agreement.

Current Referral Processes.

We asked caregivers of youth with intensive behavioral health needs about the referral process. Then we asked clinicians who received those referrals what information they look for in the referral, and how they use that information. These prompts and responses are summarized below.

We asked caregivers, "Do you recall who referred your child to [Agency]?" Per caregivers whom we interviewed, youth in this sample were referred to services by a variety of sources. Parents were the most frequent source of service referrals, accounting for 39% of referrals. Schools accounted for 17% of referrals. Other behavioral health agencies accounted for another 17% of referrals. Child Protective Services, Pediatricians and Crisis Centers each accounted for 5% of referrals. Two caregivers indicated that they did not recall who made the referral for services (11%).

Union Point Group

These responses indicate that referrals from people who are not behavioral health or human service professionals make up the vast majority of referrals for youth with intensive behavioral health needs. In order to facilitate timely access to appropriate resources, the referral process needs to be well-publicized and easily understood by a very broad array of professionals and non-professionals.

Then we asked caregivers, "Once referred to [Agency], do you remember about how long it took before someone from [the Agency] contacted you?" Responses to this question ranged from 'within a day' to 'a few months.' Only one caregiver indicated that they did not remember how long the wait took. Fifteen caregivers had a response recorded which we included some estimate of how long it took before they were contacted. Six of fifteen caregivers (40%) indicated that they waited a month or longer before being contacted by the treating agency, despite the intensive nature of their youth's behavioral health needs.

Magellan Healthcare, the current Managed Care Organization managing the Idaho Behavioral Health Plan (IBHP) has indicated that all IBHP members have a right to "Get IBHP services you are eligible for in a timely fashion." This is more clearly codified in their [Provider Handbook Supplement](#) (per September 27, 2024) which states that, "An initial mental health (MH)/substance use disorder (SUD) appointment must be offered and, if accepted by the member, provided within 10 business days of the request." These requirements are the same as the timeliness requirements of the previous Managed Care entity, Optum Idaho ("An initial MH/SUD appointment must be offered within 10 business days of the request," per the Optum Idaho Provider Manual, January 2023, p. 35). This indicates that the lack of timely care is not a result of anticipating changes in MCO providers' timeliness standards.

We asked therapists, "When a youth is referred to you, what information do you look for in the referral? (What information helps you get oriented to the youth and their family?)" This question allows us to understand the information clinicians may prioritize for inclusion on a standardized referral form.

Responses included, in order of frequency:

- Diagnostic and functional assessments, including assessment of strengths (5);
- Medical diagnoses and medical information (4);
- Crisis and risk assessment (3);
- Family history and context (2);
- Information from other professionals (2);
- Desires for treatment (1).

Therapists identified these elements as helping them assess the type, severity and urgency of behavioral health concerns. As well, they offer a first check for the presence of co-morbidities. These elements also function to incorporate the family context, and what has already been learned by other professionals in the initial assessment of need. Finally, asking about 'desires for treatment' provides an entrée into the goals and motivations for treatment-seeking, and may help the clinician evaluate how well their services fit with the end goals of the caregiver and youth.

We also asked whether there is a standard referral protocol in place at their agency, which guides how youth are connected to appropriate care. All clinicians that we interviewed reported that there is a standard protocol at their clinic for connecting youth to the right care.

However, it is noteworthy that half of the therapists indicated that the protocol was not followed in this case. In two of these cases, referral from an outside body led to quicker access to care. In one instance, previous experience with the agency led to quicker access to care. In another instance, a clinician noted that following the protocol, "Depends on [the] person and clinical need and risk. Suicidal ideation and homicidal ideation will reduce wait times." These responses indicate that existing protocols do not systematically address a number of common occurrences for youth referred with intensive needs.

Referral Processes Addressing Idaho's Pressing Referral Pain Points.

We completed a selective review of state children's behavioral health services referral and service connection processes. The review focused on three states that have successfully exited a federal Settlement Agreement involving their children's behavioral healthcare system: Massachusetts, Hawai'i and Washington. All three of these states use a standardized functional assessment to determine Level of Need for treatment. Massachusetts and Washington states use the Child and Adolescent Needs and Strengths (CANS) tool. Hawai'i uses the Child and Adolescent Functional Assessment Scale (CAFAS). We specifically looked to find instances in which these states had implemented referral processes and supports addressing the pain points identified by youth, parents and providers in Idaho. These pain points include:

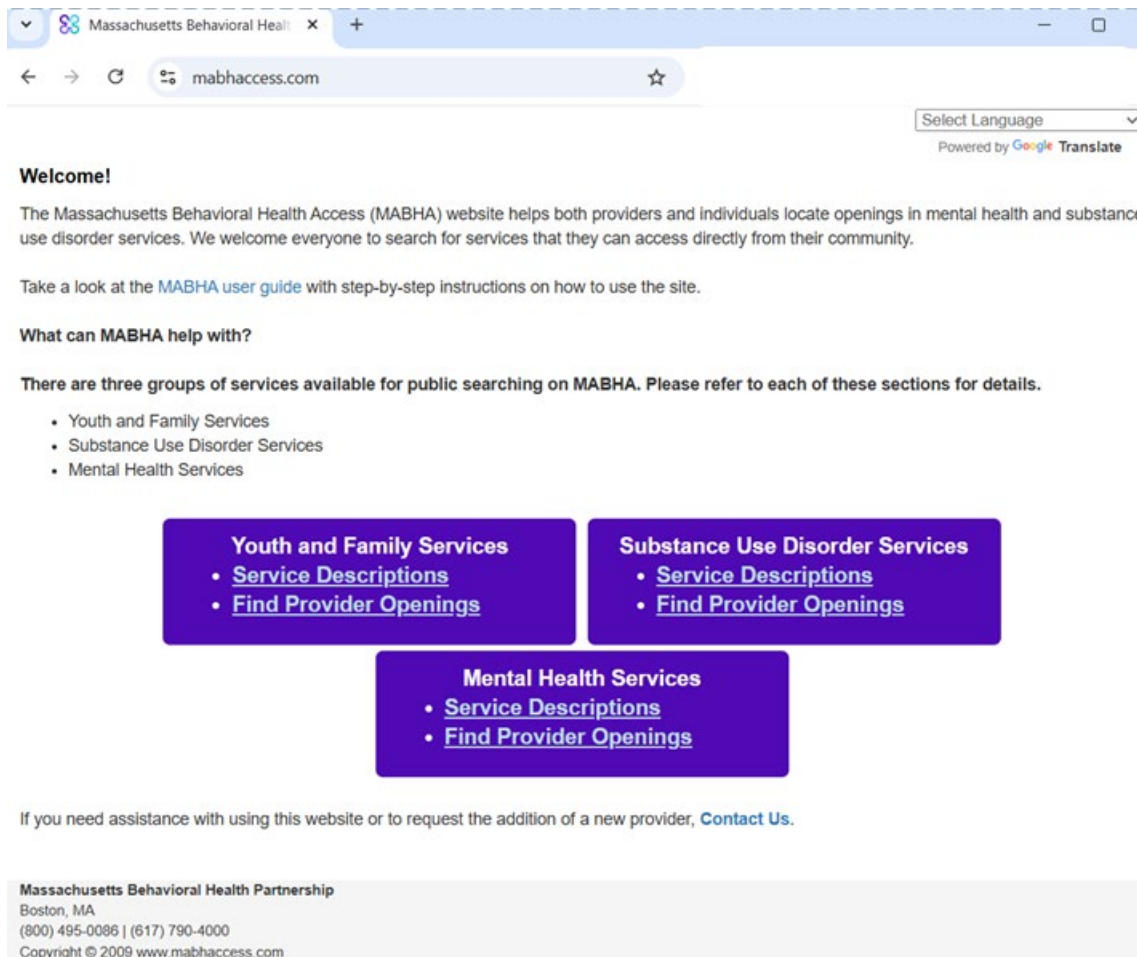
- rapidly and consistently assessing and communicating intensity of need;
- quickly identifying and connecting to providers with current availability for specific services;
- generating accountability for referrals at the provider and system levels, thus minimizing the instances of children 'falling through the cracks' of the system.

Throughout these descriptions we provide selections from, and links to, documents which further detail information about these processes.

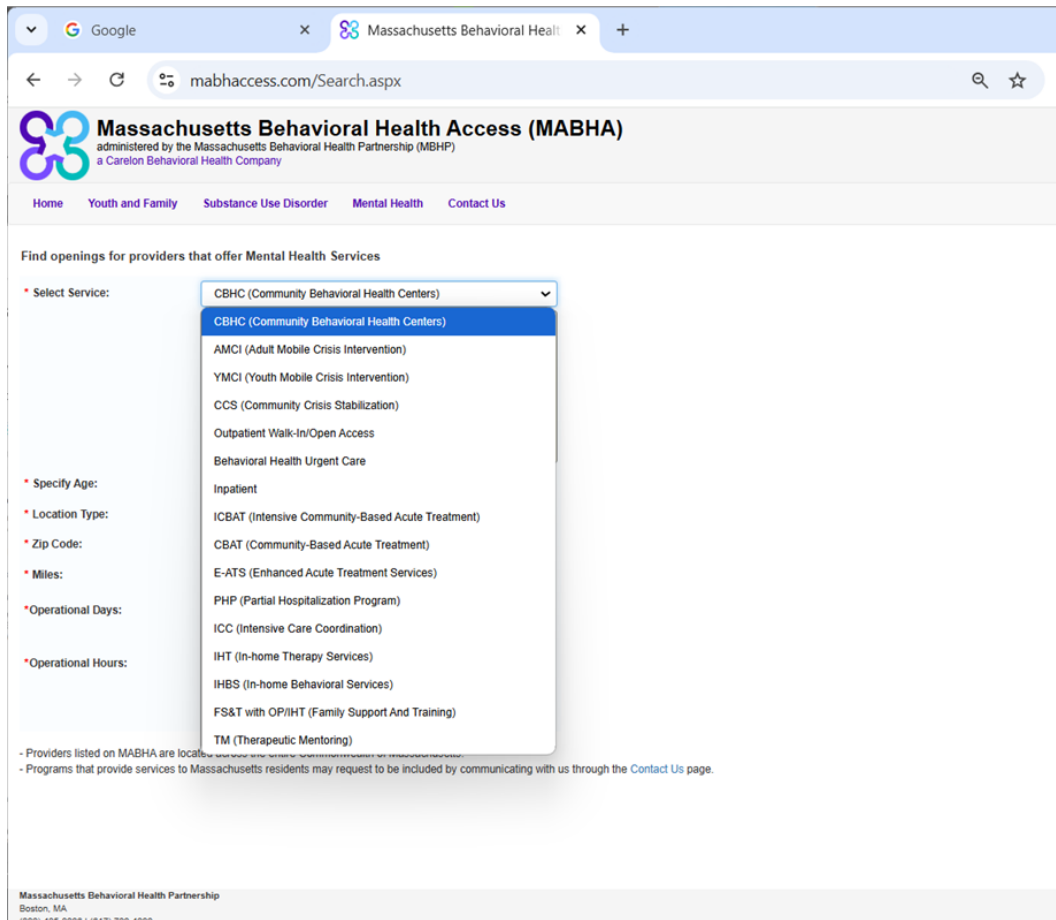
Massachusetts.

The State of Massachusetts’ Children’s Behavioral Health Initiative (CBHI) is designed to serve Medicaid-eligible youth with a Serious Emotional Disturbance (SED). Individuals looking for behavioral health services can access a public portal (at: mabhaccess.com) and click through to find current provider openings (Figs. 1-4).

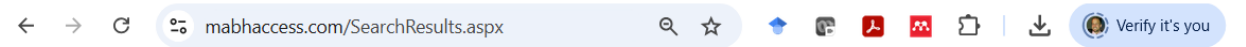
Figure 1. Service locator portal front page.



These openings are searchable using a series of parameters which address many of the key concerns expressed by families in Idaho. These parameters include: service type, age of child / youth, location and distance, and days and hours of operation.



When an individual inputs their parameters, the search engine finds provider matches, and produces them for the individual. Beyond the parameters listed above, what is notable about the search results is that they list the provider’s current number of current openings for that service, as well as any notes to families that the provider has entered. These notes are in the ‘Comments’ column of the example below. The system also works to create provider accountability for updating their available capacity. It does this by including a ‘Last Updated’ column in the results grid. This lets families know immediately whether they can trust the service availability data to be accurate today.



Massachusetts Behavioral Health Access (MABHA)
 administered by the Massachusetts Behavioral Health Partnership (MBHP)
 a Caredon Behavioral Health Company

Home Youth and Family Substance Use Disorder Mental Health Contact Us Login

Print Select Language
Powered by Google Translate

Results for IHBS (In-home Behavioral Services), age 16, city Boston in a 30 miles radius

* Service availability is not guaranteed. Please call before going to facility.

Facility	City	Available Capacity (Openings)	Referral Phone	Comments	Gender	Distance (Miles)	Last Updated
Gandara Mental Health Center - IHBS (Ages 0-20)	Boston	0	857-366-7040 ext. 6407	STATE LATINO SPECIALTY. Therapists speak English and Spanish. We Accept MBHP, BMC, Tufts Network Health, Fallon, and some commercial plans. The wait time is six months. Please request a referral form from Patricia Romero at promero@gandaracenter.org	All	2.62	1 day ago
Northeast Family Services - IHBS (Ages 0-20)	Dorchester	0	978-873-5414	Waitlist for IHBS. About a 6-12 month wait for all commercial insurances. Please submit referrals on our website! https://northeastfamilyservices.com/	All	4.36	2 weeks ago
Italian Home for Children - IHBS (Ages 0-20)	Jamaica Plain	0	617-571-1914	4+ month wait	All	5.82	2 months ago
The May Institute, Inc.-IHBS (Ages 0-20)	West Roxbury	0	781-437-1384	Day time availability is a shorter wait. 11-12 month wait in other towns. Due to large catchment area, please call for wait times for specific towns.	All	7.41	2 days ago
Toward Independent Living & Learning (TILL)-IHBS (Ages 0-20)	Dedham	0	781-302-4641	Braintree, Randolph, Quincy,	All	9.73	4 days ago
MENTOR South Bay - IHBS (Ages 0-20)	Wakefield	1	508-427-5362	IMMEDIATE availability for male and female clinicians in Beverly, Peabody, Salem, Lynn and Wakefield areas. To refer go to southbaycommunityservices.com .	All	9.84	21 hours ago
Bay Coast Behavioral - IHBS (Ages 0-20)	Braintree	0	774-294-5722	Due to a large catchment area, please call to check current areas of availability. All Insurances. We evaluate cases on a case by case basis for in person services for IHBS, IHT, OP and ABA services	All	10.88	3 days ago
MENTOR South Bay - IHBS (Ages 0-20)	Weymouth	3	508-427-5362	Availability soon in the Quincy, Braintree and Randolph area. Can refer online or at 508-427-5362.	All	14.26	21 hours ago
The Edinburg Center, Inc.-IHBS - MetroBoston Region (Ages 0-20)	Bedford	4	781-761-5060	ACCEPTING REFERRALS FOR: Acton, Bedford, Belmont, Burlington, Newton, Waltham, Watertown, Woburn, and Wilmington.	All	14.52	2 months ago
Toward Independent Living and Learning, Inc.-IHBS (Ages 0-20)	Danvers	0	781-302-4641	Braintree, Randolph, Quincy,	All	15.69	4 days ago
MENTOR South Bay - IHBS (Ages 0-20)	Brockton	0	508-427-5362	large waitlist. Please contact 508-427-5362 to make a referral or submit online at southbaycommunityservices.com .	All	18.69	21 hours ago
South Middlesex Opportunity Council-IHBS	Framingham	0	(508) 879-2250 x.	Limited capacity. One english speaking clinician with	All	19.68	2 days ago

Massachusetts continues to further support their referral and connection process through the innovative use of a multi-channel access line. It allows individuals to call a behavioral health access line, and be immediately assessed, triaged, and routed to the appropriate level of support. For individuals in crisis, this may be the Crisis Line a mobile crisis team, or Behavioral Health Urgent Care. For individuals with non-urgent behavioral health concerns, this is a handoff directly to a nearby Community Behavioral Health Center. The pathway is presented below (per [Massachusetts' Behavioral Health Roadmap, March 2023](#)).

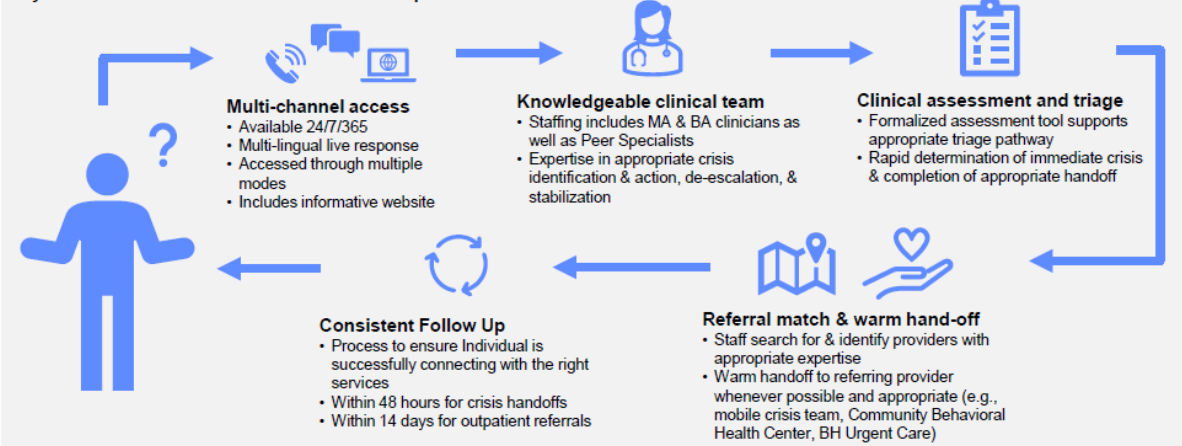
Behavioral Health Help Line

NOW LIVE!

(833) 773-BHHL

The **24/7 Behavioral Health Help Line** is a single, **insurance-blind, multi-channel entry point** for Commonwealth residents in search of mental health and SUD treatment.

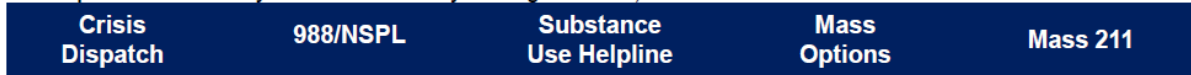
Key elements of the 24/7 Behavioral Health Help Line



Enabling technology:

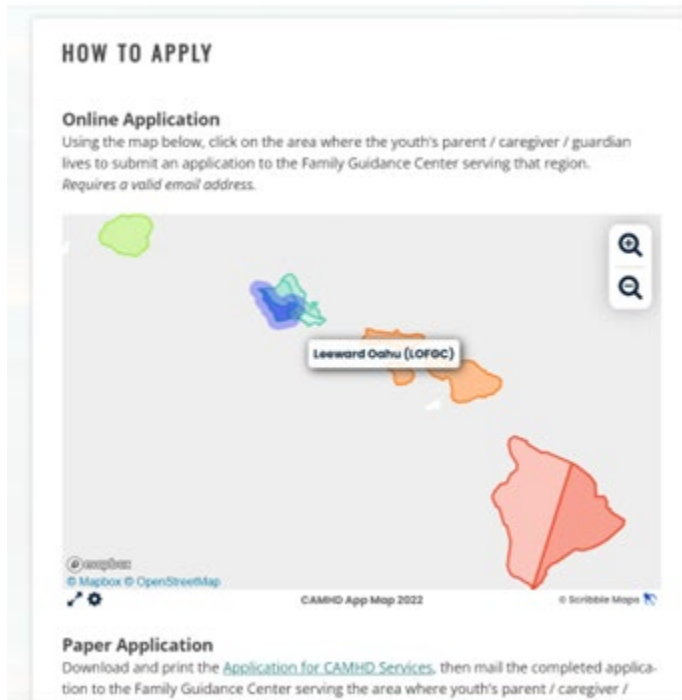


The Help Line will be closely coordinated with key existing resources, such as:



Hawai'i.

The Child and Adolescent Mental Health Division (CAMHD) of the State of Hawai'i primarily uses an electronic referral form submission process. Individuals searching for children's behavioral health services can go to a [single website](#), and choose their location.



Once they have selected their location, they are directly to an online application form. The form can be completed by a referring agency or caregiver. A series of phone numbers are provided for region-specific assistance with completing the online application (or a paper version for persons who are not using the online system).

This centralized referral process allows CAMHD to assign a Care Coordinator to each referred individual. The Care Coordinator is responsible for registering the youth in the system, and linking the youth to appropriate care with a contracted provider.

Care Coordinators link youth to appropriate contracted providers based on an assessment completed by a Clinical Lead. This linkage is done electronically, via a [record and tracking system used statewide](#). The Care Coordinator tracks provider acceptance, waitlisting, or

rejection of the youth. Providers use an electronic records portal in which referrals are updated in real time.

- To view referrals, click on the **Customer** name or the action dropdown (downward arrow on the far right of the screen) and select **View Details**

Customer ↑	Service Requested	Date Referral Sent to Agency	Provider Referral Status	Status Reason
Adams, Amanda	Individual Therapy - 60 minutes	10/23/2018	Submitted	Submitted
Barnes, Kelly	Functional Family Therapy (FFT)	10/21/2018	Submitted	Submitted

- From the **Referral Details** page, review the Customer, Contacts, Case, and Service Plan information

2.2 ACCEPTING REFERRALS

- Open a referral and click **Accept the Referral**

Home > Provider Profile > Referrals > Referrals Details

Referrals Details

- Should your agency decide to reject this referral for any reason, please indicate such by completing the following required steps within two (2) working days of receipt of the referral packet from the FGC:
 - Indicate by checking the box below if your agency is rejecting the referral.
 - Have agency Clinical Lead input his/her name below.
 - Have agency Clinical Lead input signature below.
 - Provide a written justification of the rejection by Clinical Lead.
 - Submit this form within two (2) working days of receipt of the referral.
- PLEASE NOTE: The above five (5) steps must be completed if the agency rejects a referral. Please contact the FGC MHCC assigned to the referral to discuss any delays in returning this form within two (2) working days as required.

Accept the Referral Reject the Referral

- On the **Referral Acceptance Form (RAF)**, complete the following fields:
 - Provider Referral Status* (select option: Accepted by Provider; Accepted but No Start Date; or Accepted as Waitlist). Choose:
 - Accepted by Provider** if you anticipate starting services within 2 weeks
 - Accepted as Waitlist** if you anticipate starting services after 2 weeks
 - Anticipated Admit / Start Date* (if Status = Accepted by Provider or Accepted as Waitlist)
 - Date Waitlisted & Waitlist Number* (if Status = Accepted as Waitlist)

Providers are contractually obligated to accept geographically and clinically appropriate referrals. Should a provider reject a youth’s service request, there is a specific protocol that must be followed (per CAMHD’s [Referral Acceptance Protocol Policy and Procedure 80.614](#)). There is also a clear standard for service initiation and clear cutoff for when a referred youth must be put on a waitlist.

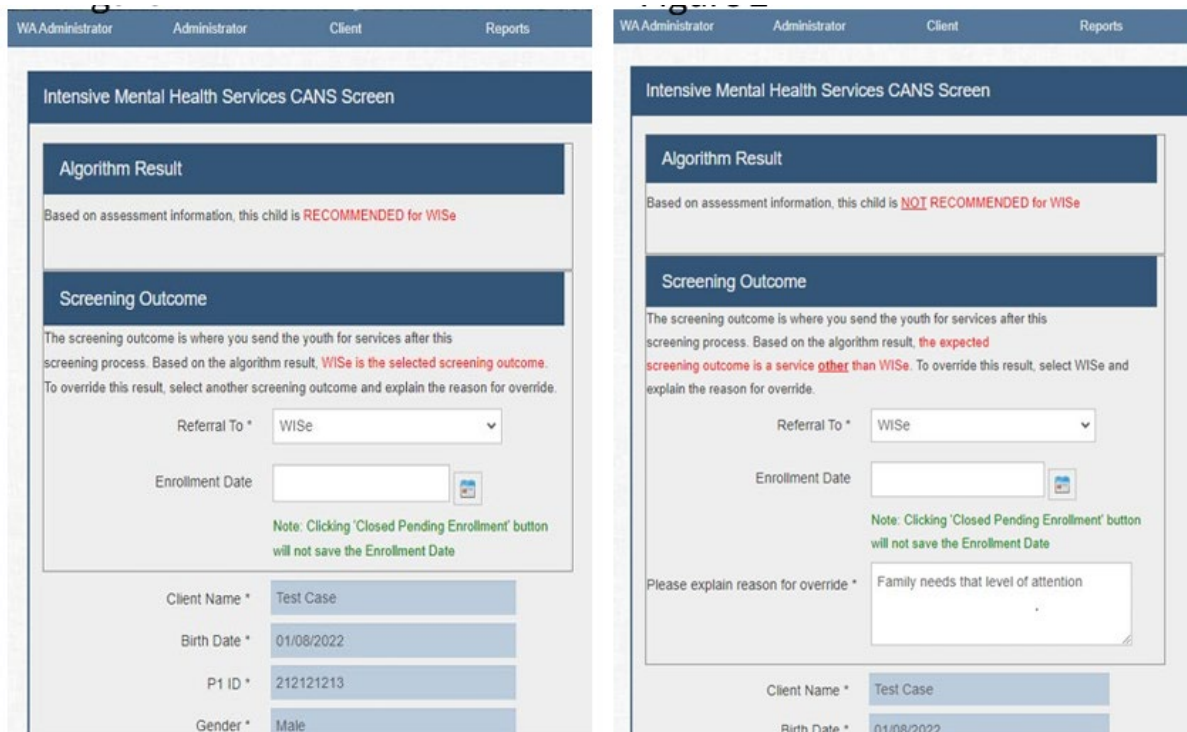
Within two (2) working days of receipt of the referral packet from the Care Coordinator, the contracted provider shall complete and return to CAMHD the Referral Acceptance Form (See Appendix 10) found in the referral packet to confirm a date for initiation of services. If the requested service is available, the admission/start date shall be as soon as possible, but must be within fourteen (14) days of acceptance otherwise the youth must be placed on the agency's waitlist ([State of Hawaii, Department of Health, Child & Adolescent Mental Health Division. Child and Adolescent Mental Health Performance Standards. \(2018\), Contracted Provider Referral Acceptance Protocol, p. I-16](#)).

Waitlists are reported and reviewed weekly, statewide. This provides visibility and accountability for timely access to care.

Washington.

Wraparound with Intensive Services (WISE) is the program developed by the State of Washington to screen for SED and connect youth and their families to care coordination and appropriate intensive community-based treatment. Similar to Hawai'i's CAMHD, referrals are electronically routed to regional screeners who rapidly assess for needs and strengths, and then connect the youth with appropriate contracted services. There is a publicly accessible list of agencies providing these screens, sorted by County (available at: <https://www.hca.wa.gov/assets/free-or-low-cost/wise-ffs-referral-list-by-county.pdf>). The 26-item CANS-based screener is frequently completed over the telephone, in order to eliminate barriers to access. The screening must be completed with 14 days of referral ([see the flowchart on page 14 of the WISE manual](#)). The screen must include a referral destination upon submission.

As the screening is conducted, the assessor completes an electronic screening form. The form can be submitted with the click of a button, and immediately generates a Level of Care recommendation. The recommendation can be overridden by the screening clinician.



Overrides require that the screening clinician provide a brief narrative justification for the override, per the figure above.

When the system fails to provide adequate capacity for immediate entry to the program, youth must be offered interim services. For children enrolled with a Managed Care Organization (MCO), they 'must be offered care coordination and / or case management' ([per the Washington State Health Care Authority, WISE Interest List Quality Improvement and Monitoring Memo, January 2024, p. 2](#)).

The system promotes accountability by publishing quarterly reports to their website that track screening outcomes, connection to WISE services, and the average dose of treatment provided per month. An example report is available [here](#). A series of dynamic reports which track trends since 2015 are also provided, so that variation in referral, connection, and outcomes over time can be monitored and acted on (example [here](#)). Included in these reports are the ability to look at both referral source and cross-system involvement at referral. These reports are the most comprehensive publicly available reports for monitoring and understanding the referral and care connection process that we have encountered to date.

It is important to note that IDHW has several elements of the infrastructure to generate such reports already in place.

Summary.

IDHW has previously taken a series of steps that facilitate a standardized, statewide process for referral to appropriate treatment services. These steps include: developing a series of screeners across contexts to quickly assess the intensity of treatment need; contracting with a statewide provider to complete CANS assessments and verify need; completing the procurement of the Idaho Behavioral Health Plan; expanding incentives for the development of community-based intensive treatment services.

We asked caregivers and youth about their experiences trying to access appropriate care. This was done to identify how well the current referral process works. In particular, we were interested in understanding how current experiences of access could inform the design of a streamlined, efficient, timely connection with appropriate services. Facilitators to accessing appropriate services were identified in file reviews, caregiver and youth interviews, and youth focus groups. Information from clinician interviews and the provider survey helped to describe the system context of these facilitators. We also reviewed a select set of referral forms and processes from state children's public behavioral health systems which have successfully exited a federal Settlement Agreement.

We identified a series of referral components that facilitate a standardized, timely process for referral and rapid connection to care. They include:

- Statewide electronic record system for referral, screening, and rapid determination of treatment need and care complexity;
- Explicit timelines for acting on a referral, paired with ongoing, consistent reporting and connection to alternate appropriate services when initial timelines are not met;
- Real-time routing to local screeners or assessors, followed by identification of available, appropriate community-based service providers per real-time capacity data;
- Proactive identification and provision of Medicaid-reimbursable supports, such as transportation, treatment in the home or other convenient settings, and services provided during extended hours.

Question #2. How are service plans individualized to provide appropriate care while addressing current service access barriers?

Idaho's Settlement Agreement is consistent with federal EPSDT regulations (Title 19, Section 1905a), indicating that children and youth with behavioral health concerns have a federal entitlement to timely, appropriate care from IDHW. Each of the Quality Reviews that we have completed to date has identified a lack of intensive or specialized community treatment providers as an ongoing barrier to treatment effectiveness. Two consecutive [Quality Reviews](#) also identified shrinkage in the proportion of providers of intensive community-based treatment. Our most recent data indicate that the proportion of intensive community-based treatment providers has stabilized ([see Question #4](#)). Until this pool of providers grows substantially, there will continue to be instances in which appropriate treatment services are not available in a timely manner.

Given these difficulties in accessing appropriate care, in this Quality Review we looked at the specific services identified for provision on each youth's Treatment Plan. Then we asked caregivers, youth and practitioners about the services listed, efforts made to make sure that appropriate services were provided, and the need for any other services, given the identified barriers to service access in Idaho.

Services identified for Provision.

Eighteen of nineteen youth whose files were reviewed had at least one identified service in their Treatment Plan. One individual was assessed but did not have a Treatment Plan on file.

Sixteen youth had Treatment Plans that identified a need for individual psychotherapy (89%). Two youth had only one service on their plan that was not individual psychotherapy (11%). One youth was identified as only needing Community Based Rehabilitative Services (CBRS). One youth was identified as only needing Family Therapy (with youth present).

Five of these eighteen youth (28%) were identified as needing a second service type. This included:

- Group Psychotherapy (2 youth)
- Family Counseling (1 youth)
- Case Management (1 youth)
- Psychological Testing (1 youth)

We also asked caregivers about the services that they believed that their child needed. They provided us with specific services that sometimes varied considerably from what was listed on the initial Treatment Plan. For instance, parents told us that their children needed:

- “CBRS, family counseling and [to] learn more about his recent autism diagnosis but they didn't provide any of it”;
- “Counseling, peer support, more in depth treatments for youth, teen focused, healthy activities. Group settings would be helpful. Would love social skills building in a same space to practice those.
- One caregiver indicated that she wanted to understand the range of services available to her youth, but that the agency, “Only offered counseling.”

Two individuals indicated that they were never provided a menu of services. Another individual indicated that the treating agency, “Couldn't provide them [additional services] due to lack of staff.”

Frequency, Duration and Setting of Care.

‘Appropriate care’ encompasses the idea of a fit between the severity and urgency of needs and the frequency and duration of treatment. Insufficiently intensive care may function akin to an inadequate dose of medication, having little immediate or lasting effect. The setting in which care is provided may serve as a facilitator or barrier to receiving an appropriate dose of treatment. For instance, having to travel a great distance to see a provider may require time and money that families can ill afford. We looked at treatment plans to see the extent to which they specified access to low-barrier, appropriate care.

Union Point Group

For the primary service identified on the Treatment Plan, the frequency of provision was specified in fifteen of nineteen (79%) plans. In thirteen of these instances, the treatment frequency was identified as 'weekly.' In one instance it was identified as 'every other week.' In the remaining instance, the frequency was noted as 'multiple times a week.' In two files, the treatment session length was included; in both instances it was specified as 45 minutes long. In two instances, the duration of the treatment was specified (3 months; 1 year).

In order to ascertain the fit between the services specified on the plan and the youth's needs, we asked caregivers whether they felt that the dose of care provided was appropriate to their child's needs. Of the eight responses obtained, four indicated their child received a sufficient dose of treatment, and four indicated a desire for more frequent or longer duration sessions. A parent who indicated that their child received a sufficient dose described how the therapist adjusted the duration of sessions based on the child's needs, "[Now we have treatment sessions for] one hour a week. We would have several sessions up to 2 hours, especially in the beginning." A parent who indicated that the dose was insufficient described only being able to access very short sessions, stating, "It was what I wanted but she [therapist] only has room for half an hour appointments. I think we don't get enough time."

Parents identified a variety of reasons for insufficient treatment dose. Regarding session duration, one parent remarked, "Half an hour is all they could give us. Are they here to help us or because of their agenda? Two of the appointments they had to make an exception but it took a lot to do that. I only have so many hours during the day. It was too short." Another caregiver offered that they, "Want more [frequent sessions] but [there's] no availability." Highlighting the provider shortage, one parent stated that, "[the] Counselor would schedule and just not show up. There was never a reschedule or notice she was going to be gone."

A lack of supports to receive care was also noted. One parent, although stating that, “I am satisfied with the amount of time we are getting,” also stated that, “We were going every week but it was just too much to take her out of school, so we go every other week. We were never offered after hours counseling. We weren't offered telehealth.” Another stated that the agency “...was not helpful. Many times appointments could not happen because of transportation issues.”

Conversely, multiple parents who were satisfied with the dose of treatment provided indicated the importance of providers' scheduling flexibility. One parent stated of their child's therapist, “There have been a few times she was able to meet outside the normal appointment time.” Another parent indicated that it was helpful that their therapist, “Worked with me on scheduling.” Sometimes, families have repeated challenges trying to manage treatment appointments. One parent indicated that, “We had to reschedule four times, but she [therapist] was flexible.”

Taken together, these responses indicate that there is a clearly identifiable set of barriers to adequate care that can be measured, tracked, and addressed within Medicaid's current regulatory framework. When these barriers are addressed, parents are more likely to indicate that they have an experience of care that is positive and helpful for their youth.

Efforts made to Address Service Barriers and Provide Designated Services.

Caregivers and Youth. We asked caregivers, “Some therapists ask whether there is any help that you need to be able to make appointments. Do you remember anyone at [Agency] asking you a question like that?” There were fifteen responses to this question. Six of fifteen caregivers (40%) indicated remembering a question like this being asked. Seven caregivers (47%) indicated that this question was not asked. Two caregivers (13%) could not recall whether or not this question had been asked of them.

Forty-six percent of responding parents indicated that they were asked if they needed help with transportation. Twenty-one percent of parents indicated that they were asked about the need for services available in the evening or on weekends. Thirty-three percent remembered being asked about the need for Telehealth (telephone or web-based treatment sessions).

Just over one-third of caregivers indicated that there was a discussion of how to address specific services not being easy to get (36%).

Clinicians. We asked therapists, “How do you usually check to see if families need concrete help to participate in treatment? For instance, if they need transportation support, or sessions over the phone, or appointments outside of usual business hours.” All interviewed clinicians indicated that they asked about supports for attendance. They described a range of supports for addressing each of these potential barriers to service access.

When asked about transportation, clinicians described a series of supports offered:

“[In the] very first meeting, there is a talk about barriers and things that can be done to help with relief of barriers. [We] offer respite, appt changes, telehealth, in home services and transportation if needed. Often [we] just met in the home for services, including therapy.”

“Yes, transportation was initially a problem, but was lifted. [We] offered telehealth and transportation services. Moved to an appointment [time] that worked for her best.”

“...[W]e talked about all barriers that could be. Gas mileage reimbursement for parents, flexible scheduling with hours and [therapist going] to elementary and high school to meet with kids there to reduce [barriers].”

In terms of scheduling, clinicians stated that:

“[I was] very supportive of scheduling need and meeting in person at an alternative location where the kids were located for summer school. Made it easier for access and timing.”

“[I] worked with [the] family to address different times and [my] availabilities.”

“Attendance was terrible, so there were difficulties there, [they] would change appointment times and [I] was very flexible in the days and times.”

“[The] care coordination team gathers all information ahead of time, they look at transportation, preference on provider, scheduling needs along with other standard questions.”

Two clinicians specifically mentioned using Telehealth to reduce the burden of attending sessions:

“[The] client started [treatment] very quickly. Counseling is done through telehealth to reduce overall burden for treatment.”

“[Scheduling was challenging, so] Telehealth was offered and done at some points as well.”

We note that since the majority of clinician interviews were lost in a data management incident at IDHW, these eight clinicians’ responses may be skewed in some manner. In order to address this methodological concern, we looked at direct agreement between the caregiver and their treating clinician.

In these instances, their rate of agreement was:

- 67% regarding asking about barriers to attendance;
- 33% on providing services on nights or weekends;
- 67% regarding addressing transportation needs.

In each of the instances of disagreement, the clinician indicated that they asked about or offered the support, and the family did not perceive or recall that the support had been offered. This points to a need for clearer, standardized communication and tracking regarding supports being offered.

Summary.

Accessing appropriate care can be a challenge when there is a shortage of specialty mental health providers. We found that behavioral health treatment providers do not have clear strategies for what to do when services are not available at their provider agency, or in their immediate network. Some providers only discuss services that they know are available at their agency. Others tell consumers that services are not available, though they are required to be provided per the Settlement Agreement and EPSDT regulations. IDHW needs to address this directly.

We also found that supports for accessing care are offered inconsistently. For instance, providers are more likely to describe transportation supports than availability during extended hours. Though providers indicated that they always discussed the availability of supports with families, these discussions were not well remembered by caregivers or well documented in the chart. There needs to be a better way to create a shared understanding of available supports.

In order to address the concerns identified, IDHW can:

- Create and disseminate a brief, family-friendly service menu describing each of the services and supports listed in the Jeff D Settlement Agreement, for use by providers;
- Include, along with the menu, instructions for what a provider can do to access a medically necessary service for a youth when it is not locally available;
- Partner with family advocacy agencies to educate youth and families about the importance of including desired services from the service menu on their Treatment Plan;
- Structure a standardized Treatment Plan form for use statewide, and include sections on attendance supports and addressing delays in service availability.

Question #3. How are care coordination services prioritized and accessed in the first 30 days post-assessment?

Per the Jeff D Settlement Agreement, “Services are provided regardless of the Class Member’s behavior, placement setting, family circumstances or availability of services” (p. B-4, (5) a.) IDHW has faced consistent shortages of providers and treatment capacity, particularly for individuals with intensive treatment needs. The most recent [Family Survey](#) (published in April of 2024) indicates that 46% of surveyed families of children with intensive behavioral health treatment needs report that they are able to see someone when services are needed. Exactly half were ‘Able to access recommended services.’ Similarly, 49% indicated that they were able to get services in their local community. In sum, recent evidence indicates that approximately half of the children eligible for intensive community-based treatment services are not receiving them.

These data point to the need for creative and persistent assistance in navigating access barriers and finding resources which may not be locally available. Care coordination is designed to pair families with individuals whose job it is to accomplish these tasks. The Jeff D Settlement Agreement’s Commitments (number 19) include that, “The Parties agree that Class Members with more intensive needs shall be provided Intensive Care Coordination (ICC), as defined in the Services and Supports document.”

In this Quality Review we looked to see whether and how the offer of Care Coordination was made to families of youth with high-intensity needs. We also took the opportunity to assess the extent to which YES providers offer Peer Support (Parent or Youth Peers) to families. These Peers provide alternate sources of expertise about system navigation and resource finding. The lived experience of persons who have had to navigate the systems themselves can serve as both a source of engagement with families, and as a practical resource for locating a wide array of formal and informal supports.

Care Coordination Prioritization and Access.

Caregiver and Youth Experience of Care Coordination. We asked caregivers directly whether they:

- were made aware of the range of coordination and treatment services available to them;
- were offered a Care Coordinator;
- desired a Care Coordinator;
- received Care Coordination services;
- identified Care Coordination and service access as high priorities for system improvement.

We asked this set of questions to determine current processes for offering and accessing Care Coordination. The prompts also allow us to better understand the extent to which Care Coordination capacity and practices are identified as a priority for system improvement.

Range of YES Services Available Described.

Just over two thirds of interviewed caregivers (68%) indicated a positive experience with the service descriptions and choices they were provided, a clear strength in the care processes we examined. The remaining third described frustration about the lack of information or service availability. Caregivers with a positive experience often described a range of services being offered. One parent stated:

“I felt relieved that someone finally had options for us. They offered individual and family counseling and skills training and eye [movement desensitization and reprocessing] therapy. They offered lots of things that I hadn't heard of before. I was mostly just hoping that someone would get through to her. Her criminal charges were stacking up and her behaviors were not being tolerated.”

Caregivers with a negative experience of service choices described frustration with the lack of choice and paucity of services offered. One caregiver stated that, “No choices [were] given about the type of service or the service providers.”

Union Point Group

Another parent indicated that, “They offered counseling and help supporting his IEP. We wanted CBRS, family counseling and learn more about his recent autism diagnosis but they didn't provide any of it.”

File Review. Discussion of the array of available services does not appear to be a priority for documentation. In only three of the nineteen reviewed files (16%) was there documentation of a discussion of the array of available services.

Offer of Care Coordination.

Caregivers were asked specifically if they were offered a Care Coordinator. Seven of fourteen caregivers indicated that they were offered a Care Coordinator (50%). One caregiver who was not offered a Care Coordinator stated that the agency told them that they did not currently have the staff and that they were, “Working on it and they will let me know” when they do have the staff. Three of the seven caregivers who were offered a Care Coordinator indicated that they accepted the offer (43%). Those that did not accept had a variety of reasons for not accepting. These reasons included already having a Care Coordinator in another system (“I have one through DDS. We talked about it and one was offered, but we didn’t need it. They offered to help where they could”) and not feeling like a Care Coordinator was needed (“I didn't feel like we needed a case manager assigned, we just needed a little bit of extra help.”)

File Review. In four of twenty files reviewed (20%), there was a documented offer of Care Coordination as a support. In two instances, the reviewer indicated that a Case Manager, Targeted Care Coordinator or Wraparound Facilitator was working with the family (10%). In two instances there was documentation that the support was declined. In only one of nineteen files (5%) was there evidence of Child and Family Team meetings documented by the therapist. These findings suggest under-documentation of the offer of Care Coordination in service records.

Offer of a Peer Partner.

Persons with lived experience of seeking public behavioral health treatment services are an important source of assistance and navigation in many treatment systems. These individuals often can engage with caregivers and youth through their common lived experiences, and their expertise in the day-to-day realities of navigating a fragmented service system. Because of the value of this type of support, we asked caregivers, “At some Agencies, they have 'Peer Supports,' who are trained parents and young adults who have also gone through this system. They help families navigate the system and advocate for the right services. Do you remember being offered a Parent or Youth Peer?” Six of seventeen caregivers (35%) indicated that a Parent or Youth Peer was offered to their family.

File Review. In two of eighteen files (11%) there was documentation of a Parent Peer being offered by the therapist. In one case the support was accepted, and in the other case it was declined. In one of eighteen files (6%) there was documentation of a Youth Peer Partner being offered by the therapist. Documented offers of Peer Support occurred at roughly half the rate that caregivers recalled being offered the support.

Desire for Care Coordination.

We asked caregivers who were not offered a Care Coordinator if they wished to have one. Of the five responses recorded, two of the five (40%) indicated that they wished that they had been provided with a Care Coordinator.

Receipt and Experience of Care Coordination.

Caregivers described a set of largely positive experiences with Care Coordinators. One stated, “One of the first meetings we had was with a targeted care coordinator. It worked well and was an easy process. No complaints.” Another caregiver described the experience in glowing terms:

She helped. She went through all the work and I can go back to her anytime that I want to. She is super on top of it. Two or three people talked to us about it. They were all on board for whatever you need. Everything was offered to me.

Another caregiver indicated that they appreciated the Care Coordinator, but that service access issues remained unresolved, “He has had a Care Coordinator for awhile. [The] Care Coordinator understands [the child’s] needs but there is a lack of services and availability in rural areas.”

Improved Agency and System Responses.

We asked two questions regarding the system’s response to a child’s needs. The first question that we asked was, “When you think about the first few weeks of trying to get help for [youth name] at [Agency name], what do you wish had been different?” Forty-one percent of caregivers indicated a need to make the initial referral and connection to services quicker and more transparent. Representative comments included:

“[I wish] that they would have advertised so that I would have known where to take him.”

“That it wouldn't have taken so long to see someone. That he could have seen an actual therapist and not a student and that someone could have helped in the home.”

“Idaho needs to catch up to other states. Services are lacking. Clinicians are doing the best that they can. Education needs to be offered. The resources are limited and they need more.”

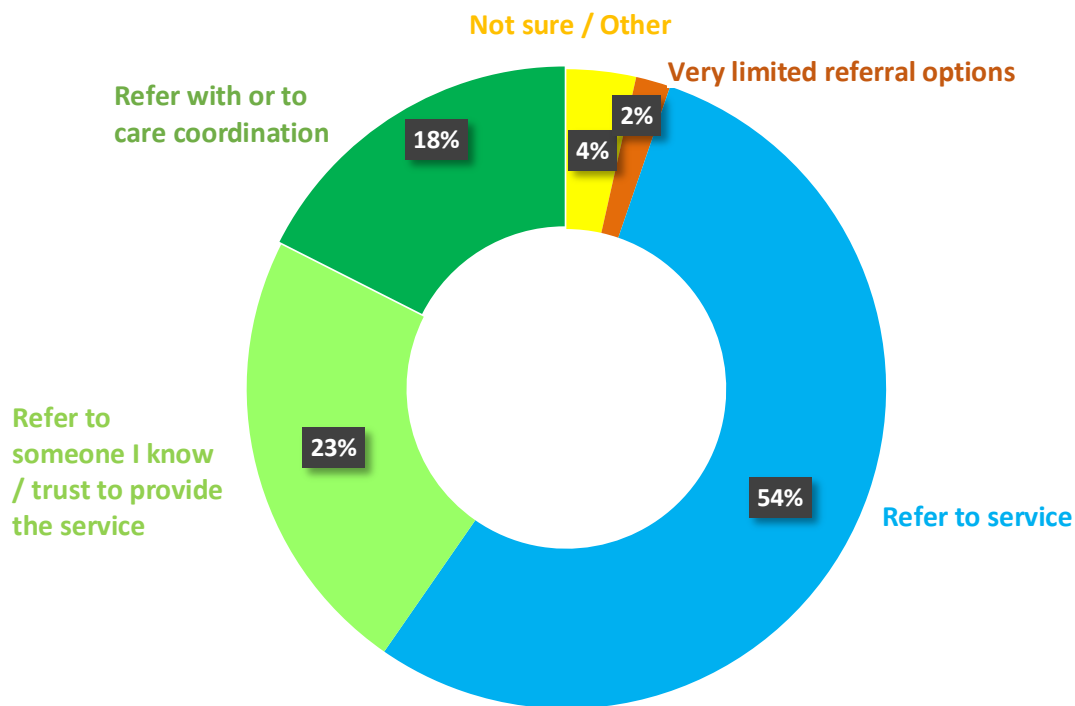
The second question that we asked was, “If there was just one thing that the system could change about your experience in those first few weeks, what would it be?” Six of fourteen respondents indicated a need for better access to appropriate services. Parents described a series of supports needed to make this happen: prioritized referral (“A referral for faster treatment if there was an opening even if it means that agency would lose business”), assistance navigating the system (“Provide parental assistance to navigate the system. Maybe there could be classes to teach parents how to navigate the system or parenting classes so these problems could be avoided in the first place”), and an increase in the number of providers available, particularly in rural areas (“Overall the sheer number of providers needs to change. [We need] Incentivized program for rural areas. Compensation for travel time to rural areas”).

Provider Agencies’ Use of Care Coordination.

We also completed a statewide survey of behavioral health providers in the network. In this survey, we asked providers about whether they served youth who had needs that required help outside of their agency, and what they did if they encountered such concerns.

Agency Respondents. Agency respondents (n = 57) indicated that 25-31% of youth served in their agency need additional behavioral health services that their agency does not provide (Median = 25%, Arithmetic Mean = 31%). 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 1).

Chart 1. Agency Respondents’ Processes for Connecting Youth Needing Other Services.



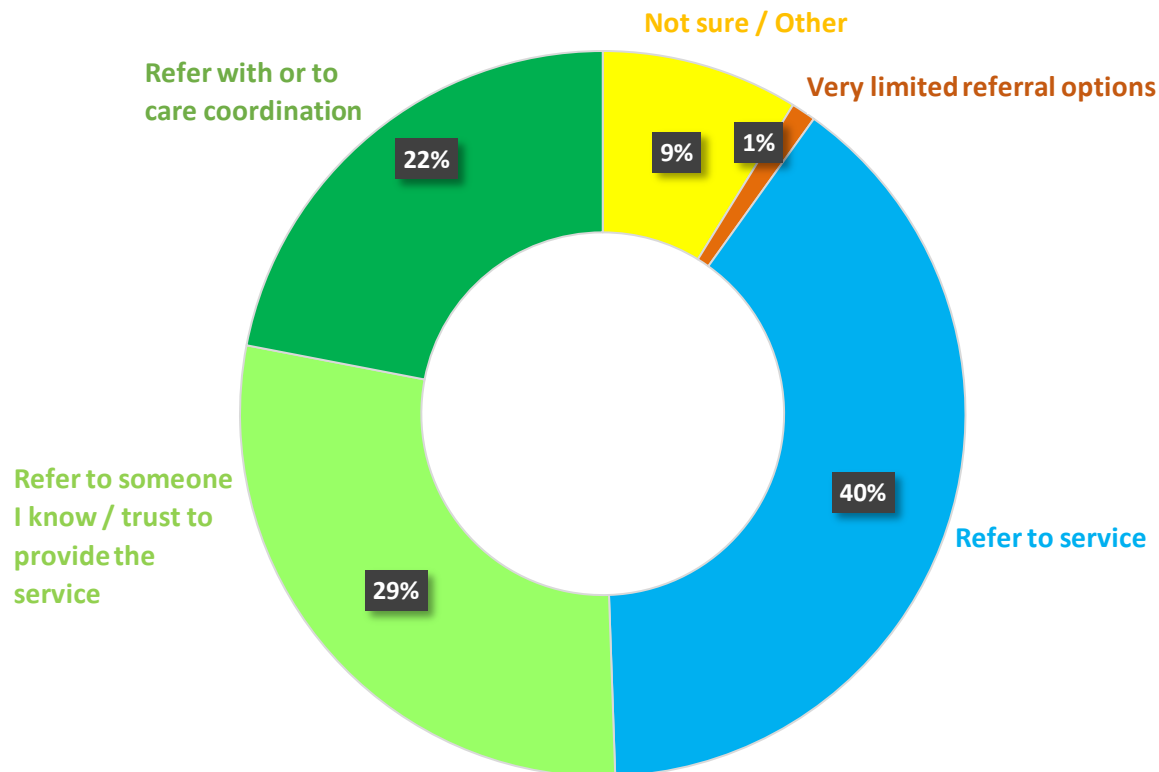
Of note, only about 1 in 5 agency respondents mentioned using care coordination when youth required services outside of their organization. About 8% fewer agency respondents mentioned using care coordination in 2023 compared to 2022. This may be related to the fact that the availability of care coordination services has decreased over the last three years.

For example, our provider surveys indicate a decline in agencies offering Targeted Care Coordination. In 2021, 50% of agencies reported providing Targeted Care Coordination; in 2022 this dropped to 37%, and in 2023 this dropped to 33%.

Additionally, the percentage of agency providers who said that they refer to someone they know/trust modestly decreased. In 2022 this represented 27% of providers; in 2023 it was noted by 23% of providers. In order to get youth connected to services during the first 30 days of treatment, providers likely utilize care providers whom they know personally. If respondents' networks are shrinking, it will be harder to efficiently connect youth to appropriate care.

Individual Practitioners. Individual practitioners (n = 91) indicated that about 25-30% of youth served in their agency will need additional behavioral health services not provided by their agency (Arithmetic Mean = 30%, Median = 25%). When asked what happens when a youth has these needs, respondents provided a variety of answers (Chart 2), which we have classified by theme.

Chart 2. Individual Practitioners' Processes for Connecting Youth Needing Other Services



Both individual practitioners and agencies routinely need to make referrals to outside service providers in order to meet the needs of their clients. When asked what percent of their youth have needs requiring outside services, 84% of individual practitioners and 98% of agency respondents reported that some youth they see require outside services. Twenty-five percent of individual practitioners indicated that more than half of the youth they see require outside services; 30% of agency respondents indicated this.

About one in five respondents mentioned the use of care coordination or care coordinators to connect youth with needed, outside services. Individual practitioners mentioned the use of care coordination more frequently in 2023 (22%) compared to 2022 (16%). Individual practitioners also reported relying on their personal referral networks more frequently in 2023 (29%) than in 2022 (14%).

Taken together, these findings indicate a growing burden on providers in finding appropriate care for children and youth with serious or complex needs. Should the provider network change significantly with the new IBHP vendor, we would expect that these challenges could become even more acute.

Summary.

The second commitment in the Jeff D Settlement Agreement is, "Class Members with more intensive needs shall be provided Intensive Care Coordination (ICC), as defined in the Services and Supports document." The [most recent QMIA Quarterly report](#) indicates that "During SFY 2024, just 62 (unduplicated) youth received Wraparound, indicating a substantial unmet need for Wraparound services" (p. 15). [A recent needs estimate](#) by Boise State University indicates that 1,536 youth needed Wraparound in SFY 2024. This indicates that less than 1% of the estimated need for Wraparound was met.

The number of individuals provided with a version of Intensive Care Coordination that is not Wraparound is not provided in the QMIA report. Nor does the QMIA report the number of persons who are offered and accept a Peer Partner to help them navigate the system.

Our data indicate that these other system navigation resources are offered at a rate substantially higher than that of Wraparound. In our interviews of caregivers of youth with high intensity needs, half recalled Care Coordination being offered and just over one-third recalled a Peer Partner being offered to them or their youth. There was no discernible pattern to whom was offered Care Coordination or a Peer Partner.

Given the enormous unmet need for Intensive Care Coordination, three actions are critical:

- all three types of system navigation supports (Wraparound, Intensive Care Coordination, Peer Supports) should be carefully tracked and their capacity further developed;
- the scarcity of these resources continues to underscore the essential task of explicitly and consistently identifying who are the families and youth who are the highest priority for being offered these services. IDHOW needs to develop and train on this identification protocol;
- once identified, it is essential that a protocol is created for providers to follow that facilitates access to care coordination for the highest priority families and youth.

Beginning on the following page is a series of questions (Nos. 4–6) whose answers are provided by provider agencies and individual practitioners. We note that these questions were asked of providers and practitioners in the Fall of 2023. We submitted these answers as a sub-report to IDHW in the Spring of 2024, in order to ensure that IDHW could use this information in a timely manner.

The questions and answers are also provided here (below) in the context of the full Quality Review.

Question #4. What change has there been in the provider network’s capacity for intensive community-based treatment?

Chart 3 (below) identifies agencies' self-reported service array. Response percentages are based on survey responses from 57 child-serving agencies who completed the Fall 2023 survey’s agency-related services questions.

Chart 3. Agency Respondents’ Current and Planned Services.

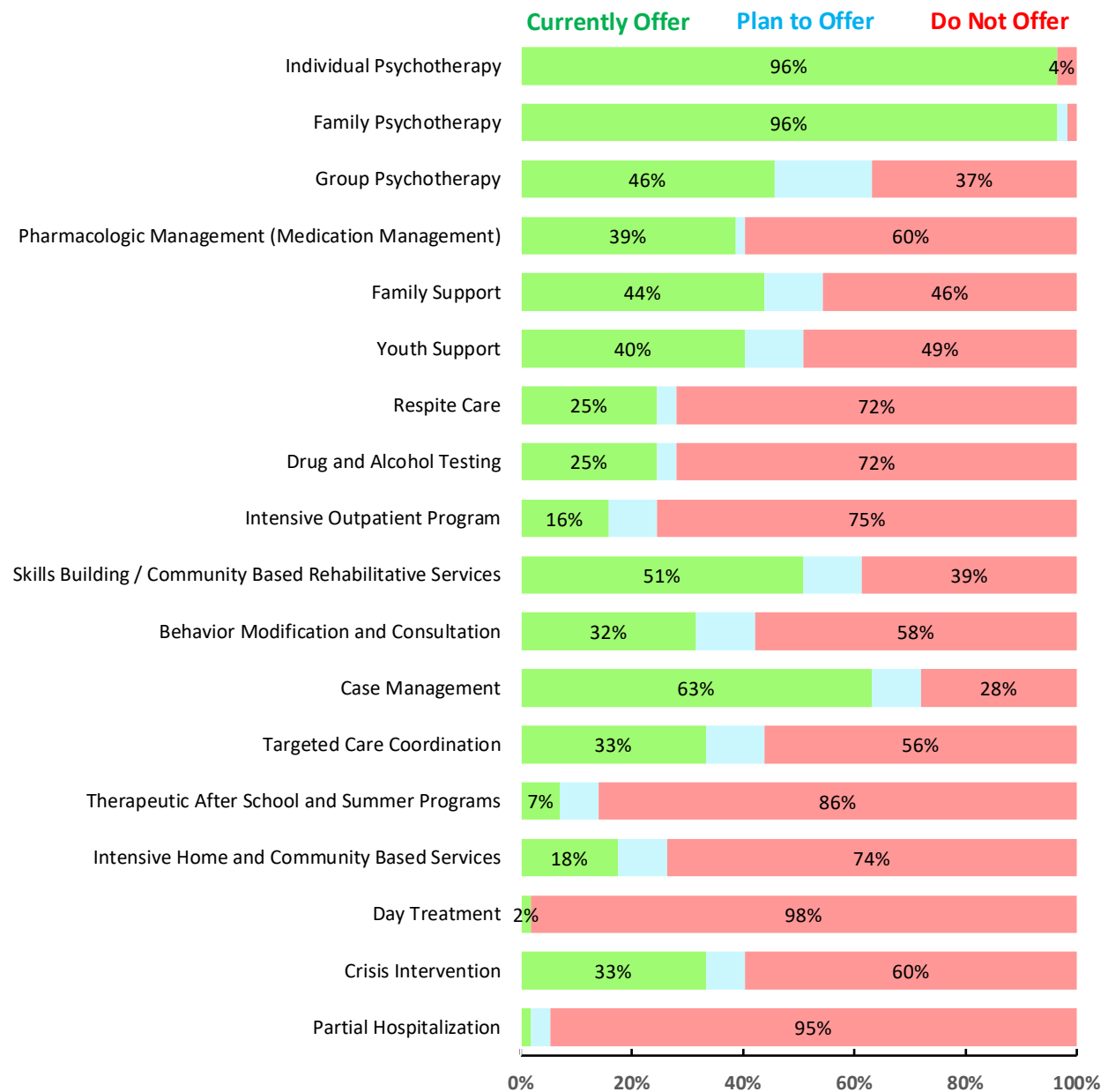
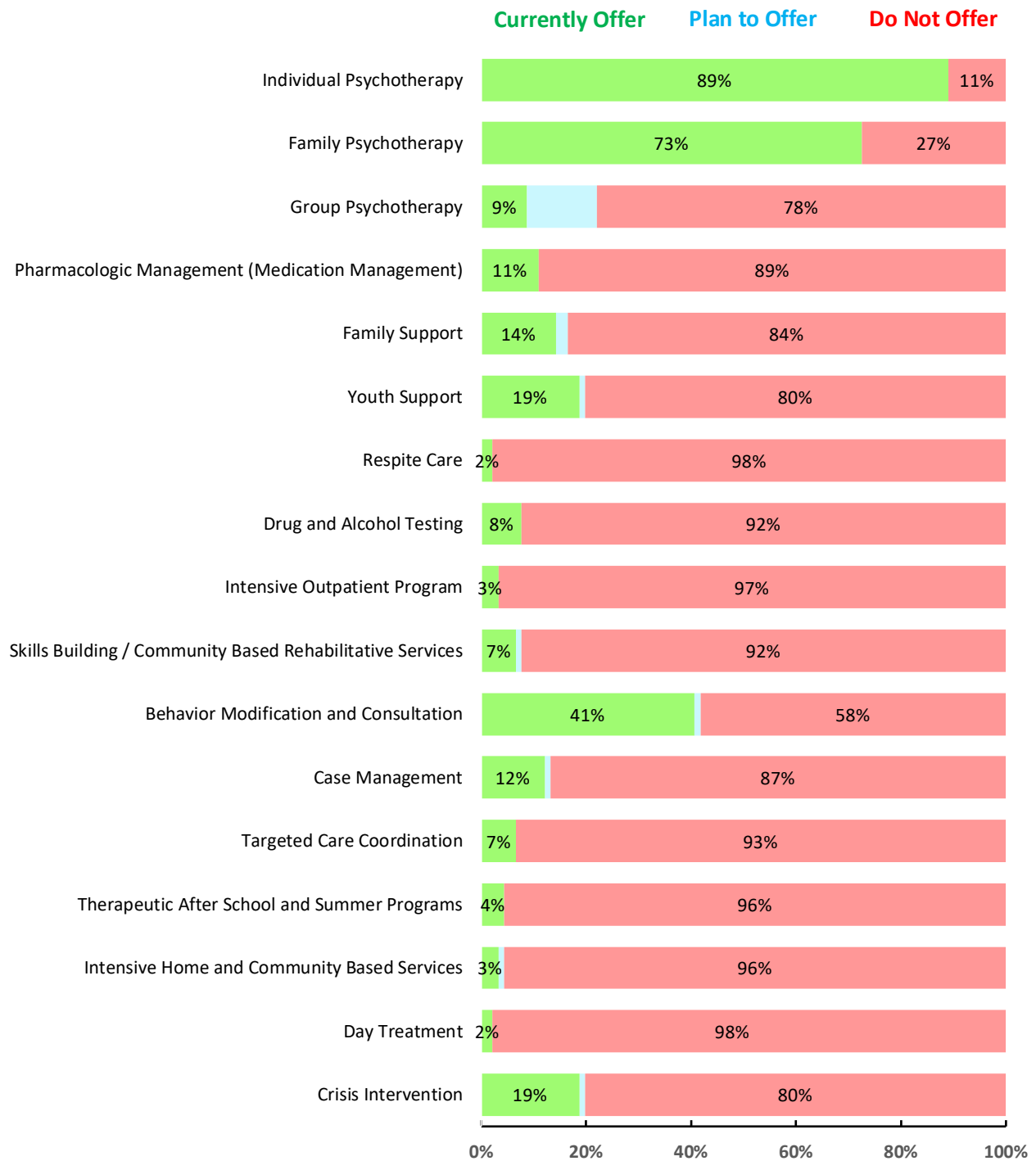


Chart 4 (below) identifies individual practitioners' self-reported service array. Response percentages are based on survey responses from 91 child-serving individual practitioners.

Chart 4. Individual Practitioners' Current and Planned Services.

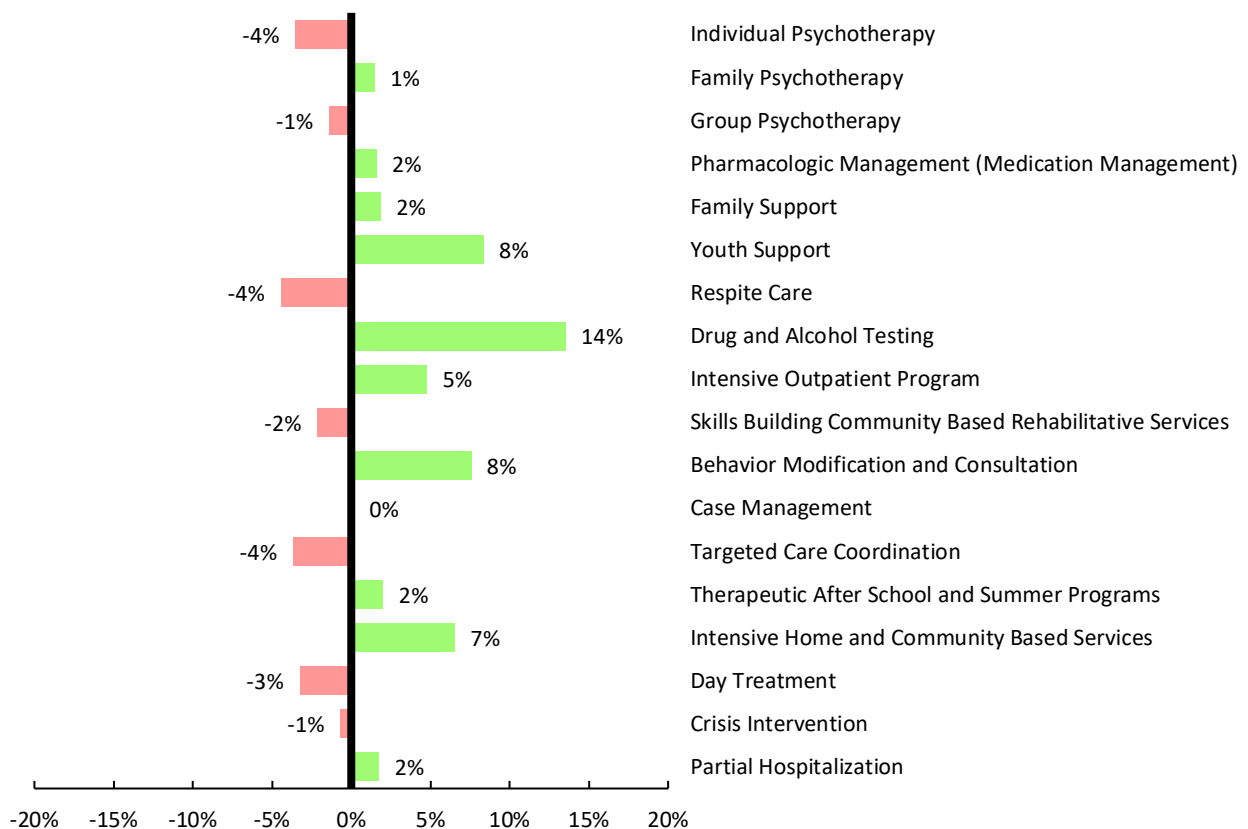


Service descriptions used in both the Agency and Individual Practitioner surveys are lightly edited versions of the descriptions appearing in the Optum Provider Handbook. These descriptions are included in Appendix A for reference.

Summarizing the Current Service Array.

As we have identified in previous iterations of the Quality Review, Idaho’s YES population is disproportionately skewed towards youth with high levels of behavioral health concerns. Yet the service arrays we see in Charts 3 and 4 focus on services which are appropriate for youth with mild to moderate behavioral health concerns. Only about 8% of individual practitioners provide services targeted towards youth with severe or complex behavioral health needs.

Chart 5. Net Change in Care Types that Agencies Currently Provide (from 2022-2023).



Across multiple service types, provider agencies are also unlikely to provide the intensive treatment options best suited for youth with severe or complex needs. Sixteen to twenty-five percent of agencies indicate that they provide Intensive Outpatient Programs, Intensive Home and Community-Based Services, or Drug and Alcohol Testing. Only 2% of respondents indicated that their agency provides Day Treatment; similarly, 2% indicated that they provide Partial Hospitalization.

This indicates that youth who are exiting Hospital or Residential-based care may have difficulty finding the types of very intensive, community-based treatment options needed for community re-integration. Similarly, youth at risk of Out-of-Home Care are also likely to experience challenges in finding appropriate community-based treatment options.

Projected versus Actual Growth in Service Capacity between 2022 and 2023.

In the 2022 QR we asked respondents about their intentions to add a new service type in the next six months. Across services, about 6% of providers indicated that they planned to add at least one specific service in the next 6 months. When this year's respondents were asked about services they currently provide, they were 2% more likely than last year's respondents to currently be providing a given service (Chart 4). This is the first time in three years of provider surveys that respondents have indicated a net addition in services provided. Though statistically insignificant, the change bears further monitoring.

We examined the provision of eighteen different types of services. Providers were more likely to provide ten types of services in 2023 than they were in 2022. Seven services were less likely to be offered in 2023 than in 2022. One service (Case Management) was offered at the same rate. For 12 of the 18 services assessed, the magnitude of change was less than 5%. For one service (Drug and Alcohol Testing) there was there a double digit increase in the percentage of providers providing this service.

More agencies responded to these questions in 2023 (57 agencies completed these items) compared to 2022 (38 agencies responded). Minor differences in services endorsed may be due to a wider array of agencies responding to the survey.

Question #5. Do network providers perceive any change in the state-level barriers and supports that impact the expansion of intensive community-based treatment?

Understanding Why Services are Expanded or Reduced.

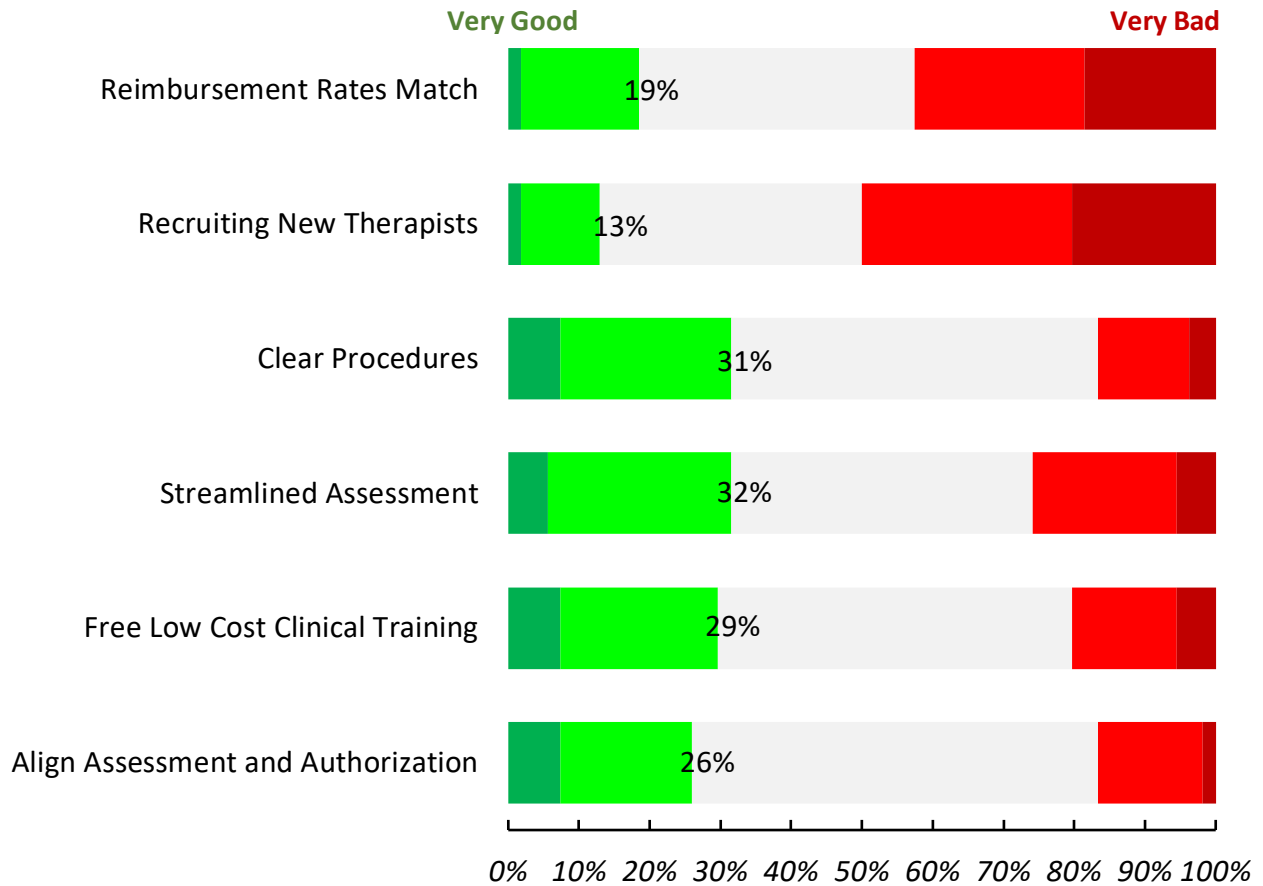
Service expansion or reduction can be influenced by multiple factors. Idaho providers previously indicated that the following factors are important in their decisions to add or reduce the scope of care they provide:

- Availability of clear procedures for service initiation;
- Reimbursement rates consistent with the costs of doing business;
- Effort needed to recruit therapists willing to work in the public sector;
- Supply of affordable, high-quality training needed to provide effective services;
- Alignment between assessment and service authorization procedures;
- Streamlined assessment processes.

We used these responses to construct a scale asking how well or poorly IDHW addressed these needs in order to support service expansion. Fifty-four agencies (Chart 6) and 87 individual practitioners (Chart 7) responded to these questions in the survey.

Respondents rated, on a 5-point scale ranging from “Very Good” to “Very Bad,” how well IDHW currently provides these supports for service expansion. These supports are arranged in the chart 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.

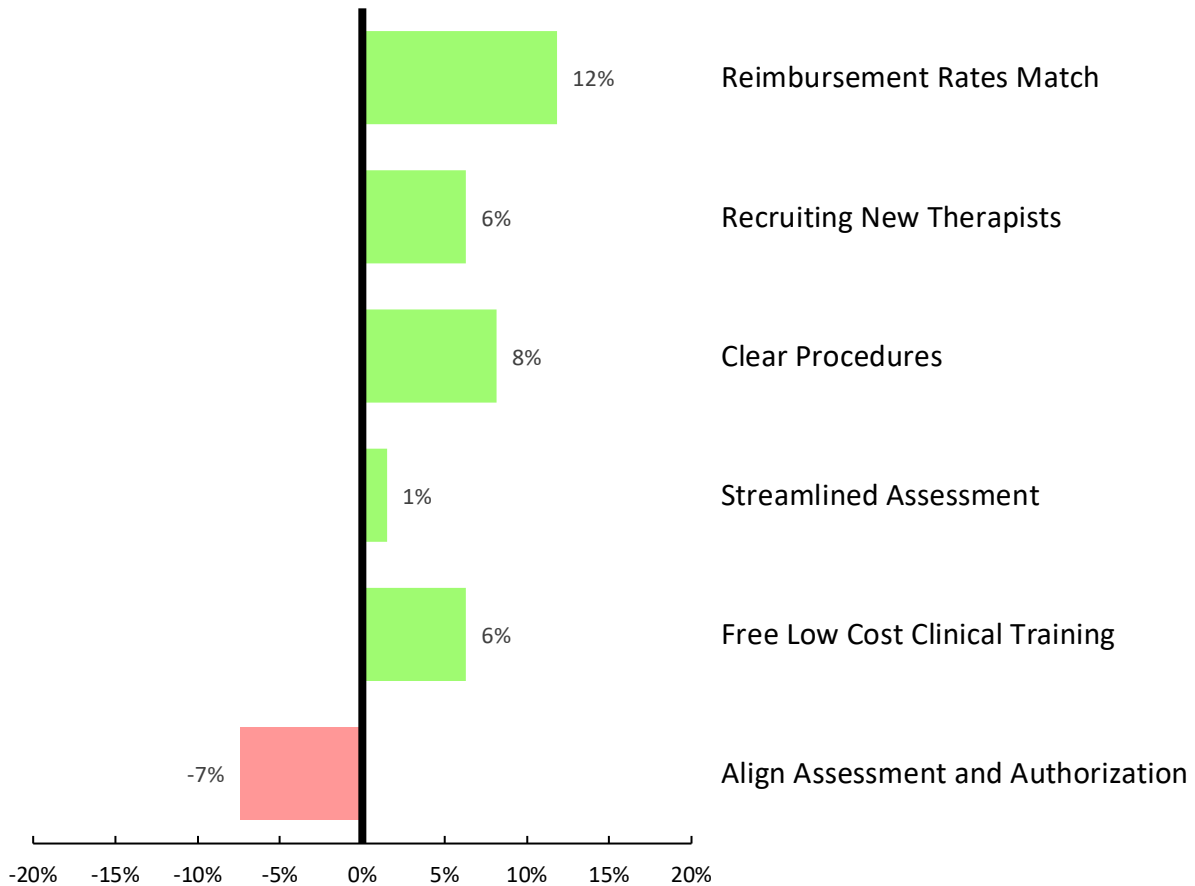
Chart 6. Agency Respondents’ Satisfaction with Supports for Service Expansion.



The percentage of agency respondents satisfied with the State’s supports for expanding the continuum of care ranged across items from 13% to 32%, averaging 25% across all supports. Consistent with the previous year’s survey, the most important supports for service expansion (“Reimbursement Rates Match Costs,” “Help Recruiting New Therapists”) had the lowest rates of satisfaction.

Chart 7 (below) describes the net change in agency satisfaction with the State’s supports for expanding the continuum of care between 2022 and 2023.

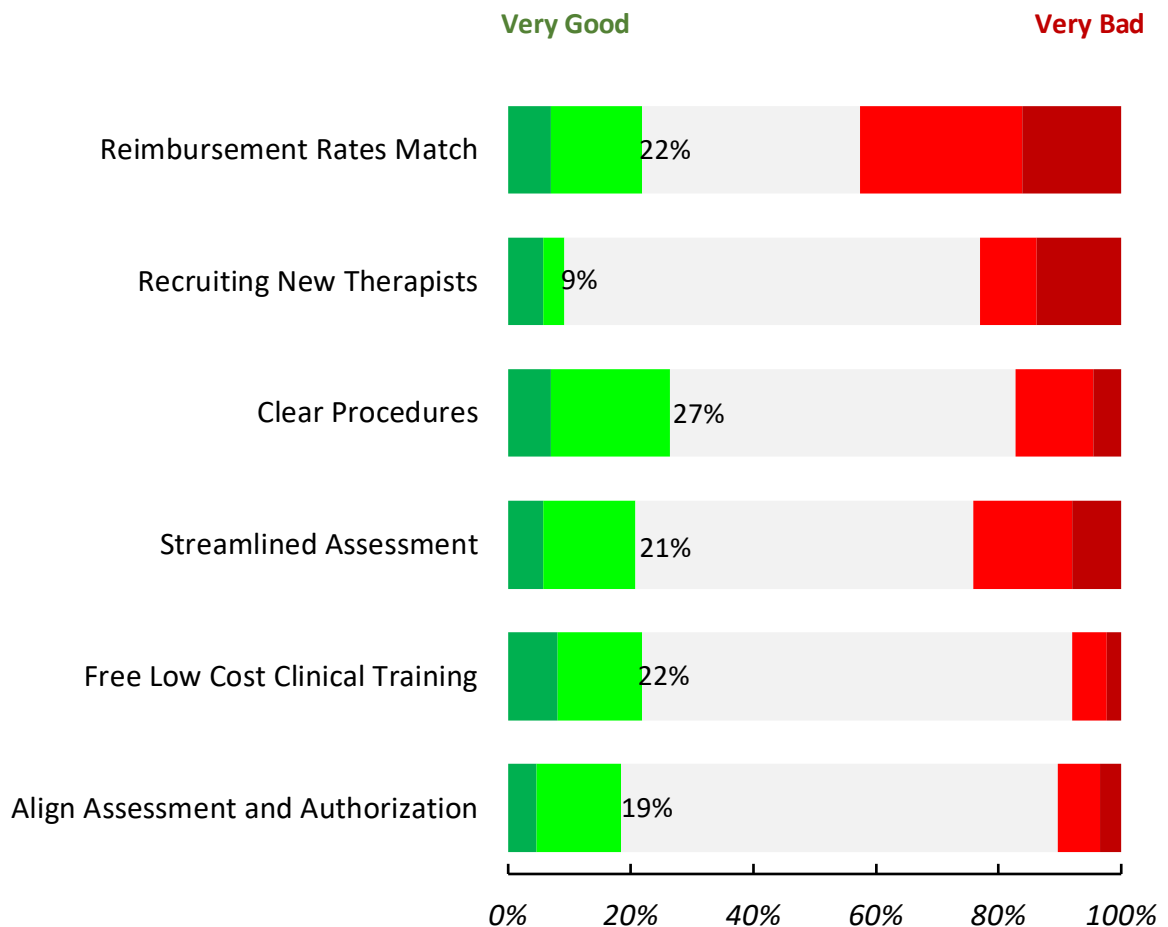
Chart 7. Net change in Agency Provider Satisfaction with the State’s Supports for Expanding the Continuum of Care (from 2022-2023).



Overall, agency providers reported somewhat higher average levels of satisfaction with state supports in 2023 (25%) compared to 2022 (21%). Satisfaction improved in 2023 for five of the six supports (with net changes ranging from 1-12%). Agency respondents reported a 7% decline in satisfaction with one state support (aligning assessment and authorization).

The largest reported change in satisfaction was a 12% increase in satisfaction with reimbursement rates. Satisfaction with rates changed from 7% in 2022 to 19% in 2023. This may be related to the July 1st, 2023 fee schedule increases to most behavioral health services. Rates were increased for 38 services, including a 20% rate increase for individual psychotherapy. We note that several substance use treatment services saw 30% reimbursement rates increases in the past year, which may have contributed to the double-digit expansion of Drug and Alcohol Testing (Chart 5).

Chart 8. Individual Practitioners’ Satisfaction with Supports for Service Expansion.



Across support types, individual practitioners' satisfaction with supports ranged from 9% to 27%. Practitioners were satisfied with supports, on average, 20% of the time. "Recruiting new therapists" and "Align assessment and authorization" had the lowest rates of satisfaction among individual providers.

Both agency and individual respondents also emphasized the need for recruiting new therapists, with agencies identifying this as the top need for service expansion. Clear procedures were also identified as a leading concern across provider types. The need for clear procedures may be especially salient with the advent of a new Managed Care entity; we discuss this in greater detail in the following section.

Overall, all groups surveyed indicated an ongoing need for IDHW to substantially improve efforts to engage and equip providers for service array expansion. The current data indicate very modest improvements in perceived supports from IDHW. Substantially more persistent and effective efforts to provide the listed supports are likely required to expand the service array consistent with the Settlement Agreement.

Question #6. What efforts are the IDHW Division of Behavioral Health and Medicaid undertaking to grow the network of specialized community-based treatment providers?

This specific question was developed in response to the transition to the new IBHP administrator. Though IDHW has [some efforts underway](#) to develop statewide capacity for intensive services via training and upskilling of providers, network providers ultimately must decide whether or not to expand their service array. The transition to a new IBHP administrator offers the opportunity to engender hope and trust in IDHW as a competent regulatory and payment entity. Thus in this question we focus on how providers experience the efforts undertaken by IDHW in the transition to Magellan Healthcare as the IBHP provider. Note that these questions were asked of providers in September of 2023.

In order to answer this question, we asked providers:

- a) What concerns do you have about transitioning to the new Managed Care Organization's provider network?
- b) What supports would be helpful to your organization to successfully transition to the new Managed Care Organization's provider network?

We received one hundred and thirty-two responses to these two prompts. Fifty-one agency providers and 81 individual practitioners provided responses. These responses were first categorized into themes. Then, the frequency of responses within each category was tallied. This provides a rough metric of the extent to which these concerns may be front of mind for providers, not necessarily the extent to which they may impact their engagement. Then we analyzed the comments within each theme. We used the providers' own words to create clear and specific descriptions of their concerns, and the supports needed to facilitate integration into the new provider network.

High priority supports identified by individual practitioners and agency providers include:

- a) Clarifying expectations and policies;
- b) Proactively preparing providers to enter the network;
- c) Implementing sustainable reimbursement rates and processes;
- d) Providing children and families with uninterrupted service access.

In the pages that follow, each focus area is briefly described. Examples of concerns and needed supports for each focus area are provided in corresponding tables, with direct quotes from providers. Summary examples of these supports are provided in Table 1, and then in expanded form in Tables 2-5.

Table 1. Concerns and Supports Associated with Managing the IBHP Vendor Transition

Clarifying expectations and policies.	
<i>Concerns</i>	<i>Needed Supports</i>
“We have not received any kind of policy to create programs or our own policy around the new plan.”	“If we could get our hands on policy and stipulations ASAP for the programs...”
“Preparing for credentialing process as an agency. ... This was a lengthy and complicated process getting set up.”	“As much information as possible well before the transition date. Provider manual, policies, anticipated changes, etc.”
“not knowing expectations or what will change”	“Transparency on what to expect so we can budget, staff, and prep.”
Proactively preparing providers.	
<i>Concerns</i>	<i>Needed Supports</i>
“Lack of training, [want] training [that] is at times that we do not need to cancel client”	“Provider forums that actually answer our questions....”
“Needing to reformat documentation and train providers in changes”	“Introductions and training on processes and procedures”
“Convolutd transition progress”	“Be able to have ongoing, consistent meetings with the managed care organization, so that we can all collaborate..”
Implementing sustainable reimbursement rates and processes.	
<i>Concerns</i>	<i>Needed Supports</i>
“reimbursement rate, if we will be paid right away”	“Any major changes should be done gradually and with plenty of communication well in advance of changes.”
“That there will be a lapse in claims payment. we do not currently have money to get us through this time.”	“Higher reimbursement, to incentivize more bringing more people into the field after the mass exodus during the pandemic.”
“We fear that reimbursement rates will be scrutinized and minimized”	“We hope the new organization will advocate and effectively be able to offer higher reimbursement”
Providing uninterrupted service access.	
<i>Concerns</i>	<i>Needed Supports</i>
“...how will the eligibility / billing transition be for clients.”	“All covered members automatically transferred or covered initially”
“I fear that Magellan will be like Optum and only care about cutting services...”	“....increase services, increased pay rate for services, less or no authorization for services for mental health services...”
““Changes to the service array what is staying and what is going..... increases/decreases to the number of units services are allotted to care for clients”	“IDHW being extremely clear with Magellan as to.... what thresholds are appropriate for approval.”

Focal Action Area 1: Clarify expectations and policies.

Table 2. Respondents’ descriptions of needed clarifications.

Clarify expectations and policies.	
<i>Concerns</i>	<i>Needed Supports</i>
<p>“We have not received any kind of policy to create programs or our own policy around the new plan. I am concerned about the auth process. I am concerned about our systems being able to communicate with each other.”</p>	<p>“If we could get our hands on policy and stipulations ASAP for the programs - as well as job qualifications for the programs we will be able to credential for - that would be helpful for us to think through which programs we may want to open.”</p>
<p>“Preparing for credentialing process as an agency. We currently hold Agency Credentialing with Optum. This was a lengthy and complicated process getting set up. New policy and procedures, forms, expectations and training of providers will also significantly impact our operations for services.”</p>	<p>“As much information as possible well before the transition date. Provider manual, policies, anticipated changes, etc.”</p>
	<p>“Information on transition expectations, overall needs from us to make sure the transition is smooth.”</p>
	<p>Transparency on what to expect so we can budget, staff, and prep.</p>

Providers described two sets of concerns to be addressed in this first set of focal actions. These included lack of clarity regarding credentialing requirements and the absence of policy and procedure documents. There was also an allusion to a third concern. This was that systems provided by the new vendor would not operate as needed for information to be transmitted and appropriate actions taken. Providers indicated that they want to be able to make a ‘smooth’ transition to the new vendor, but that the lack of information on what changes to make in program operations were hindering their ability to do so.

Focal Action Area 2: Proactively prepare providers.

Table 3. Respondents’ descriptions of needed preparations.

Proactively prepare providers.	
<i>Concerns</i>	<i>Needed Supports</i>
“Lack of training, [want] training [that] is at times that we do not need to cancel client”	“Provider forums that actually answer our questions instead of provide generalized answers and tell [us] to email a general email address with our questions.”
“Needing to reformat documentation and train providers in changes”	“Introductions and training on processes and procedures”
“Convolutd transition progress”	“Lots of communication, training and ability to get questions answered.”
“That they [new Vendor] aren't ready”	“Be able to have ongoing, consistent meetings with the managed care organization, so that we can all collaborate and have an understanding of what works and what doesn’t work”

Adding to the intent identified in the previous action area, providers indicated that a hands-on approach to transition preparations was needed. Specifically, providers identified a need for accessible training on the changes that would be coming. Providers indicated marked frustration that they could not get their questions answered in the forums provided by the new vendor. Providers have indicated a desire to collaborate with the new vendor and problem solve throughout the transition period. However, their responses indicate that this willingness has not been met with consistent, meaningful responses from the vendor.

Focal Action Area 3: Implement sustainable reimbursement rates and processes.

Table 4. Respondents’ descriptions of needed processes and advocacy.

Implement sustainable reimbursement rates and processes.	
<i>Concerns</i>	<i>Needed Supports</i>
“reimbursement rate, if we will be paid right away-When OPTUM first took over agencies did not see payments for services rendered for months”	“Any major changes should be done gradually and with plenty of communication well in advance of changes. Concerned that billing will collapse if Magellan is as ill-prepared as Optum was in 2013.”
“That there will be a lapse in claims payment. I have been involved in the last three transitions and each time there was a lapse in timely payment. In the past our agency had savings to back us up but we do not currently have money to get us through this time.”	“Higher reimbursement, to incentivize more bringing more people into the field after the mass exodus during the pandemic. We are too short staffed and our ability to help all those that come to us is dwindling.”
“We fear that reimbursement rates will be scrutinized and minimized to save on cost, whereas it should go the opposite direction.”	“We hope the new organization will advocate and effectively be able to offer higher reimbursement for the services our communities need.”

Providers identified three types of actions to address fiscal concerns. These were:

- minimizing the delay in reimbursement;
- testing billing processes and systems before instituting changes;
- continuing to advocate for higher reimbursement rates for providers.

There was note of weariness among providers that with each systems change instituted by IDHW, substantial payment delays occurred. Providers observed that vendors have previously worked to cut reimbursement rates. This puts them in direct conflict with providers’ need to generate sustainable margins for their organization, and to attract new practitioners. They also noted two important changes in context, which may make this transition different from previous system transitions. First, organizations may not have sufficient reserves to whether delays in payment. Second, practitioner priorities appear to have changed since the pandemic, making it more difficult to attract and retain practitioners without strong incentives for joining the Network.

Focal Action Area 4: Provide uninterrupted service access.

Table 5. Respondents’ descriptions of actions needed to retain continuity of care.

Provide uninterrupted service access.	
<i>Concerns</i>	<i>Needed Supports</i>
“Transition period-adequate training / transparency of policies / how will the eligibility / billing transition be for clients.”	“All covered members automatically transferred or covered initially”
“Increase in crisis that are non bill (due to client losing insurance)”	“No disruption of services and fair reimbursement rates”
“I fear that Magellan will be like Optum and only care about cutting services so they can fulfill their Bonus requirements and will not be mindful to the needs of the community. Cutting off needed services for clients (CBRS), and/or being too restrictive in how the service can be provided.”	“....increase services, increased pay rate for services, less or no authorization for services for mental health services...”
“Changes to the service array what is staying and what is going..... increases/decreases to the number of units services are allotted to care for clients, what is going to require prior authorization and how much time/documentation/steps is there”	“IDHW being extremely clear with Magellan as to what you wish to do and what thresholds are appropriate for approval.”

Related to service access, providers identified two needs. One need was short term: to make sure that all members are covered throughout the transition period. The second was longer term: to make sure that access to services of the appropriate type and duration were not curtailed by the vendor. Providers described a series of previous instances in which the IBHP vendor curtailed a particular service or restricted the units of services which could be provided. Providing mechanisms for ensuring that youth are not dropped from coverage during the transition, and that services are authorized consistent with assessed need and providers’ professional judgment.

Summary

In last year's Report, we noted that "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."

IDHW took a substantial first step in addressing this by increasing provider reimbursement rates. In our survey, there was a corresponding double-digit increase in provider satisfaction with reimbursement rates. The largest rate increases, for Substance Use service providers, likely also helped drive double-digit increases in the availability of Drug and Alcohol Testing services.

Providers have indicated that a reimbursement rate increase is only one step in stabilizing and growing the Provider Network.

Respondents indicated continuing concerns regarding the new IBHP vendor's poor communication and lack of detail regarding credentialing, reimbursement processes, service authorization procedures, and client transition procedures. This Report finds that current IDHW efforts to make the Provider Network attractive to the provider community are not well communicated, clearly focused on high-impact actions, or publicly accountable. Across indicators, on average, only 25% of provider agencies indicated satisfaction with state supports; this drops to 20% with individual practitioners. For IDHW to operate as an effective, high performing system these satisfaction rates would need to increase by over 300%. The behavioral health industry is increasingly marked by competition for practitioners due to personnel shortages, increasing demand, and technological changes. To compete, IDHW needs to center its efforts on making the Provider Network an understandable, hassle-free, promptly and predictably reimbursing entity that results in appropriate, effective care for families and youth.

Efforts to grow a continuum of care appear inconsistent with the magnitude of the need.

This year's Provider Survey was designed to answer three related questions:

1. What change has there been in the provider network's capacity for intensive community-based treatment?
2. Do network providers perceive any change in the state-level barriers and supports that impact the expansion of intensive community-based treatment?
3. What efforts are the IDHW Division of Behavioral Health and Medicaid undertaking to grow the network of specialized community-based treatment providers?

In terms of capacity for intensive community-based treatment, we found that:

- a) The percentage of providers offering intensive community services plateaued this year after decreasing in the previous year;
- b) Despite recent rate increases for providers, there is not a corresponding increase in the desire to expand the breadth or intensity of services offered;
- c) Providers' lack of trust in IDHW continues to limit support for expanding the continuum of care.

Recommendations.

IDHW cannot grow the continuum of intensive supports needed for Idaho's children without significant investment by its provider network. Providers are unwilling to invest in expanding their services due to a lack of specific supports provided by IDHW. This problem may be amplified in the transition to a new IBHP vendor. We note that the survey results were obtained in September and October of 2023, and additional provider resources may have been made available in the interim.

Providers rightfully ascribe responsibility for the MCO's actions to IDHW. The lack of growth in the service continuum and the pervasive low trust of providers indicates that IDHW staff need to set and track specific goals for engaging and growing the provider network, particularly providers who can offer intensive community-based treatment.

We recommend four goal-directed actions for expanding the network of behavioral health treatment providers available to provide intensive community-based treatment for youth:

- (1) IDHW take ownership of provider engagement as a core responsibility of the Department, not the Managed Care Organization. This requires Leadership to set, track and act on numerical, quarterly targets for provider engagement;
- (2) Routinely (and no less than quarterly) use CANS outcome data and family and youth interviews to identify current gaps in effective treatment of specific psychiatric and functional needs;
- (3) Reduce the financial costs of training and upskilling current therapists by providing no-cost training, certification and fidelity management for community-based intensive treatments identified in (2) for youth via the Center of Excellence;
- (4) Align outcomes with incentives by pursuing the development of substantial value-based incentives for providers who implement effective intensive community-based treatments.

References

Page	
18	Magellan Healthcare (January, 2025). Idaho Behavioral Health Plan (IBHP) Provider Handbook Supplement Appendix C - Program Services. https://magellanofidaho.com/documents/2446693/3042016/ibhp_prov_handbook_appC.pdf/2046bdcf-dab9-fa0b-f5ff-4fb5371edbe5?t=1718993330450
18	Optum Idaho (January, 2023). Provider Manual.
21	State of Massachusetts, Children's Behavioral Health Initiative. (January, 2025). Massachusetts Behavioral Health Access. https://www.mabhaccess.com/Home.aspx
23	State of Massachusetts, Executive Office of Health and Human Services. (March, 2023). Behavioral Health Roadmap: System Changes Rolling Out in 2023. https://www.umassmed.edu/globalassets/systems-and-psychosocial-advances-research-center/2022/dmh-conference/2023-dhm-commish-roadmap-overview-and--update-april-2023.pdf
25	State of Hawai'i, Child and Adolescent Mental Health Division. (August, 2022). How to Apply. https://health.hawaii.gov/camhd/how-to-apply/
25	State of Hawai'i, Child and Adolescent Mental Health Division. (November, 2019). MAX Provider Portal. https://health.hawaii.gov/camhd/max-provider-portal/
26	State of Hawai'i, Child and Adolescent Mental Health Division. (December, 2024). CAMHD Performance Standards - Teal Book. https://health.hawaii.gov/camhd/performance-standards/
28	State of Washington, Health Care Authority. (November, 2023). Contact(s) for WISE referrals. https://www.hca.wa.gov/assets/free-or-low-cost/wise-ffs-referral-list-by-county.pdf
28	State of Washington, Health Care Authority. (February, 2024). Service Delivery, Policy, Procedure, and Resource Manual. https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf
29	State of Washington, Health Care Authority. (January, 2024). WISE Interest List Quality Improvement and Monitoring. https://www.hca.wa.gov/assets/program/wise-interest-list-monitoring.pdf
29	State of Washington, Health Care Authority. (April, 2024). WISE Dashboard. https://www.hca.wa.gov/assets/program/wise-dashboard-cy2024-q1.pdf
29	State of Washington, Health Care Authority. (November, 2024). WISE Quality Management Plan, CANS 5+ Quarterly Report for Quarter 3, 2024 Statewide WA Behavioral Health System. https://fortress.wa.gov/hca/wisebhasreports/Statewide_5Plus.html
31	Israel, N. (Fall, 2022). Quality Review of Youth Empowerment Services. https://yes.idaho.gov/wp-content/uploads/2023/01/QR-Report_Final-Report_2022v2.pdf

- 38 Williams, N., Beauchemin, J. & Vega, N. (July, 2024). Idaho Youth Empowerment Services (YES) Family Survey Results, 2024. <https://yes.idaho.gov/wp-content/uploads/2024/07/2024YESFamilySurveyResults.pdf>
- 38 United States District Court for the District of Idaho. (June, 2015). Jeff D Settlement Agreement, Joint Motion and Stipulation for Approval of Settlement Agreement and Proposed Orders.
- 46 State of Idaho, Idaho Department of Health and Welfare. (October, 2024). Youth Empowerment Services QMIA Quarterly Report Q4, SFY 2024. https://yes.idaho.gov/wp-content/uploads/2024/10/QMIA-Quarterly-YES-Report-Q4-2024_FINAL.pdf
- 46 Beauchemin, J. & Williams, N. (June, 2024). Biannual Estimate of Need for Intensive Care Coordination using Wraparound in Idaho, SFY 2024 (June 2024 report) <https://yes.idaho.gov/wp-content/uploads/2024/07/ICCAAnalysisProjectedNeedJune2024.pdf>
- 56 State of Idaho, Idaho Department of Health and Welfare. (October, 2024). Welcome to the Division of Behavioral Health Center of Excellence. <https://healthandwelfare.idaho.gov/coe>

Appendix A: Service List and Descriptions

Below are the service types, service type abbreviations, and service descriptions provided in the Provider Survey. Descriptions are lightly edited versions of the service descriptions provided in the Optum Idaho Provider Manual.

Table 2. Service Types and Descriptions

Service Type	Description
Individual Psychotherapy.	Youth can talk with a behavioral health care professional about emotional issues youth may be having and learn coping skills to help them manage them.
Family Psychotherapy.	Families can talk with a behavioral health care professional about emotional problems youth and their family may be having and learn coping skills to help youth and their family manage them.
Group Psychotherapy.	Youth meet with a group of people with similar emotional issues and a behavioral health care professional. Group members share experiences and practice coping skills to learn how to manage issues as independently as possible.
Pharmacologic Management (Medication Management).	A doctor or nurse meets with youth to discuss the medicines youth are taking and order new prescriptions youth might need.
Family Support.	Family support helps a youth's family learn to how to help manage their treatment. This service is provided by a parent who also has lived experience of caring for a child with behavioral health issues, and specific specialist training.
Youth Support.	Youth support helps youth learn how to manage their treatment, makes sure that youth know their rights, and helps youth speak for themselves. This service is provided by someone who also has lived experience of mental health issues as a child or youth, and specific specialist training to teach them how to work with youth. This can be done individually or in groups.
Respite.	Respite care is a short-term or temporary care so youth and their primary caregiver can have a break, and to give relief to the person who usually takes care of the youth.
Drug/Alcohol Testing.	A test to see if a youth has been using chemical substances or alcohol.

Table continues on next page.

Table 2. Service Types and Descriptions (cont.)

Service Type	Description
Intensive Outpatient Program (IOP).	This service gives youth outpatient therapy to help manage their behavioral health or substance use disorder needs and meet their treatment goals. Adolescents participate at least two hours per day, three times a week.
Skills Building / Community Based Rehabilitative Services.	Services are provided in a youth's home or community to help them gain skills for successful living, overall wellness, independent living.
Behavior Modification and Consultation.	The provider works with youth to develop strategies to improve skills for identified behavior; this support can be provided at any time and in any setting to meet the youth's needs.
Case Management.	A behavioral health care professional helps youth learn how to coordinate and access their medical, mental health, and community-living supports.
Targeted Care Coordination.	A trained individual helps youth access services and coordinate care between various providers and agencies. The Coordinator may: help navigate the system of care; run Child and Family Team (CFT) meetings; link the youth to services and supports; develop, implement, and monitor the youth's person-centered service plan; update the CANS assessment for the youth if requested by the treating clinician.
Therapeutic After School and Summer Programs (TASSP).	Qualified behavioral health professionals work with youth on behavioral goals in a recreational or after school setting.
Intensive Home and Community Based Services (IHBS).	Provided for children and youth who have severe needs. Intensive Home and Community Based Services include specialized treatments, and are used to increase stability and help prevent out of home placements.
Day Treatment.	This service provides therapeutic outpatient care for severe needs that require more than intensive or routine outpatient care. This service may include managing medication, skills building or group, individual, and family therapy. Youth are in therapy at least 3 to 5 hours per day, 4 to 5 days a week. Day Treatment providers coordinate and communicate with other agencies, including coordination with schools.

Table continues on next page.

Table 2. Service Types and Descriptions (cont.)

Service Type	Description
Crisis Intervention.	Crisis Intervention services allow youth to talk to a behavioral health professional in a face-to-face setting, and are available 24-hours a day, seven days a week.
Partial Hospitalization.	Partial Hospitalization is a structured program that you attend for 20 or more hours a week and you do not spend the night in the hospital. Services may include: individual, group and family psychotherapy, cognitive behavioral therapy, substance use monitoring, and more.

Appendix B: Full Methodology

Methodology

File Review Method and 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. This year's File Review was limited to the first 30 days of care post-assessment. This time frame was chosen so that we could understand how individuals were initially provided with appropriate care. Twenty-one file reviews were completed and included in this year's analyses.

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 while 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. For this year's QR, we used an abbreviated version of the module which captured the type of treatment provided, the number of treatment sessions, their frequency, and their duration.

Inter-rater reliability. 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 0.74 on the test vignette. With targeted feedback, their reliability increased to 0.82 on a second set of vignette materials. This is the second year in a row in which rater reliability has exceeded 0.80, indicating that the raters are highly reliable.

Caregiver and Youth 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. Nineteen caregivers completed interviews; eighteen had data allowing for inclusion in all analyses. Four youth had complete interviews.

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. Modules are completed in sequence, in the same order that these actions are likely to occur during a course of care.

The modules are: referral, initial assessment, diagnosis, goal setting and treatment planning, treatment selection, therapy / treatment process, care coordination, treatment review, crisis prevention and response, transition, and system policy and performance. We received interview data for eight clinicians.

Sampling for the File Review, Caregiver and Youth Interviews and Clinician Interviews.

Entering the Quality Review, our goal was to sample eight youth each from four types of agencies: urban agencies with high effectiveness, urban agencies with low effectiveness, rural agencies with high effectiveness and rural agencies with low effectiveness.

Our assumption is that differences in clinical outcomes in these organizations stem from differences in clinical practices. We compared agencies' Initial and 120-Day Child and Adolescent Needs and Strengths (CANS) scores on four domains: Strengths, Life Functioning, Risk Behaviors, Behavioral and Emotional Needs. Following the recommendation of Lyons, 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 agencies. We then identified organizations with at least a 0.5 Standard Deviation (SD) difference in initial treatment outcomes. Again this year we observed that there is an S-curve of effectiveness among Idaho's providers.

Based on these data, we identified eight candidate provider agencies. We completed 21 interviews with caregivers across six of these agencies. Eighteen of these interviews are represented in the analyses herein (see the section on 'Challenges' for why three are not represented). Five individuals were served by high-performing rural clinics. Three individuals were served by less effective rural clinics. Five individuals were served by high-performing urban clinics. Five individuals were served by less effective urban clinics. Our interview acceptance rate was approximately 30%.

We note that this recruitment effort oversamples individuals in higher performing agencies. We also did not reach out to individuals who were referred to an agency, but did not have a subsequent completed CANS assessment. In this way the results of this QR are biased towards individuals who persist in seeking services, as well as individuals who receive effective treatment.

Provider Survey Method and Measures.

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. For the past two Quality Reviews, we have 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 continuum of care available to YES members.

A second section of the survey focused on the drivers of care expansion (or contraction). We used six items regarding supports for service implementation generated by providers in previous QRs. We again asked providers to rate the importance of those supports, and how well the IDHW provides those supports. This year's provider survey also asked two open-ended questions about concerns and desired supports related to the transition in IBHP vendor.

Sampling for the Provider Survey.

An invitation email with a survey description and link was provided to all individual practitioners, and all agency representatives in Optum Idaho's statewide behavioral health provider network. The provider list was obtained from Optum Idaho. We removed exact duplicate email addresses, email addresses to multiple individuals in the same agency at the same physical address, and email addresses that were not associated with an identified individual.

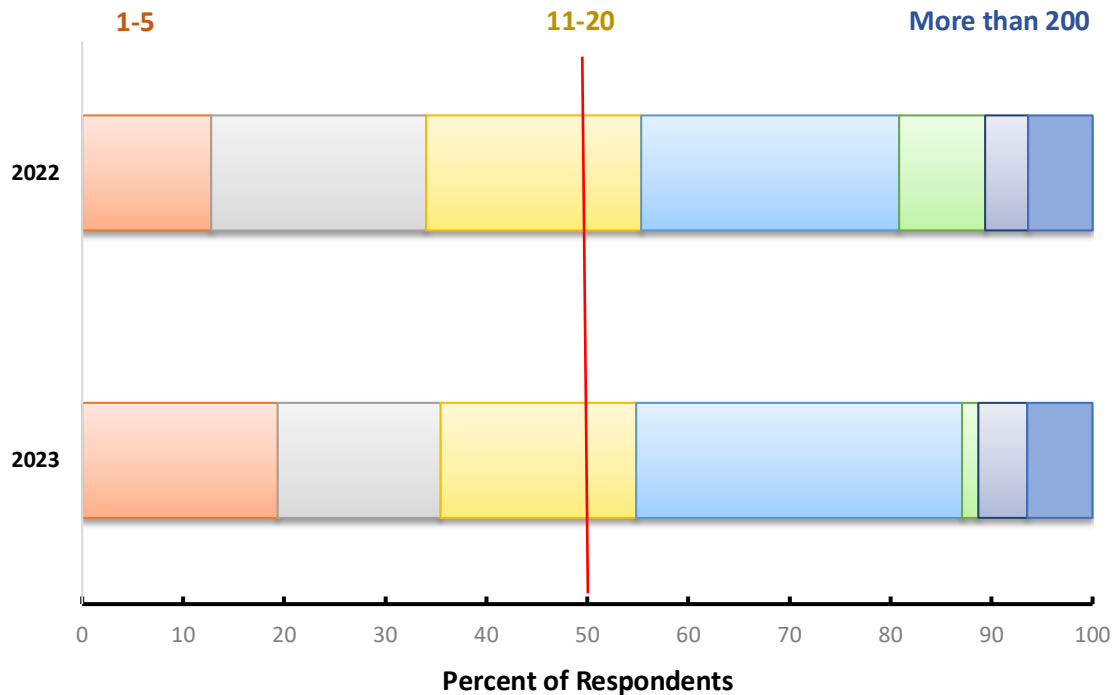
We sampled all resulting individual practitioners. In order to reduce the burden on agencies, we sampled one agency representative per location (address) in a given region. We retained 841 unduplicated agency contacts or individual practitioners. This included retention of 44 Telehealth/Virtual Visit-Only Providers. Each were contacted by e-mail for participation in the survey.

Of the 841 respondents contacted, 160 (19%) did not open the survey. Ninety-eight (12%) of the e-mails bounced back, indicating an invalid or inactive e-mail address. Eleven persons opted out (1%). The remaining 572 (68%) opened the survey. Two-hundred and fifty-nine (31%) of these respondents clicked through the survey. Two hundred and thirteen respondents provided partial (40; 19%) or complete (173; 81%) responses. Fifty-two of these individuals indicated that they did not provide behavioral health services to youth in the previous year and were excluded from further survey analysis.

Survey invitations were first sent out on September 15th, 2023. Automated reminders were sent out weekly to persons who had not opened or had not completed the survey. The survey was closed three weeks later, on October 6th, 2023.

More providers were invited to participate in the survey in 2023 (841 providers) compared to 2022 (547 providers). Provider response rates were similar across both years. In 2023, 25% (213 respondents out of 841 total invitations sent) either completely or partially responded to the survey, compared to 29% (158 respondents out of 547 total invitations sent) in 2022.

Chart 9. Agency Size by Survey Year



The size of the respondents’ provider agency was largely consistent between 2022 and 2023 (Chart 9). The median agency size in both years was between 11 and 20 employees. In both years only 11 percent of responding agencies had more than 100 employees.

Challenges.

Sampling Period. By the end of the QR data collection process only one IDHW staff member was engaged in data collection. This drop in resources created a serious bottleneck and lag in completing this year’s QR. The length of time between service receipt / provision and interview can make it more difficult to recruit individuals for interviews and exacerbate biases in recall.

Sampling. Two caregiver interviews and up to thirteen clinician interviews were conducted but not included as a result of data loss. The contractor (Union Point Group) was informed by IDHW staff that the IDHW IT department had summarily deleted the secure storage in which these interviews were maintained. IT personnel were only able to recover the interviews represented here. Because of this, the analyses here likely do not represent the full range of clinician practices currently employed by Idaho behavioral health professionals when accepting a referral and initially connecting youth to appropriate care.

Process Fidelity. During the QR process, IDHW transitioned their existing contracting IT system to a new system. Contract invoices were unable to be processed and paid, resulting in the suspension of contract work. During this time, IDHW Quality Management Improvement and Accountability staff continued to conduct clinician interviews. The contractor did not monitor these interviews. This may have resulted in non-standard administration of the interviews.

Future QRs would greatly benefit from an allocation of resources appropriate to this task.

End of Document.

This page intentionally left blank.