

## **Alaska's Partnership to Improve Outcomes for Adolescents and Families**

### **Abstract**

**Project Name: Alaska's Partnership to Improve Outcomes for Adolescents and Families**

Alaska's "Partnership" project will expand use of two evidence-supported practices: Parenting with Love and Limits® (PLL)<sup>1</sup> and the Transition to Independence Process (TIP)<sup>2</sup>, and will refine the practices for village settings and Alaska native populations to address disparities. The project will deliver high quality treatment, family therapy and in-home services to adolescents and their families and engage youth of transition age in treatment and support services.

The priority population will be adolescents and transition age youth aged 12 to 24 who experience substance abuse and serious emotional and behavioral disorders and their families. In addition, the project will target rural and Alaska Native youth and youth who are at risk of moving into treatment that is more restrictive and/or out of their homes and communities due to complex and co-occurring diagnoses and behaviors.

The Alaska Department of Health and Social Services (DHSS) has contracts with Dr. Scott Sells (PLL) and with STARS Behavioral Health (TIP) and has established grants funded pilot projects in TIP and PLL. The "Partnership" project will assist the DHSS to leverage these on-going pilot projects and reach the critical mass to develop a system that can support long-term sustainability. This project will create an urban training hub to implement the services and to deliver and coordinate training using telemedicine and distance technologies. It will also support a rural provider to establish a village hub with scattered remote sites to deliver services. In the last year of the project, we anticipate adding additional sites, as the original sites should no longer need on-going training. We estimate that the "Partnership" project will result in best-practice services for a total of 1,328 youth. We anticipate serving the following number of youth in Years 1-4 of the project: Year 1 (174); Year 2 (292); Year 3 (344); and Year 4 (518). We estimate an approximate cost of \$2,861 per youth.

Measurable objectives for the project include 1) implementing PLL and TIP to fidelity in two sites, 2) demonstrating improvement on PLL and TIP outcome measures including: abstinence from substance use, improved mental health, decreased involvement with juvenile justice or running from home, increased educational and vocational attainment, and expanded social supports. Family outcomes include addressing parenting skill deficits, creating a sense of community and lowering parental resistance to using outside expertise and services. 3) In addition, the project will increase delivery of behavioral health services to Alaska Native youth and families to reduce disparities and 4) keep youth in their homes and communities and decrease movement into residential settings, out of community and out-of-state.

**State of Alaska’s Partnership to Improve Outcomes for Adolescents and Families  
Substance Abuse and Mental Health Services Administration: FY 13 Cooperative  
Agreement for State Adolescent and Transitional Aged Youth Treatment  
Enhancement and Dissemination**

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## Alaska's Partnership to Improve Outcomes for Adolescents and Families

### Section A: Population of Focus and Statement of Need (15 points)

#### *Comprehensive Demographic Profile:*

The target population for the Partnership Project is adolescents 12 – 18 *and* transitional age youth and young adults 18 – 24 who experience substance abuse disorders or co-occurring substance abuse and mental health disorders, and their families. We anticipate that 33% of the youth served will be Alaska Natives and that 58% will be male and 42% female. Additional information about the demographics for youth to be served is outlined below.

We will focus on two areas of the State: the Anchorage/Matsu area, and a rural tribal area. The Anchorage/Matsu area contains the majority of Alaskans with 46.3 percent of the population<sup>3</sup> and 46.2 percent of the non-White children in the State.<sup>4</sup> There are significant differences between Matsu and Anchorage demographics.

The Anchorage area has a total population of 298,610 with a relatively diverse population of youth: 53,246 White youth (0 - 19), 10,223 American Indian/Alaska Native youth, 12,067 youth of Asian/Native Hawaiian/Pacific Islander descent and 8,673 Black/African American youth.<sup>5</sup> Females make up 49.3 percent of the Anchorage population and children under 18 make up 29.7 percent.<sup>6</sup> 16.8 percent of the children over five speak a language other than English at home. 7.8 percent of the families are below the poverty level (2007 – 2011 data) and the unemployment rate is 4.9 percent.<sup>7</sup> The 12-month per capital money income for 2011 was \$35,580 and the homeownership rate was 61.4 percent.

The Matsu area has a total population of 93,925. It is less diverse, with 24,202 White youth (0 – 19), 2,734 American Indian/Alaska Native youth, 564 youth of Asian/Native Hawaiian/Pacific Islander descent and 654 Black/African American youth.<sup>8</sup> Females make up 48.4 percent of the population and children under 18 make up 26.1 percent. Just 6.8 percent of the children over five speak a language other than English at home. 9.7 percent of the families are below the poverty level (2007 – 2011 data) and the unemployment rate is 7.8 percent.<sup>9</sup> The 12-month per capita money income for 2011 was \$29,292 and the homeownership rate was 78.7 percent.

Demographics in much of rural Alaska are markedly different. For example, Alaska Natives/American Indians make up 14.9 percent of the Alaskan population, but are the majority in many rural communities (examples: 90.3 percent in the Wade Hampton Census area, 80.1 percent in the Northwest Arctic Borough and 74.6 percent in the Nome Census area). Children under 18 make up a significantly larger percentage of the population (40.9 percent in Wade Hampton, 35.1 percent in Northwest Arctic, 34.1 percent in Nome). And, not surprisingly, more children over five speak a language other than English (36 percent in Northwest Arctic, 47.6 in Aleutians West, 57.3 percent in Wade Hampton).<sup>10</sup>

Rural Alaska also has more families living in poverty (30 percent in Wade Hampton, 25 percent in Nome, 19.6 percent in Northwest Arctic) and a higher unemployment rate (10.7 in Nome, 14.5 in Northwest Arctic, 22.1 Wade Hampton). In addition, the 12-month per capita money income is lower (\$21, 751 for Northwest Arctic, \$20,325 for Nome, \$11,476 for Wade Hampton) and the homeownership rate is lower (38.3 percent in Aleutians West, 54.5 percent for Northwest Arctic, 52.9 percent for Nome, 67 percent for Wade Hampton).<sup>11</sup>

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### *Stakeholders & Resources for Project Areas/State*

The Alaska Department of Health and Social Services (DHSS) is in the ending stages of a successful collaboration with Alaskan stakeholders (Bring the Kids Home), and has received assurance from stakeholders that they will collaborate with DHSS on the Partnership Project.

Bring the Kids Home (BTKH) is an initiative of the Department of Health and Social Services, the Alaska Mental Health Trust Authority and stakeholders to reduce placement of children in out-of-state residential psychiatric treatment centers (RPTC). Between SFY 2004 and SFY 2012, BTKH achieved an 80.9 percent decrease in out-of-state RPTC admissions and a 41.4% decrease in overall (in-state + out-of-state) RPTC admissions. In addition, RPTC recidivism dropped from 20 percent to 5 percent.<sup>12</sup> BTKH resources have allowed DHSS to pilot best practices, expand capacity, and to make policy, practice and regulation changes to support a strong network of community-based approaches to serving this population.

DHSS has not yet identified providers for the Partnership Project. However, **one grantee will be in the Anchorage or Matsu area.** This area has approximately 46.3 percent of the Alaskan population. Rural children and families often move into this area to access intensive behavioral health services. The Anchorage/Matsu area provides the largest number of possible applicants, and the largest pool of available staff which will improve long-term sustainability of PLL and TIP and make it easier to disseminate the practices statewide. While the Anchorage/Matsu area has a broader range of services, it also has the most concentrated population of children in need of intensive services. Multiple behavioral health treatment providers serve adults, children, youth, and families and residential and outpatient substance abuse and mental health services are available through Medicaid, grants and private pay or insurance. State-funded programs receive a grant and are able to access Medicaid for eligible clients. Southcentral Foundation (SCF) is the tribal health provider for the area and provides medical and behavioral health to tribal beneficiaries using Indian Health Services funds, Medicaid and grant funding. State-funded programs provide integrated substance abuse and mental health services.

In addition, Anchorage has a case management project to facilitate "speedy access" to substance abuse treatment for parents of children involved with the State's child protective services agency, the Office of Children's Services (OCS), either that are in OCS custody and/or as a condition of retaining custody. The Family Care Court is a therapeutic court that handles Child in Need of Aid cases and provides treatment and referrals for parents referred by protective services. In addition, the Wellness Court for felony offenders and the Mental Health court for misdemeanants, addresses offenders who need substance abuse and mental health referrals. A pilot project in Matsu provides care management for children in residential psychiatric treatment centers (and their families) to prevent the need for residential placement.

The Anchorage/Matsu area has many social service providers, including Covenant House, outreach services, soup kitchens, and faith based organizations. Family and youth organizations include a Statewide Family Network and a "Youth Move" chapter. Statewide parent resource and referral is available through the Alaska Youth and Family Network, the Stone Soup Group, the Alaska Parent Information and Resource Center, and other programs. The Anchorage and Matsu school districts are working to expand school behavioral health services: Anchorage is focusing on fetal alcohol spectrum disorders and Matsu is implementing Positive Behavioral Interventions and Supports. Two State grantees in the Matsu/Anchorage area are implementing Parenting with Love and Limits (PLL), an evidence-based family treatment and two are implementing the Transition to Independence Process (TIP): however, few providers are trained in TIP or PLL.

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### The second grantee will be in a rural/tribal population hub and the surrounding villages.

Resources in rural Alaska are often quite limited: tribal health corporations are the major providers of health and behavioral health services and few other services may be available. Indian Health Services, Medicaid and grant resources fund behavioral health services; however, many tribes have difficulty maximizing use of Medicaid to cover health and behavioral health services. Tribal Councils have a key role in rural Alaska and may be involved with housing, education, transit, senior services and other social service activities. Schools districts take on a strong role as well, providing assessment, screening, and recreational and social opportunities. DHSS is currently implementing PLL and TIP on Kodiak Island and the surrounding villages and this project will offer an initial model for the Partnership Project. A PLL clinician in a rural hub community provides clinical services in-person and via video-conferencing in conjunction with four behavioral health aides working in six villages.

### Population of focus, subpopulations and disparities in service use

The geographic catchment area for the Department of Health and Social Services (DHSS) is the entire State of Alaska. Alaska is approximately 1/5 the land mass of the lower 48, and largely inaccessible by road. There are 229 Alaska Native tribes and significant populations of minority groups. The Partnership project will make PLL and TIP available to a significant percentage (close to 50 percent) of Alaskan children and youth by targeting the major population hub, and will address disparities by targeting a rural area with many Alaska Native children and families. A state-funded survey determined that "Alaska has one of the highest per capital alcohol consumption rates in the nation and the prevalence of alcohol dependence and alcohol abuse, at 14% is twice the national average of 7%"<sup>13</sup> Alaska Natives have a higher suicide rate than other races and the overall Alaska rate is higher than the rate for the US. (See chart #1 from the Alaska Statewide Suicide Prevention Council).<sup>14</sup> In addition, Alaska Native suicide decedents are younger: 2/3 of Alaska Natives were younger than 29 but just 1/3 of non-Natives were. Suicide rates for Alaska Natives in non-hub communities were higher than for those in hub communities (60 versus 25.3 per 100,000 persons). A large proportion of both Alaska Native and non-Native suicide decedents were positive for alcohol (54% and 47%). In addition, 42% of the decedents were experiencing a depressed mood near the time of their death.<sup>15</sup>

Chart: #1



Alaska also has disparities in the number of minorities in service systems. Alaska Kids Count found that minority groups make up about 36.4 percent of Alaskan children<sup>16</sup> but about 49 percent of children admitted to residential psychiatric treatment centers represented a minority

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group.<sup>17</sup> Alaska Native/American Indian children make up roughly 22.4 percent of the total population of youth,<sup>18</sup> but were a disproportionate 37.8 percent of the youth in the RPTC sample.<sup>19</sup> The Alaska Division of Behavioral Health (DBH) found that 39 percent of the children *discharged* from in-state Residential Psychiatric Treatment Centers (RPTC) and 32 percent of the children in out-of-state RPTC were Alaska Native.<sup>20</sup> Alaska Native children in Anchorage are 14-times more likely to be involved with child protection<sup>21</sup> and the Alaska Office of Children's Services (OCS) estimates that statewide, 60 percent of the children in custody are Alaska Native. Thirty three percent of the youth referrals to the Alaska Division of Juvenile Justice (DJJ) are for Alaska Native youth.<sup>22</sup> A high percentage of children and youth placed in out-of-state residential psychiatric treatment centers also experience an intellectual disability, fetal alcohol spectrum disorder or autism spectrum disorder.<sup>23</sup> While we suspect disparities based on other factors such as sexual identity, we do not have data on those issues.

There is an acknowledged disparity for individuals with behavioral health challenges around increased risk of smoking. To address this, DBH is modifying the "Client Status Review" (CSR) tool to gather data around smoking behavior and allow intervention as appropriate.

### *Nature of the Problem including Service Gaps and Need.*

Bring the Kids Home (BTKH) stakeholders began voicing concerns about service gaps for transition-age youth starting around 2004. Covenant House reported a high number of youth in their Anchorage shelter had a history of residential mental health treatment, juvenile justice or protective services interventions. BTKH data found that 74.5 percent of the children admitted to residential psychiatric treatment were aged 14 to 20<sup>24</sup> and there were concerns about homelessness and service access. Homelessness has been an increasing concern in communities including Anchorage, Matsu, Fairbanks, Juneau, Sitka and Bethel. These youth and young adults often have fewer family and natural supports and are less likely to access behavioral health services. Eligibility for services is often lost as youth move into adulthood and diagnoses no longer qualify. These concerns resulted in implementation of TIP and development of transitional living programs. However, funding and resource issues have limited development of competence and sustainability for these practices - there are limited state and federal funds to support services for transitional-age youth.

DBH tables (Chart #2) show prevalence estimates for youth with serious emotional disturbances and substance use disorders. The over-representation of Alaska Native youth in service systems suggests that these estimates may be low for rural areas. The Penetration Rate for community-based behavioral health services for youth in Alaska is 52.6 percent (Chart #3).<sup>25</sup> The rate for rural areas may be lower due to the transportation challenges, workforce issues, and cultural and stigma issues of working in areas off of the road system.

Chart: #2

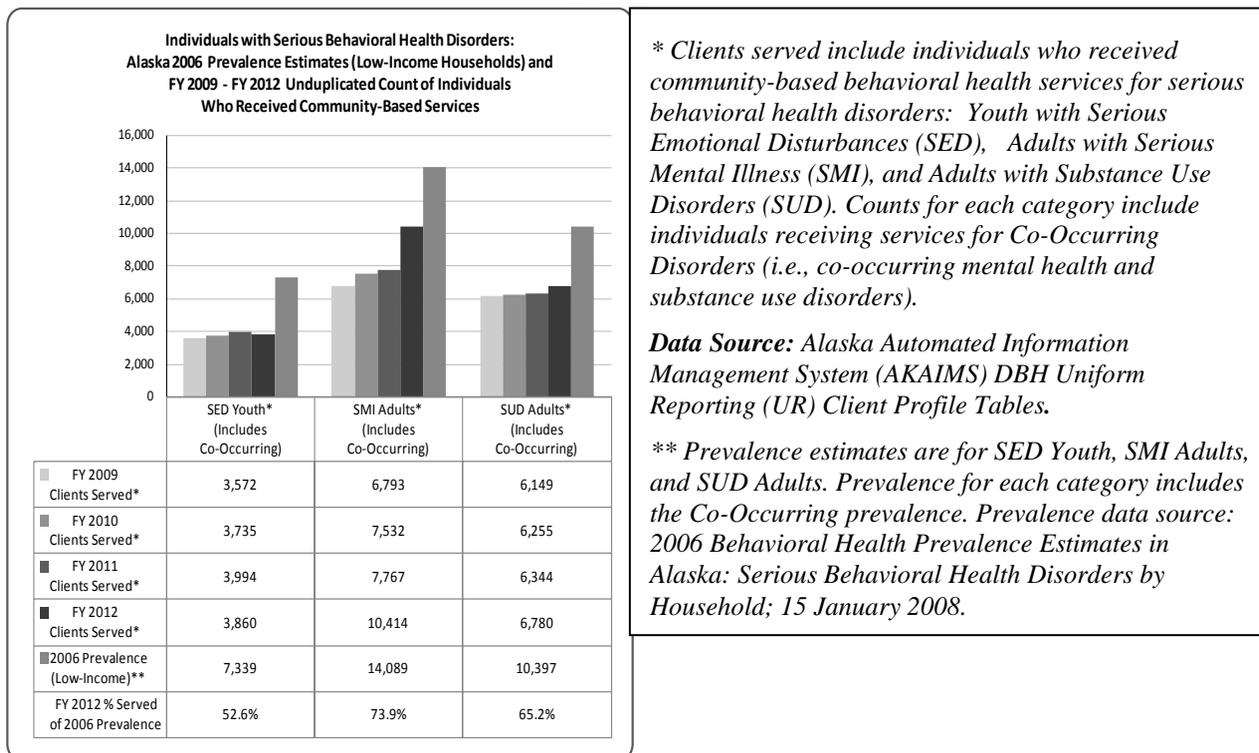
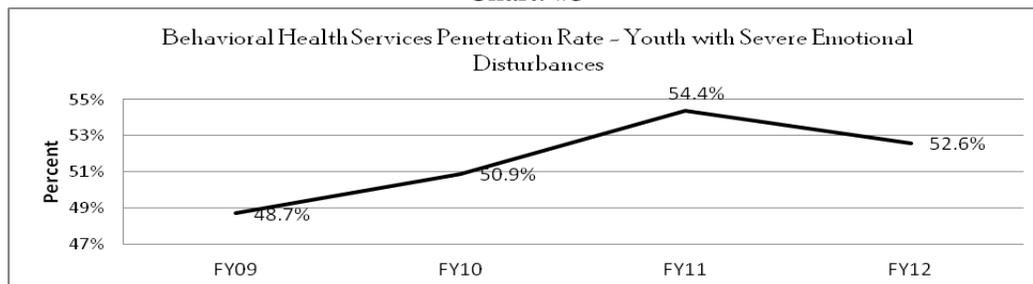


Chart: #3



**Need for Enhanced Infrastructure:**

The State of Alaska has an integrated substance abuse and mental health treatment system; however, many community behavioral health centers cannot provide evidence-based or supported substance abuse or mental health treatment services. Even in urban areas of the state, there are well-documented workforce shortages,<sup>26</sup> including a lack of master's level mental health clinicians. In addition, few master's level clinicians are trained in family therapy and in-home services and as a result, these services are under-delivered, even to children and families with very high needs. These issues are exacerbated in rural areas where there is extremely high turnover, limited housing and all food, heating oil and other necessary items must be brought in by air, or by boat. DHSS has worked to expand services to our population, but significant service gaps remain, as illustrated by data about service utilization and the Alaskan population.

Chart #4 shows utilization of mental health services by youth with serious emotional disturbances (SED) and "general mental health" service utilization. The decrease in youth with SED who accessed mental health services between FY11 and FY 12 does not meet the threshold of statistical significance. Chart #5 shows decreased utilization of substance use disorder (SUD) services for youth.<sup>27</sup> This may reflect reduced service capacity, decreased need, or another factor.

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The Alaska Youth Risk Behavior Survey shows that fewer youth are using tobacco, alcohol and drugs.<sup>28</sup> However, BTKH data shows high risk factors related to substance abuse for children admitted to RPTC. A 2011 report found that 77 percent of RPTC admissions had a family history of substance abuse and 34 percent reported a co-morbidity of substance abuse.<sup>29</sup>

Chart: #4

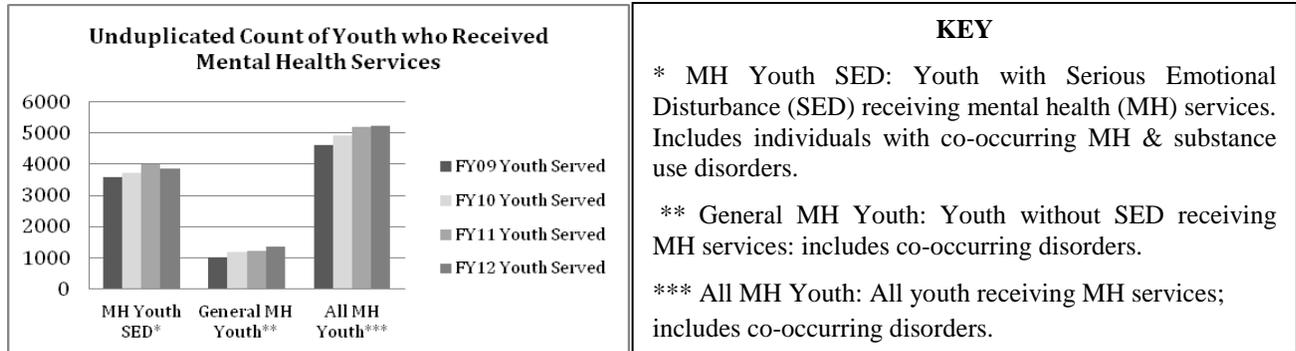
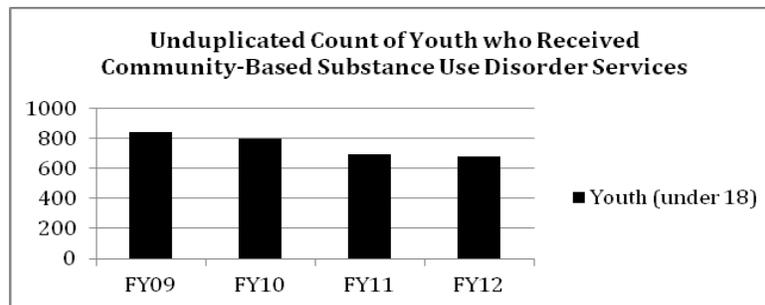
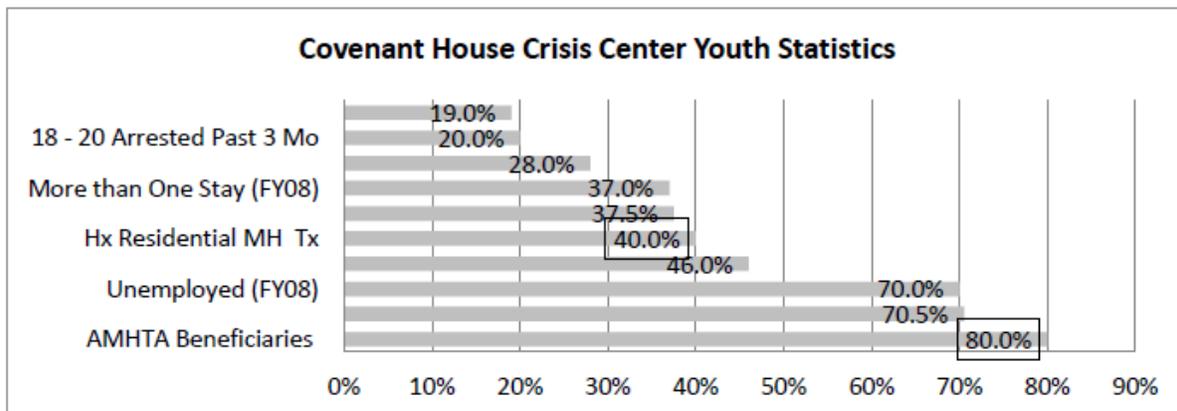


Chart: #5



Many at-risk youth in Alaska experience homelessness, on-going mental health and substance abuse problems, juvenile justice intervention, unplanned pregnancy, unemployment, and poverty. Covenant House data illustrates these issues in Anchorage. Crisis Center use has increased with more youth from off the road system: from five to 127 between 1999 and 2007. There have also been more Alaska Native youth: from 20 percent to nearly 40 percent between 1999 and 2008. Youth at the Crisis Center experience a number of challenges, see Chart #6.<sup>30</sup>

Chart: #6



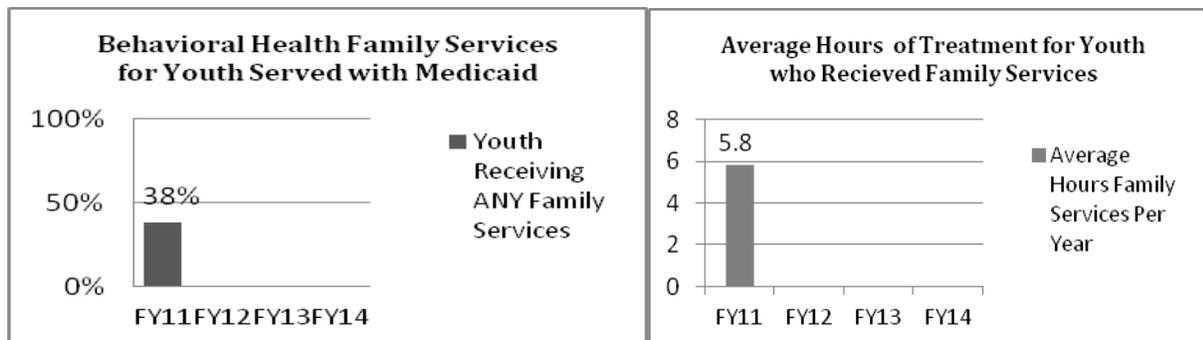
\*AMHTA (Alaska Mental Health Trust Authority) Beneficiaries = Individuals who experience mental illness, developmental disabilities, chronic alcoholism and other substance related disorders, or Alzheimer's disease and related dementia.

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In Chart #7, BTKH data shows many family problems for Alaskan children admitted to residential psychiatric treatment centers (56 percent reported neglect, 48 percent physical abuse, 40 percent domestic violence, 37 percent sexual abuse, 24 percent were adopted, and 77 percent reported a family history of substance abuse and 69 percent of mental health illnesses).<sup>31</sup> However, only 38 percent of the children who received Medicaid behavioral health services were provided with family services, and they only received an average of 5.8 hours per year.<sup>32</sup>

Chart: #7

Chart: #8



Kids Count<sup>33</sup> found significant risk factors for Alaskan youth: the confirmed victims of maltreatment for Alaska are 15 per 1,000 as compared to nine for the US. The Youth Risk Behavior Survey (YRBS) found that 12 percent of youth in Alaska “Were ever hit slapped or physically hurt on purpose by boyfriend or girlfriend last 12 months” as compared to 9.4 percent for the US. YRBS data found that youth in Alaska were more likely to have been physically forced to have sexual intercourse (AK = 9.2 percent vs. US 8 percent)<sup>34</sup> and the rate of youth residing in juvenile detention and correctional facilities for Alaska was 342 as compared to 225 nationally. The Matsu juvenile delinquency referral rate for drug and alcohol laws (age 10 – 17, 5 year average percent 2006 – 2010) was 14.4 percent as compared to 6.8 percent in Anchorage and 6.7 percent in the Southwest region. Juvenile (10 – 17) delinquency referrals for crimes against persons were 28.1 for the Southwest region and 17.2 percent for Anchorage and just 16.5 percent for Matsu.<sup>35</sup>

Housing issues are illustrated by the percent of youth who live in “crowded housing”: this is 14 percent nationally and 27 percent for Alaska. Teen birth rates also indicate issues in specific areas of the State: the teen birth rate in the Southwest region is 60 as compared to 11 in Anchorage. (Youth 15 – 19, per 1,000 females - 5 yr average rate).<sup>36</sup>

The death rate for Alaskan teens is 82 per 100,000 as compared to 49 for the United States. For American Indian teens in Alaska, this rate increases to 207. The rate of teen deaths by accident, homicide and suicide, (per 100,000) was 71 for Alaska as compared to 36 nationally.<sup>37</sup> The YRBS attempted suicide rate for Alaska was 8.7 percent vs. US - 7.8 percent (grades 9 – 12, 1 or more times past 12 months)<sup>38</sup> The violent death rate for teens from the Southwest region was even higher - 163 as compared to 38 for Anchorage. (Youth 15 – 19, per 100,000 – 5 year average 2005 – 2009). The teen suicide rate for the Southwest region was 60 as compared to 11 for Anchorage. (Youth 15 – 19, per 100,000 - 5 yr average rate 2005 – 2009).<sup>39</sup>

Healthy Alaskans 2020 scored the level of concern on social issues from “1” (“not at all concerned”) to 5 (“extremely concerned”). There was an average score 4+ for “alcohol use” in Anchorage, Matsu and the Southwest, and of 3.8 for “other substance abuse” in Anchorage/Matsu and 4.0 for the Southwest. Violence concerns were 3.9 for the Southwest and 4.0 for the Anchorage/Matsu area.<sup>40</sup>

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### Section B: Proposed Evidence-Based Service/Practice (25 points)

DBH is supporting PLL pilot projects to develop brief strategic home-based services in order to divert children with severe emotional and behavioral disorders from entering residential psychiatric treatment centers (RPTC) or to help them return from residential settings to their families or communities. In addition, DBH is supporting TIP pilot projects to improve engagement and outcomes for transition-age youth and young adults. This project will expand these efforts to new communities, refine the models for rural settings, and develop a training hub.

#### *Target Populations:*

The target population for PLL is families with youth (10 - 18) with a serious emotional disturbance who, 1) demonstrate aggressive behaviors as a primary risk factor, 2) have a co-occurring substance use disorder as a primary risk factor, or 3) have a family that is involved with multiple systems (adult behavioral health or adult justice, child protective services, juvenile justice, adult public assistance, adult or child developmental disabilities). Youth must also be 1) at risk of placement in a residential psychiatric treatment center (RPTC) or 2) currently in RPTC or in-state residential treatment and require intensive family therapy to return home. If appropriate referrals cannot be identified, the grantee may work with DBH to identify other children and families for PLL services. The target population for TIP is youth and young adults (ages 14-29) with substance abuse, emotional, and behavioral disorders. For this project, TIP will target youth 14 to 24. Goals for the Partnership Project include:

I. Improve outcomes for adolescents by implementing Parenting with Love and Limits ® (PLL) <sup>41</sup>in two new communities. PLL is an evidence-based program combining a 6-week parent education and group therapy program with individual "coaching" (family therapy) sessions for adolescents and their parents. PLL is designed for youth with substance abuse, emotional or behavioral problems. Family outcomes include:

- Lower parental resistance to seeking and using outside expertise and services (PLL)
- Reduce isolation and create a sense of community (for parents and children) (PLL)
- Fill-in missing core parenting skill deficits (PLL)
- Parents to learn creative consequences to stop child's unwanted behavior. (PLL)
- Educate parents and children on Reactive Attachment Disorder. (PLL)
- Disseminate skills to deescalate arguments. (PLL)
- Enable parents and children to enter into contracts and opening up conflict free lines of communications within the family. (PLL)

II. Improve functional outcomes for transition age youth by implementing the Transition to Independence Process in two new communities. TIP is an evidence-supported system that prepares youth and young adults for adult roles through an individualized process, engaging them in futures planning, and providing developmentally appropriate services and supports. Published studies demonstrate improvements in real-life outcomes including decreased substance abuse and improvement on mental health goals, increased educational and vocational achievement, increased social support, stable housing and decreased involvement with juvenile and adult justice. Functional outcomes include:

- Staying at home (No running away) (PLL & TIP)
- Staying in school (No truancy or suspension) (PLL & TIP)
- No law violations for two consecutive months (PLL)
- No jail (TIP)
- No hospitalizations (TIP)

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- Made progress on last treatment review (TIP)
- Decreased substance use (TIP)
- Employment when appropriate (TIP)
- Housing plan when appropriate (TIP)

III. Develop and operationalize a standardized assessment tool to meet the application requirements, with the principal strategy of implementation that will involve

- Development of a standardized behavioral health assessment that includes a Level of Care /Acuity component, (for example, the "Child and Adolescent Service Intensity Instrument CASSI)
- Alignment into the existing clinical practice of Treatment Plan Reviews (every 4 months),
- Programming the standardized assessment and LOC instrument into the AKAIMS application for electronic data entry and reporting.

IV. Reduce out-of-home and out-of-community placements for rural and Alaska Native youth and families by developing PLL and TIP implementation models in rural Alaska,

V. Ensure the long-term sustainability of PLL and TIP by developing an urban training hub and in-state trainers.

The Partnership Project will accomplish these goals by:

- Implementing PLL and TIP in two communities.
- Develop an in-state training hub and training competency for PLL and TIP.
- Develop distance learning tools and strategies for PLL and TIP.
- Analyze the service areas and developing a plan to expand services to youth who are vulnerable to health disparities.
- Developing sustainability model for expansion to additional sites, including:
  - A process for obtaining community buy-in and support from diverse partners
  - A map of possible funding streams
  - A model memorandum of agreement for community partners
  - Development of in-state trainers
  - Strategies for training and maintaining staff able to implement PLL and TIP
- DBH will fund training contracts for PLL and TIP and will issue grants to two community partners to develop services. Community providers will be required to:
  - Identify a clinician to participate in PLL training. This requires a commitment to learn a specific family therapy model and a two-year time commitment.
  - Identify at least one paraprofessional level staff (urban site) and two to three paraprofessional level staff (rural site) for full participation in ongoing PLL training.
  - Identify a cohort of care managers/clinical staff for participation in TIP training.
  - TIP & PLL urban site - identify a potential trainer for PLL and for TIP.
  - Offer non-PLL clinicians the option to audit a PLL cohort to increase training and development for clinicians not enrolled in the PLL training program.
  - Offer TIP training additional staff and community stakeholders.
  - Develop an outreach plan to identify potential families in the target populations.
  - PLL: coordinate with DBH and community providers working with referred families.
  - PLL: provide Brief Strategic Home-Based Therapy and PLL Group Therapy for up to 32 identified families (per team) per year with children in the target population.
  - Develop a plan to stay in contact with families after graduation from the programs.
  - Demonstrate effective service models through tracking referral, utilization, demographic, and clinical information and by monitoring project outcomes.

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- Demonstrate how proposed activities will maximize funding streams and link youth to resources. Utilize Medicaid/insurance for billable activities.
- Demonstrate how proposed activities will maximize use of community resources by linking and connecting families with available resources.
- Provide a yearly sustainability analysis to assist in system development, including identifying the percentage of clients who are Medicaid eligible and the portion of grant activities that can be supported via Medicaid or insurance.
- Work with the practice developers to gather and report data specific to each practice.

### *Modifications to EBP to address Disparities*

The Partnership Project will work to address disparities in service access for rural and Alaska Native Youth. Youth and families living in rural Alaska have difficulty accessing substance abuse and mental health services due to geographic, weather and transportation issues and staffing shortages, and often receive only itinerant behavioral health services. The severe limitation on master's level providers also leaves many rural families without behavioral health care. When community-based behavioral health treatment is not available, problems escalate and children move into urban settings and higher levels of care. Few urban providers have many Alaska Native staff, creating a cultural barrier for Alaska Native youth.

DHSS selected PLL and TIP because they are appropriate for youth and families from different cultural, geographic, socio-economic or educational backgrounds and with different religious beliefs, sexual identities or disabilities, and because they can be adapted to work well in different settings. Both practice models use both masters' level clinicians and paraprofessional staff: The PLL team usually includes one master's level clinician and one case manager, however, on Kodiak Island; the PLL team includes one PLL clinician and four behavioral health aides to serve six villages. The PLL clinician uses telemedicine to reach the villages between site visits. TIP also trains masters' level and paraprofessional staff. In addition, TIP can be used with youth who experience a fetal alcohol spectrum disorder: at DHSS request, STARS Behavioral Health provided training for Alaska providers around use with this population. DHSS will continue work with STARS Behavioral Health to individualize Alaska implementation to meet the needs of our diverse population. The Partnership Project will nest PLL in a TIP framework to stabilize a broad group of adolescents and transition age youth with wraparound services and referral to evidence-based family therapy when appropriate.

Alaska has a well-developed telemedicine system and Alaska regulations allow payment for case management, peer support, family psychotherapy, and short-term crisis intervention telephonically and for any service that is:

- Covered under traditional, non-telemedicine methods
- Provided by a treating, consulting, presenting, or referring provider
- Appropriate for provision via telemedicine

when delivered via telemedicine. As noted above, DBH is using telemedicine to implement PLL: a clinician in an urban hub provides on-site and distance PLL services in conjunction with five PLL case managers in scattered sites. Through the Partnership Project, DHSS will build on telemedicine to provide training, technical assistance, program development and clinical consultation and to address disparities in access to treatment.

### *Coverage of Evidence Supported Practices by other Payers and Sustainability:*

When implementing new practices, DBH asks providers to analyze and report on barriers to sustainability. DBH then addresses these through regulation and rate adjustments to the extent possible. PLL and TIP services are billable through existing Medicaid codes as:

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- Group psychotherapy
- Family psychotherapy w/ patient
- Multiple family group psychotherapy
- Therapeutic behavioral services [Group]
- Therapeutic behavioral services [Family with patient present]
- Therapeutic behavioral services [Family without patient present]

However, Alaska's billing codes do not allow billing for multi-group family therapy without the client present, which is a required PLL service. DHSS is investigating options to address this by making adjustments to allow Medicaid billing or establish a flexible funding mechanism or a grant allocation for PLL providers. Flexible funding is available through "Individualized Service Agreements" (for necessary but otherwise unfunded services to keep children in the community).

Since 2010, DHSS has been supporting tribal providers to expand behavioral health services using Medicaid. This has increased tribal billing effectiveness, and will benefit providers who adopt the new practices. DHSS is also working with tribal providers and the federal government to implement a behavioral health aide (BHA) service delivery model that allows substance abuse and mental health services by staff with education ranging from high school to masters or PHD level professionals. The BHA model allows tribes to develop in-house and clinically competent expertise using an expanded workforce and in both health and community behavioral health settings. In addition, tribal providers connected to an Indian Health Services Physician Clinic now receive an encounter rate of \$541 per day for substance abuse and mental health services delivered to beneficiaries. This provides has improved the sustainability of tribal services.

### *Integrating Evidence Based Practices across the Continuum of Care:*

TIP and PLL are becoming part of the continuum of care in Alaska. Alaska has contracted with the practice developers to provide training and technical assistance to implement TIP and PLL through several providers who have received BTKH grants to implement PLL or TIP in outpatient and residential settings. Providers are using TIP and PLL for youth with a range of challenges including substance abuse, mental health and co-occurring developmental disabilities or fetal alcohol spectrum disorders. The providers are working with the practice developers to make innovations such as expanding TIP into school and residential settings and adapting the PLL team to include multiple behavioral health aides. Three individuals are working to become in-state TIP trainers and DHSS has proposed development of an in-state PLL trainer to Dr. Sells. In to gain maximum value and impact as much of the system as possible TIP training is kept open to community partners, including staff from peer navigation providers, social service agencies, State behavioral health, protective services & juvenile justice agencies, school districts and others. DHSS is working with providers to analyze revenues streams and billing related to PLL and TIP and to make policy changes and clarifications to increase sustainability. DHSS is working with our practice developers and sites to gather data and evaluate outcomes for both practices. However, despite this strong start, a great deal more work is required in order to expand these practices statewide and ensure their sustainability.

The new urban training hub will implement the new screening and assessment process, TIP and PLL and will deliver or coordinate training and technical assistance to support and expand these practices beyond the Anchorage & Matsu area. Telemedicine will support expansion to new sites as well. The urban hub may also assist with monitoring data and fidelity. This will allow Alaska to expand use of high-quality practices and to identify areas where they require modification to achieve good results with our target populations.

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The Division of Behavioral Health holds a twice-yearly *Change Agent* meeting, which offers a forum to share outcomes and provide training to all of the Divisions behavioral health grantees. DBH also supports periodic training conferences to introduce practices such as trauma informed care. We will use these opportunities to introduce PLL and TIP to a wider group of providers as one step towards statewide implementation. DBH has already begun a conversation with providers to expand family-therapy services and asked providers to develop logic models to track improvements in this area. DBH has also begun to implement methodologies for outcome-based funding. The Office of Children’s Service (OCS) is working with their Behavioral Rehabilitation Services residential (BRS) grantees to improve family services and engagement. This has included introduction of Building Bridges Initiative tools.<sup>42</sup> The Division of Juvenile Justice (DJJ) has been methodically expanding the number of behavioral health providers working in their facilities and working to develop better transitional and family treatment services. DJJ is an active referral source for PLL family therapy services. In addition, DHSS has allocated BTKH funding to the University of Alaska to support development of a curriculum and certification process to train master’s level clinicians in Marriage and Family Therapy. This will increase the available workforces to work with families. All of these system activities will help DHSS to promote use of best practices in Alaska and across the continuum of care.

### *Implementing the EBP:*

DHSS will issue two grants, one to a community behavioral health center in the Anchorage/Matsu area and one to a community behavioral health center in a rural tribal hub. The urban site will become a training hub and the rural site will assist in developing modifications to make the practices work in rural settings, with clients from diverse backgrounds and to ensure that they are effectively serving youth and young adults with substance use disorders.

	<b>Activity</b>	<b>Responsible Parties</b>
<b>Month 1 Post Award</b>	Develop training contracts for PLL & for TIP	DHSS
	Develop DHSS bio-psycho-social standardized assessment	DHSS
<b>Month 2</b>	Finalize training contracts	DHSS
	Complete draft standardized assessment	DHSS
	Draft multi-year workforce training plan (may impact this timeline)	DHSS/PAC
<b>Month 3</b>	Finalize multi-year workforce training plan - with EBP originators - outline path for certification as a service provider or a trainer	PAC & Contractors
	Prepare for/plan first face: face TIP training (in-state trainers participate)	PAC & Contractors
	Provide training and pilot standardized assessment process	DHSS
	Data WG meets to set up data collection protocols, EHR issues, etc	PAC & Data WG

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<b>Month 4</b>	Obtain feedback & modify standardized assessment process First on-site TIP training in-state trainers participate Verify data collection plan & capacity Set up schedule for TIP training collaborative calls & supervision	DHSS PAC & Contractors Data WG  Contractors
<b>Month 5</b>	Standardized assessment process implemented TIP service delivery begins Begin TIP training collaborative monthly calls First face: face PLL training at both sites PLL service delivery begins PLL teams begins bi-monthly PLL supervision	DHSS Providers Contractors PAC & Contractors Providers Contractors
<b>Month 6</b>	Convene data WG to review data collection and EHR issues Begin development of distance learning tools for PLL and TIP Continue PLL & TIP training - test competency & fidelity Rural site visit to villages outside of rural hubs for TIP training	Data WG PAC, Contractors, DHSS Contractors Contractors
<b>Month 7</b>	Consult model originators around any need for modifications to PLL or TIP Continue PLL & TIP training - test competency & fidelity	Providers/Contractors Contractors
<b>Month 8</b>	Continue weekly PLL & TIP distance training - test competency & fidelity Face: face PLL training	Contractors Contractors
<b>Month 9</b>	Continue to develop distance training tools Continue PLL & TIP training - test competency & fidelity	PAC, Contrt, DHSS Contractors
<b>Month 10</b>	Convene data WG to review data collection and EHR issues All State face: face TIP training Continue PLL & TIP training - test competency & fidelity	Data WG DHSS/Contractors Contractors
<b>Month 11</b>	Continue PLL & TIP training - test competency & fidelity Identify urban staff to prepare to become in-state PLL trainer	Contractors Providers/Contractors
<b>Month 12</b>	Face: face training for PLL in village site outside rural hub - work with tribal/rural providers on potential modifications Continue PLL & TIP training - test competency & fidelity TIP in-state trainers certified Data WG meets to review draft data to date	Contractors Contractors Contractors Data WG

By the end year one, DHSS plans to have at least three certified in-state trainers to provide TIP training and one person identified to work towards becoming an in-state PLL trainer (with agreement from Dr. Sells) We intend to link DHSS training resources (staff and contractors) to the training hub so that external training can be coordinated through the hub.

### *Monitoring Provision of the EBP:*

DHSS has an existing relationship with the TIP and PLL practice developers and an on-going contract for training, clinical supervision and data gathering. The PLL in-state grantees are implementing PLL to fidelity and a couple of the TIP sites are implementing to fidelity (some sites are developing "TIP informed" practices). All grantee sites (and any new sites through this grant) are required to gather the data required to monitor fidelity and outcomes. In addition, sites

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gather additional data for DBH. DBH routinely pulls data on Medicaid service delivery and costs to evaluate increases in service delivery, types of service and cost effectiveness. In addition, DBH pulls data from the Alaska Automated Information Management System (AKAIMS) to gather demographic and outcomes information for the individuals served.

### Section C: Proposed Implementation Approach (30 points)

#### *Achieving Meaningful and Relevant Results:*

As described above, Alaskan providers are not consistently delivering family therapy. Barriers to providing family therapy include the availability and training of master's level staff and behavioral health associates, geographic and cultural barriers, administrative, operational and funding issues. This project will seek to overcome these barriers and increase access to PLL family therapy in two regions while also improving services to transition age youth in general. This will accomplish meaningful results for youth and families:

- Improve the quality and quantity of family therapy in the communities served,
- Engage transition age youth and young adults in treatment and support services,
- Pair TIP and PLL to leverage implementation of both practices and improve outcomes,
- Establish a cost effective, culturally appropriate model to implement PLL in rural Alaska,
- Achieve functional improvements for target pop youth:
  - Progress on treatment goals (decreasing substance use and mental health issues)
  - Achieve employment, education, housing, goals, etc
  - Reduce juvenile and adult justice involvement and runs from treatment
- Engage youth, families and stakeholders to meet the needs of youth in their communities,
- Decrease movement of Alaska Native youth into urban residential settings,
- Decrease the movement of Alaskan youth into out-of-state residential settings,
- Evaluate program cost effectiveness and sustainability

#### *Project Goal and Proposed Activities:*

The primary goal of the Partnership Project is to improve outcomes for adolescents and their families by implementing evidence-based practices to improve child and family therapy and to improve engagement and implement best practices for youth of transition age who experience substance abuse and mental health services. To achieve these goals, DHSS will develop contracts with STARS Behavioral Health for Parenting with Love and Limits training and with Dr. Scott Sells for Parenting with Love and Limits training. DHSS will also develop a standardized comprehensive assessment protocol, develop, and provide training on it.

To implement the evidenced-based practices in the community settings, DHSS will solicit for one urban grantee to develop a training hub and one rural grantee to pilot implementation in village settings. These grantees will be experienced, credentialed providers of direct client substance abuse or co-occurring substance abuse and mental health services. They will be existing providers in the community/region, or they will provide a copy of a MOU with a local provider to collaborate to implement the project in that region. This project will have a heavy training and technical assistance agenda. DHSS will work with the Project Advisory Council (PAC) to develop a multi-year workforce training & implementation plan for each site and for the State. We will use the Partnership Project to establish the necessary tools to expand implementation of these best practices into additional communities across Alaska.

DHSS intends to sustain TIP and PLL services *primarily* through billing Medicaid, grant funds and private insurance or co-pay, with flexible funding for short-term costs not fundable through other sources. The PAC will oversee development of a cross-agency State/tribal financial map of

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resources. DHSS staff and the practice developers will provide documentation and billing training. STARS behavioral health is currently providing this training to Alaska grantees.

This project will decrease disparities in service access, use and outcomes among vulnerable populations: in this case, for Alaska Native youth and families. Each year, the PAC will oversee a health disparities impact Statement and develop a plan to address disparities. Our project has been designed to reach vulnerable populations in rural Alaska and youth in urban hubs who are at risk of placement outside the State for treatment or who are at risk of poor outcomes due to substance abuse or mental health disorders.

Another project goal is to coordinate resources and encourage collaboration in the regions served. The PAC will include family and youth advocates, providers, staff from the Division of Behavioral Health, Senior and Disability Services, Children’s Services, Juvenile Justice, Medicaid, potential funders, representatives of the 2 community sites, data team members, and others as appropriate. The PAC will establish indicator measures, make plans for project development and modification, monitor progress, and work with the sites to refine planning. The PAC will ensure that services are comprehensive and coordinated across systems (behavioral health, education, health, child welfare, juvenile justice and Medicaid) and that the project takes advantage of all possible funding strategies to enhance sustainability. The PAC will oversee the project, encourage development of local teams, and establish a social marketing site and materials to explain the project to youth and community members. Materials will be in Alaska Native languages appropriate for the region served, and in English. The PAC will work with community grantees to engage stakeholders in planning, implementing and evaluating the project. This project will link with the Alaska *Youth Move* chapter was formed in Alaska, and with other parent and youth advocacy groups.

### *Project Timeline:*

<b>YEAR ONE</b>	<b>Key activity</b>	<b>Milestone</b>	<b>Responsible staff</b>
Month 1	PLL & TIP contracts & ½ time position DHSS internal work plan & staffing Project Advisory Council (PAC) DHSS Community Provider solicitation Bio-psycho-social assessment	Develop contracts Plan finalized Members set RFP posted Draft underway	DHSS -Bishop & Grigg DHSS – Joint Management Team DHSS - Bishop/Grigg DHSS - Bishop/Grigg Haines-Simeon
Month 2	PAC meeting schedule Contracts for PLL & TIP training SharePoint site Assessment instrument Community Providers selected Multi-year workforce training plan EHR system certified OR acquisition plan submitted MOUs for each project	Schedule set up Contracts signed Site set up begins Draft done Grants awarded Draft developed Certified /submitted Drafts developed	PAC DHSS - Grigg DHSS - Bishop Haines-Simeon DBH/DHSS PAC/Com Providers Community Providers Community Providers
Month 3	DHSS contract ½ time position SharePoint site Project face: face PAC meeting: Data Work Group & Project Impl Team (PIT)	Contract signed Set up complete Held First mtg held	DHSS - Bishop/Grigg DHSS - Bishop DHSS Data WG & PIT

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	<p>Multi-yr workforce training plan                  Face: face training                  DHSS on-site visits                  Introduce project to staff/community                  Train - new assessment instrument                  Provider tasks: Recruit &amp; hire staff                      Education, outreach &amp; enrollment                      EHR acquisition plan                      Develop Comm stakeholder group                      Develop data collection plan                      Yr #1 implementation plan                      MOUs for each project</p>	<p>Plan finalized                  Schedule set up                  Completed                  Feedback/ input                  Trainee eval                  Staff hired                  Plan developed                  Draft developed                  Community input                  Plan drafted                  Plans drafted                  In place</p>	<p>PAC &amp; DHSS                  PAC &amp; contractors                  DHSS /Comm Prov                  DHSS/Comm Prov                  DHSS - Haines-Simeon                  Community Providers                  Community Providers                  Community Providers                  Community Providers                  Data Team                  PAC &amp; Providers                  Community Providers</p>
Month 4	<p>First on-site training - TIP                  TIP Training Collaborative schedule                  Project Advisory Council (PAC) meets                  Verify data collection plan &amp; capacity                  Assessment instrument                  PIT team: issues/challenges for PAC</p>	<p>Evals &amp; progress                  Schedule set up                  Mtg Notes                  Plan finalized                  Feedbk/modific.                  Schedule set up</p>	<p>Contractors                  Contractors/Provid.                  PAC                  Data work group                  DHSS - Haines-Simeon                  PIT team</p>
Month 5	<p>PAC meets                  Health disparities impact Statement                  TIP service delivery                  Face: face PLL training at both sites                  Bi-Monthly PLL supervision schedule                  PLL service delivery                  Monthly TIP training collaborative                  Distance learning tools for PLL &amp; TIP                  Assessment instrument                  Data WG meets as needed                  PIT team meets as needed</p>	<p>Mtg Notes                  Draft started                  Services begin                  Evals &amp; progress                  Schedule set up                  Services begin                  Meeting schedule                  Work products                  Finalized                  Notes                  Notes</p>	<p>PAC                  PAC                  Comm Providers                  DHSS/Contractor/ Hub                  Contractors/Provid.                  Community Providers                  Contractors/Provid.                  Contractor/Urban Hub                  DHSS - Haines-Simeon                  Data WG                  PIT team</p>
Month 6	<p>PAC meets                  Community stakeholder groups meet                  Health disparities impact Statement                  Health disparities plan                  Data WG to evaluate data collection, EHR issues, etc                  PIT team meets as needed                  PLL &amp; TIP distance training continues                  TIP training - outlying rural villages                  Rural on-site TA to review documentation and billing</p>	<p>Mtg Notes                  Comm input                  Completed                  Draft started                  Notes                  Notes                  Meeting schedule                  Evals &amp; progress                  Revised plan</p>	<p>PAC                  PAC                  PAC                  Data WG                  PIT team                  Contractors/Provid.                  Contractors/Provid.                  DHSS &amp; Rural Prov</p>
Month 7	<p>PAC meets to review progress                  Health disparities plan                  Urban on-site TA – document &amp; billing                  PLL &amp; TIP distance training continues                  Data WG meets as needed                  PIT team meets as needed</p>	<p>Project update                  Plan completed                  Revised plan                  Meeting schedule                  Notes                  Notes</p>	<p>PAC                  PAC                  DHSS &amp; Urban Prov                  Contractors/Provid.                  Data WG                  PIT team</p>

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Month 8	PAC meets Data WG meets as needed PIT team meets as needed PLL & TIP distance training continues Second face: face PLL training	Mtg Notes Notes Notes Evals & progress "	PAC Data WG PIT team Contractors/Provid. "
Month 9	PAC meets Cross agency financial map started Data WG meets as needed PIT team meets as needed PLL & TIP distance training continues	Mtg Notes Notes Notes Evals & progress	PAC DHSS JMT & PAC Data WG PIT team Contractors/Provid.
Month 10	PAC meets Data WG meets as needed PIT team meets as needed PLL & TIP distance training continues All-State face: face TIP training Urban in-state PLL trainer	Mtg Notes Notes Notes Evals & progress training held staff identified	PAC Data WG PIT team Contractors/Provid. Contractors/Provid. Contractor/Urban hub
Month 11	PAC meets Data WG meets as needed PIT team meets as needed PLL & TIP distance training continues Start year 1 final report	Mtg Notes Notes Notes Evals & progress Draft report	PAC Data WG PIT team Contractors/Provid. PAC, DHSS, Contractor
Month 12	PAC meets - Cross agency financial map finished Data WG meets as needed PIT team meets as needed PLL & TIP distance training continues Finish year 1 final report PLL village site visit outside rural hub TIP in-state trainers certified Assessment instrument	Mtg Notes Notes Notes Evals & progress Final report Rural report Progress to Cert. Final product	PAC, DHSS JMT Data WG PIT team Contractors/Provid. PAC, DHSS, Contrc. Contractors/Provid. STARS BH & TIP DHSS - Haines-Simeon
Year 2	Re-do training contracts & add in-state TIP trainers certified by STARS BH. Expand use of assessment protocol Formalize/refine rural PLL/TIP model TIP/PLL fidelity - original sites Expand TIP/PLL to additional sites Certify PLL in-state trainer	Contracts w/certif trainers # providers using Model developed Staff certified New sites added Trainer approved	DHSS DHSS Contractors/Provid. Contractors DHSS/PAC Dr. Sells/PLL
Year 3	TIP training contracts w/ in-state certified trainers PLL training contract w/ in-state certified PLL trainer Expand use of assessment protocol Monitor TIP/PLL fidelity/outcomes Expand TIP/PLL to additional sites Certify additional PLL in-state trainer	Contracts w/certif trainers Contracts w/certif trainers # providers using Staff certified New sites added Trainer approved	DHSS DHSS DHSS Contractors DHSS/PAC Dr. Sells/PLL

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Year 4	PLL & TIP training contracts include certified in-state trainers	Contracts	DHSS
	Statewide use of assessment protocol	# providers using	DHSS
	Monitor TIP/PLL fidelity/outcomes	Staff certified	Contractors
	Fidelity to TIP/PLL at new sites	Staff certified	Contractors
	Expand TIP/PLL to additional sites	New sites added	DHSS/PAC
	Establish long-term plan/funding to maintain TIP/PLL post grant	Trainer approved	Dr. Sells/PLL

*Screening, Assessment & Treatment for Co-Occurring MH and SUD:*

The Alaska Division of Behavioral Health has implemented two instruments that fulfill program requirements of “screening, assessment and treatment for co-occurring recipients” of treatment within the integrated system of care; the Alaska Screening Tool (AST) and the Client Status Review (CSR). The AST functions as a standardized statewide screening instrument that is designed to screen mental health (depression, anxiety, risk to self / others) substance use disorder, co-occurring disorders, adverse experiences, FASD, traumatic brain injury, major life change and intimate partner violence. The AST screening for MH and SUD is further informed by critical secondary clinical presentations to support assessment and treatment planning.

The Client Status Review of Life Domains (CSR) is a self-report instrument developed by the department that is used to measure a recipient’s quality of life at the time of intake and at subsequent 4-month intervals during treatment, and at discharge from services. Information from the Client Status Review is used in multiple ways: 1) the initial Client Status Review conducted prior or during the intake assessment process supplements screening information obtained in the Alaska Screening Tool (AST) to inform the assessment and treatment plan. 2) The initial Client Status Review functions as a baseline measure of a persons’ quality of life prior to an assessment and entry into services. This initial Client Status Review can be compared with subsequent Client Status Reviews to monitor change over time and outcomes. (3) The Client Status Review is used to revise a client’s behavioral health treatment plan, and measure change at discharge.

The Client Status Review measures multiple life domains. These include “Health”, “Safety”, “Productive Activity”, and “Living with Dignity”. It is important to note that the CSR will be updated by this project start date, and will include specific *Health Risk Behaviors\** of tobacco use, physical activity, and nutrition.

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Chart: #9

<p>Health</p> <ul style="list-style-type: none"> <li>• Physical Health</li> <li>• Mental Health</li>   <li>• Substance Use</li> <li>• Harm to Self</li> <li>• Emergency Services</li> <li>• Tobacco</li> <li>• Physical Activity</li> <li>• Nutrition</li> </ul>	<p>Safety</p> <ul style="list-style-type: none"> <li>• Legal Involvement</li> <li>• Domestic Violence</li>   <li>• General Safety</li> </ul>	<p>Productive Activity</p> <ul style="list-style-type: none"> <li>• Employment/School</li> <li>• Other Productive Activity</li> </ul>	<p>Living with Dignity</p> <ul style="list-style-type: none"> <li>• Housing</li> <li>• Supports for Recovery</li>   <li>• Meaning in Life</li> <li>• Life in General</li> <li>• Service Quality</li>   <li>• Service Outcomes</li> </ul>
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The AST, CSR, and a related Clinical Guidance Document are accessible on the following url: <http://dhss.alaska.gov/dbh/Pages/Resources/Regulations.aspx>

The DBH views this project as an opportunity to develop and operationalize a standardized assessment tool that meets the application requirements accordingly, with the principal strategy of implementation that will involve (1), the development of a standardized behavioral health assessment that includes a Level of Care /Acuity component, such as the “Child and Adolescent Service Intensity Instrument (CASSI),<sup>43</sup> (2) the alignment into the existing clinical practice of Treatment Plan Reviews (every 4 months), and (3) programming the standardized assessment and LOC instrument into the AKAIMS application for electronic data entry and reporting. At a minimum, this will allow for the following benefits:

- Aggregate reporting on assessment findings
- Assessment and treatment review processes that result in measurement and recording of acuity and severity of service need
- Monitors the alignment of service allocation and delivery with presenting need, to determine over/under utilization of services.
- Reflects broad service systems interaction i.e. mental health, substance abuse, social services, juvenile justice, health education, vocation developmental disability etc.
- The concept of Service Intensity allows for more flexibility in defining the needed amount of service without being prescriptive regarding the place where the service is provided. This encourages levels of “treatment intensity” rather than restrictiveness and costliness of institutional settings.
- Objective, quantifiable criteria for level of care placement, continued stay, and outcomes
- Conduct necessary “case risk adjustment” to accurately measure outcomes based on acuity/severity.
- Allows for positioning for future case rates based on severity.

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### *Ensuring Client Input into Implementation:*

The Project Advisory Council (PAC) will guide the planning, implementation and evaluation of the Partnership Project. Youth and family advocates from project communities will be encouraged (and mentored) to take a turn on the PAC. Advocates from *Facing Foster Care Alaska* and the *Alaska Youth and Family Network* (Statewide Family Network and Youth Move) will participate as well. We will share project outcomes and obtain feedback at PAC meetings, community meetings and at BTKH meetings and events.

### *Organizations to Participate:*

The community partner agencies will be major participants. Their roles will include hiring and supervising staff, implementing PLL and TIP, gathering data, implementing an electronic health record, evaluating outcomes, communicating about and collaborating on the project, and participating on the PAC. The urban site will be responsible for coordinating training, developing in-state trainers, and working with the PAC to set up distance training and oversight strategies. The rural site will take the lead on identifying issues related to rural implementation of PLL and TIP and working with the PAC and the TIP and PLL developers to make adjustments to implement the practices successful and with fidelity.

Other partners will include the Office of Children's Services (OCS), the Division of Juvenile Justice (DJJ), the Division of Behavioral Health (DBH), the Division of Senior and Disability Services (SDS) and the Office of Health Care Services (HCS). These partners will participate on the PAC to ensure coordinated planning for cross system youth and families. Tribal partners will play a key role in rural implementation. A tribal health corporation may be one of the community partners implementing the project. Local tribal councils are likely to be key players in communities with few resources. Tribal councils may provide space or be involved in services, or may play a strictly advisory role.

School districts are key players in rural Alaska and are likely referral sources as well as providing resources in the communities. In some areas, school staff has participated in TIP training to improve their interactions with older youth in the school setting. Covenant House Alaska is a participant in BTKH planning and will be involved from that angle. In addition, Covenant House will be a referral source for family services and is a collateral service provider for many homeless or runaway youth in the Anchorage and Matsu areas.

Two Anchorage/Matsu grantees are implementing TIP: Denali Family Services and Anchorage Community Mental Health. Both organizations will be involved via their role in BTKH planning and they are likely to be collateral service providers for some of the youth and families served. The Alaska Youth and Family Network (AYFN), is Alaska's Statewide Family Network, houses a Youth Move chapter, participates in BTKH planning, and provides peer navigation and supports Statewide. AYFN will participate as a collateral service provider, through BTKH participation, and as a CAP member. Facing Foster Care Alaska (FFCA) is an organization of former and current foster care youth that participates in BTKH planning and helps to put on the yearly Youth Advocacy Summit. FFCA will partner through participation in the PAC.

The Alaska Mental Health Trust Authority (The Trust) collaborated with DHSS to start and to fund BTKH. The Trust provides planning, organization support, and funding to leverage system development. The Trust will participate on the CAP and may support administrative activities with BTKH funding. The Trust also provided grant-writing support for this application. Staff from the Alaska Mental Health Board /Advisory Board on Alcoholism and Substance Abuse will collaborate on the Partnership Project. The planning boards are involved with youth homelessness and service development for youth of transition age, and will sit on the CAP.

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### *Provide a Per-Unit Cost:*

\$950,000 – 20% for data and performance assessment = \$760,000. So:

Year #1 = \$760,000 divided by 174 children = \$4,367.8 per-youth

Year #2 = \$760,000 divided by 292 children = \$2,602.7 per-youth

Year #3 = \$760,000 divided by 344 children = \$2,209.3 per-youth

Year #4 = \$760,000 divided by 518 children = \$1,467.2 per-youth

### *Selection of Local Community-Based Treatment Providers:*

DHSS will solicit for two community-behavioral health provider partners to implement the Partnership Project: one to provide services in the Anchorage/Matsu area and one to provide services in a rural/tribal region. We plan to use a competitive solicitation to identify the appropriate provider in the urban area and we may also use a competitive solicitation for the rural project, however, readiness and capacity issues may limit selection of a provider for that project to certain areas. Additional considerations for the urban project will be that the provider must have sufficient capacity to develop a training hub to coordinate/provide training to disseminate the practice to additional communities. The urban provider must be able to implement the best practices and have significant competence in delivering both substance abuse and mental health services.

The rural tribal project will target a provider who serves a rural area with a large Alaska Native population. The provider will need to have capacity to support at least a full time clinician implementing PLL and to implement TIP services. The agency will need to have or be able to develop sufficient telemedicine capacity to work in rural village sites in order to reach the required number of PLL children and families. The criteria below will assist us to obtain the appropriate agencies as partners on the Partnership Project.

### *Required Experience*

This project will seek applicants with at least 3 years prior Alaskan experience providing Behavioral Health Services to youth with substance abuse and/or serious emotional disorders and their families who meet the criteria for the target population described in this RFP. Proposal evaluation will consider the applicant's history of compliance with grant requirements and previous experience in providing the same or similar services. The history of compliance will include a summary of audits and successful resolution of any audit findings. The applicants will provide a brief overview of prior experience providing the same or similar services to the target population. If the applicant is not a current or prior year grantee of DHSS or this program, the proposal must include references and documentation of the successful delivery of same or similar services to the target population, and include a copy of their most recent audit.

### *Number to be Trained & Training Events:*

DHSS resources for the Partnership Project will train at least two new PLL teams (one in each location). The urban team will include one clinician and one or two paraprofessionals working to become certified in PLL. We will also require that an additional clinician and the clinical director audit PLL training. The rural team will include one clinician and two to four paraprofessionals working toward PLL certification. We will ask the rural site to include an additional clinician or clinical director if that is feasible. If possible, we will negotiate for additional teams to be included in the training contract. **Conservatively, five staff will be trained in the first year: two from the urban site and three from the rural site. One of these individuals will work towards becoming a PLL trainer.** In addition, we will have two to four people auditing the PLL training. The PLL training schedule for the first year includes **three on-site training events**

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and **monthly telephonic** training, supervision and mentoring. This schedule may be modified in discussion with the practice developers and the community sites.

DHSs resources will also fund training in the Transition to Independence Process. TIP training is open to both clinical staff and paraprofessionals within the grantee agency and from other behavioral health and/or other social service agencies. This makes it more difficult to anticipate the number of individuals who will be trained. However, we estimate that 20 to 40 individuals will be present at each Anchorage/Matsu TIP training. From this cohort, 20 to 30 individuals will be skilled at TIP by the end of the first year. Two or three of these individuals may seek to become a TIP trainer. For the rural site, we estimate 5 and 15 individuals will participate in each training. From this cohort, 5 to 8 staff skilled will be skilled at using TIP by the end of the first year, and one person may seek to become a trainer. **Conservatively, 25 staff from the two agencies will participate in all three trainings and achieve basic competence in TIP in the first year. Three staff will work towards becoming certified TIP trainers.** The TIP training schedule for the first year includes **three on-site training events and bi-monthly clinical training**, supervision and mentoring. This schedule may be modified in discussion with the practice developers and the community grantees. One of the TIP trainings will be an "all State" training, where TIP grantees from across the State come together to learn and practice skills.

### *Unduplicated Number of Individuals Served:*

PLL teams treat 32 youth in a year, or roughly 3 youth per month. Two teams will start to provide clinical services by month three of the project. In years two and three, the sites will be running at full capacity. We have conservatively added additional sites in year #4. We based demographics for the rural site on our current rural site, which has 80% Alaska Native and 20% White or Other. We based demographics for the urban site on the urban TIP site, which has 75% White, 10% Alaska Native and 15% other.

TIP can be used with all adolescents with behavioral health challenges served by an agency. Each agency has a unique strategy in terms of which staff participates in TIP training. For this reason, we based urban site estimates on the number served by our existing TIP urban site during start-up and subsequent years. That site has 75% White, 10% Alaska Native and 15% other, and has 60% male and 40% female. For the rural TIP site, we based our estimates on a small site in S.E. Alaska, with modifications as we anticipate that the Partnership Project will allow us to start a site in a smaller community that is more heavily Alaska Native. We assumed 80% Alaska Natives and 50% male and 50% female. We conservatively added additional sites in year #4 (Chart #10)

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Chart: #10

Estimated Number of Youth to be Served					
PLL - Urban	Year One - 10 months	Year Two	Year Three	Year Four w/addtl. site	Project Total
AK Natives	3	4	4	7	18
White	20	24	24	44	112
Other	4	4	4	8	20
Females	50%	50%	50%	50%	50%
Males	50%	50%	50%	50%	50%
<i>Totals</i>	27	32	32	59	151
PLL - Rural	Year One - 10 months	Year Two	Year Three	Year Four w/addtl. site	
AK Natives	22	26	26	48	122
White/Other	5	6	6	11	28
Females	50%	50%	50%	50%	50%
Males	50%	50%	50%	50%	50%
<i>Totals</i>	27	32	32	59	150
TIP - Urban	Year One - 10 months	Year Two	Year Three	Year Four w/addtl. site	
AK Natives	8	17	20	28	73
White	60	127	154	214	555
Other	12	26	31	43	112
Females	40%	40%	40%	40%	40%
Males	60%	60%	60%	60%	60%
<i>Totals</i>	80	170	205	285	740
TIP - Rural	Year One - 10 months	Year Two	Year Three	Year Four w/addtl. site	
AK Natives	32	46	60	92	230
White/Other	8	12	15	23	58
Females	50%	50%	50%	50%	50%
Males	50%	50%	50%	50%	50%
<i>Totals</i>	40	58	75	115	288
<b>Totals</b>	<b>174</b>	<b>292</b>	<b>344</b>	<b>518</b>	<b>1328</b>

*Use of SAMHSA Grant Funds, 3rd Party Revenue and Other Revenues:*

DBH standard grant language requires that all grantee agencies bill Medicaid, insurance and co-pay. Grantees are required to have policies and practices in place to calculate a fair self-pay rate for the individuals who come into their care but may not deny treatment based on ability to pay. These requirements are outlined in State statute and in regulation.<sup>44</sup> Each agency is required to ensure that the cost of services not covered by insurance are discounted based on the patient's ability to pay. Ability to pay is determined by a patient's *annual* income and family size according to the most recent U.S. Department of Health & Human Services Federal Poverty Guidelines.<sup>45</sup> These guidelines also require that agencies develop a business process that *first* bills private health insurance and *then* public health insurance and must take reasonable

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measures to obtain healthcare information including policy number, policyholder, and name and address of insurance company.

To assist in developing strong business practices, DHSS is working with tribes to provide gaps assessment and follow up supports to address issues revealed in the gaps assessment. This process helps tribes to analyze and address gaps in their service systems from business practices around Medicaid enrollment and insurance, to clinical service delivery, documentation and follow up for denied claims. This project has helped tribes to become aware of issues with billing to Medicaid or insurance service systems and has increased billing and revenues.

### *Service Coordination Across Multiple Levels and Systems:*

The Project Advisory Council (PAC) will include representatives from:

- DHSS Joint Management team
- Community grantee sites
- Statewide Family Network
- Youth Move Alaska
- Facing Foster Care Alaska
- Covenant House Alaska
- Department of Education
- Division of Public Health
- School districts
- Alaska Mental Health & Substance Abuse Planning Boards
- Alaska Mental Health Trust Authority
- Other stakeholders

DHSS has existing mechanisms for internal collaboration: 1) The DHSS Senior Leadership Team is responsible for Department budget and policy decisions and approved the project application. 2) The Joint Management Team (JMT) is responsible for operational decisions and will participate on the PAC. The JMT includes deputy directors and lead staff from behavioral health, children's protective services, juvenile justice, senior and disability services, Medicaid, Licensing and the BTKH Coordinator. These teams ensure internal system alignment.

DHSS has on-going collaboration with external stakeholders: DHSS meets with the Tribal Behavioral Health Directors (TBHD) quarterly in a tribal/rural work group. The TBHD will participate on the PAC should this project be funded. DBH providers are required to form Community Action Planning (CAP) work groups to gather input from stakeholders and ensure coordination across the treatment system and with DBH. DBH holds twice-yearly Change Agent meetings and periodic training conferences and other on-going work groups with providers. DBH will report on the Partnership Project and provide TIP and PLL training at these settings. BTKH stakeholders meet quarterly and will provide input into the Partnership Project. A Youth Move representative will also join the PAC.

### *Use of Funds to Enhance the Adolescent and Family Service System:*

The two community-provider agencies may use up to 20% of their grant funds for data collection, performance measurement and local performance assessment. They will use the remainder of their project funding for training, start-up and implementation of Transition to Independence Process and Parenting with Love and Limits services. These practices will improve youth engagement and increase participation in clinical substance abuse and mental health treatment as well as facilitating wraparound services and supports such as vocational and educational services and transportation. The community agencies will provide outreach to identify youth and families who will benefit from behavioral health services and family services. Transition-age youth and young adults will receive TIP services and appropriate youth and families will be referred to Parenting with Love and Limits for intensive family therapy and in-home services. These two sites will deliver services in a variety of settings including the

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community, the school, the home or a foster home. Anticipated costs include staff recruitment and training, program start up, development and policy and procedure development. In addition, there will be costs related to the work of the PAC (teleconferences, non-State travel, food, honorarium, etc) and for infrastructure development, electronic health record, reporting, data analysis and evaluation. Providers will also pay for social marketing, recruitment and outreach.

DHSS/DBH will issue grants to the two community partners for implementation of services for the project and DBH will maintain a contract with Dr. Scott Sells and with Stars Behavioral Health for implementation of PLL and TIP. DHSS will pay for costs related to cross-training on PLL, TIP and the new assessment protocol outside of the two sites (for State staff working directly with youth, non-grantee providers of substance abuse and mental health services, additional agencies, etc)

DHSS will pay for a half-time consultant with expertise in substance abuse and mental health. This position will work with the Project Advisory Committee (PAC) as a contractor DBH. In addition, DHSS will pay for staff travel and other costs associated with the implementation of the Partnership Project. DHSS will pay for social marketing work, staff time and participation in the PAC and other project meetings, staff time for evaluation and reporting related to the project.

The DHSS has developed and implemented the Alaska Automated Information Management System (AKAIMS), a web-based application and database that serve the dual purpose of a management information system (MIS) and an electronic medical record (EMR). The AKAIMS Project was initiated in February 2003. As an MIS reporting tool, the system allows the Division to meet current and emerging State and Federal reporting requirements, such as state Quarterly Reporting, Treatment Episode Data Set (TEDS), Government Performance and Results Act (GPRA), both Mental Health and Substance Abuse Block Grants and the National Outcome Measurements (NOMs). As an Electronic Health Record (EHR), AKAIMS provides an agency the ability to create a full Electronic Health Record (EHR) compliant with HIPAA and 42-CFR part II standards. The AKAIMS meets federal requirements of meaningful use certification, as of December 2011. For the purposes of this project, DHSS will cover the cost of modifications to Alaska's AKAIMS for any additional evaluation or data analysis.

### *Feedback Loop - State and the Community-Based Treatment Providers:*

The Project Advisory Committee (PAC) will guide oversight of the project and monitor the work plan, implementation, data and barriers. A project implementation team (PIT) will support on-going activities and day-to-day issues. The PIT will include the community grantees, the half-time contractor, the DBH Deputy Director, the DHSS BTKH Coordinator, the DBH State Adolescent Treatment/Youth Coordinator, and others. A data work group will address issues around electronic health records, data collection, data analysis, etc. This group will include the community grantees, the half-time consultant, the BTKH Coordinator, the State Adolescent Treatment, the consultants, and others.

A SharePoint site and face-to-face meetings will allow DHSS and the PAC to share information and documents related to the project. A training plan will be developed that will include face: face trainings at both sites. As much as possible, we will co-train the rural and urban sites and link them to on-going TIP and PLL pilot projects. Whenever appropriate, we will invite additional providers and stakeholders to participate in project training. This allows providers who are further along to act as resources to providers in early implementation. Distance learning and telemedicine will be used for some services and for ongoing mentoring and training. This will allow us to link providers from different communities and parts of the State and to create a learning network. We currently have three in-state trainers under development for TIP. After

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these individuals achieve certification from STARS BH, we will use the urban hub to link these individuals to the new projects to provide on-going coaching and mentoring. Once we are able to develop an in-state PLL trainer at the urban hub, we can shift some of the work done by PLL and TIP practice developers to the in-state training team to reduce costs and increase sustainability. We intend to set up an aggressive schedule of face-to-face contact, training and telephonic consultation. We may be able to phase this back if implementation goes well.

### *Embedding Project Components in the Existing Service Delivery System:*

The project will be operated by the Department of Health and Social Services. Grants for community partners will go out of the Division of Behavioral Health to agencies that are State grantees providing behavioral health services using grant funds, Medicaid, co-pay and insurance funding. DHSS has designed the Partnership Project to align with on-going efforts to 1) increase rural tribal behavioral health service delivery, 2) expand community-based service systems, 3) increase family services, and 4) improve outcomes for at-risk youth of transition age. Where there are existing coalitions for other federal efforts (such as for suicide prevention) providers are DBH grantees. All DBH Treatment Grantees are required to participate in a community planning process that will identify current and future strategies between local community grantees that will facilitate implementation of an integrated behavioral health service system. Further, applicants are required to outline current and future strategies between local community grantees to gain clinical and administrative efficiencies in the delivery of behavioral health services.

### *Leveraging Multiple Funding Streams:*

The project will rely on federal funds for program start-up, training, staff development, travel and other costs related to implementing the program. Medicaid and State general funds will replace federal funds as providers become competent and bill for services delivered. In addition, DBH has a flexible general fund account (Individualized Service Agreements – ISA) for children with SED or SUD who are at-risk of a residential placement and need an individualized service. ISA cover short-term costs that cannot be billed to other funding sources and which are necessary to stabilize a child in a community setting.

### *Potential Barriers & Solutions:*

DHSS is still evaluating sustainability for TIP and PLL; however, we have identified two funding issues: first, PLL requires “multi-family group therapy” without the child present. This is not allowable in Alaska Medicaid. DHSS is evaluating strategies to build this into Medicaid or an alternative funding source. Secondly, TIP engages youth/young adults with severe substance abuse and behavioral health challenges and other issues but some services associated with TIP are not billable. This group of young adults may not stay in one place long enough to become eligible for Medicaid or to work a Medicaid treatment plan. TIP offers a way to engage these young people, however, not all TIP services will be billable and not all clients will have qualifying diagnoses or meet criteria for Medicaid. This results in a billing gap for TIP.

There are also barriers specific to the rural site: distance and geographic issues, staffing issues, cultural issues, and sustainability issues. We will use telemedicine strategies for training, clinical oversight, and some services. We selected practices that use staff with less than a master's degree to maximize the ability to find staff in the rural settings. This may also allow us to take advantage of the behavioral health aide model that tribal organizations are developing. In rural Alaska, staff costs are high and turnover is frequent. One strategy we have used for PLL sustainability is to require that trainings include the clinical director of each agency and an “auditing” clinician as well as the designated clinical trainee and the designated paraprofessional trainees. Cultural issues will also affect the effectiveness of PLL and TIP, so we will work

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closely with Dr. Sells and the STARS team to develop culturally appropriate language and concepts and to monitor effectiveness.

In terms of sustainability, the rural pilot project will be challenged by the extremely high costs of staffing, services, supplies and travel in rural Alaska. However, tribal health providers who are connected to an Indian Health Services Physician Clinic are now eligible for a Medicaid "encounter rate". This rate just increased to \$541 per day and will allow behavioral health aides to deliver and bill for a range of Medicaid services. However, many tribal organizations have trouble developing and maintaining the training, staff and infrastructure for Medicaid billing. To address this challenge, DHSS and the Tribal Behavioral Health Directors have been collaborating to increase effective use of Medicaid resources. This collaboration has resulted in resources for tribal providers including a gaps assessment process; DHSS staff technical assistance, and culturally competent training tools. DHSS will continue this effort with the tribal partners as the project moves forward.

### *Project Sustainability:*

Our intention is to fund the services through Medicaid and/or existing grant funding. We will work with the community partners to obtain a sustainability analysis to identify funding challenges to sustainability. Where possible, we will make regulatory or rate adjustments to allow fiscal sustainability. If required, and if justified by outcomes, DHSS will fill in sustainability gaps with State resources allocated through BTKH. BTKH is supporting start-up costs for PLL and TIP pilot projects in several communities and, as providers achieve competency, we may be able to shift some funding to new communities. DBH has over \$1,000,000 in BTKH funding that is supporting TIP and PLL pilot projects.

In terms of program continuity, three grantee staff are working to become TIP trainers currently. DHSS has been in discussion with Dr. Sells about developing an in-state trainer for PLL, and we intend to move that forward at the urban hub. Alaska has high turnover for clinical staff in rural settings, and we are developing telemedicine tools to allow distance training and have developed a model of requiring additional staff to audit PLL training. We will also develop staff at less than the master's degree level in order to reach more children and families in rural Alaska. Within DHSS, we will include the DBH Deputy Director, the DBH Policy and Planning Manager, the DBH Child and Youth Treatment/Adolescent Coordinator and the DHSS BTKH Coordinator in the program oversight. In addition, DHSS has solicited a broad group of stakeholders to participate in the PAC including staff from several DHSS divisions, a representative from the Alaska Board on Alcoholism and Substance Abuse and the Alaska Mental Health Board, staff from the Alaska Mental Health Trust Authority, and provider and youth and family advocates. This broad group will help to ensure continuity and drive to move forward even if there are organizational or leadership changes within DHSS.

## **Section D: Staff and Organizational Experience (10 points)**

### *Capability and experience of the applicant organization:*

Alaska has approximately 1/5 of the landmass of the lower 48 States and the Alaska geography makes it extremely challenging to provide services. The population in Alaska is small; however, it is diverse with high needs in many areas. The Alaska Department of Health and Social Services (DHSS) is responsible for oversight and management of State services through Divisions including Medicaid, behavioral health, children's protective services, juvenile justice, developmental disability, public health and public assistance. The Division of Behavioral Health (DBH) is responsible for State-funded behavioral health prevention and treatment services. The

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Department and its Divisions have a long history of engaging in innovative strategies to address the unique challenges and difficulties of providing services in Alaska.

DHSS routinely collaborates with stakeholders including family and youth advocates, providers, tribes, and other State departments in order to affect health and behavioral health outcomes and wellbeing of Alaskans. A recent collaboration within DHSS has been the Bring the Kids Home (BTKH) Initiative, which began in 2004 and has successfully reduced admissions to out-of-state residential psychiatric treatment centers by over 80%. BTKH success required changes in internal and external policies and practices, innovative funding strategies, new grant funding, expanded data capacity, and collaboration with stakeholders in order to create statewide change. Over \$1,000,000 in DHSS BTKH funding is supporting on-going PLL and TIP pilot projects in Alaska – this funding will continue to support implementation of these best practices in order to achieve statewide implementation.

DBH will oversee the grants and contracts for the Partnership Project and has demonstrated the ability to implement new programs as seen by BTKH outcomes and many other division initiatives (integrating substance abuse and mental health services and integrated Medicaid regulations, developing trauma informed services, setting up a model for fetal alcohol spectrum disorder surveillance and treatment, and a 5-year Medicaid Waiver Demonstration project awarded through CMS to provide home and community based services to youth with FASD and who met level of care criteria for RPTC placement). In addition, the Department has a successful and on-going effort to implement PLL and TIP: the same team would manage the Partnership Project. In addition to a very accomplished clinical team within the Division of Behavioral Health, the Department has access to expertise in telemedicine, social marketing, research, data, Medicaid and financing, and many other areas of expertise that will be available to ensure the success of the Partnership Project.

### *Key Staff Positions and Qualifications & Staffing Plan:*

The DBH Operations Manager will be the Project Director for the Partnership Project. The Bring The Kids Home Coordinator in the Department of Health and Social Services will act as a co-director and have technical supervision of the project. The DBH Children's Behavioral Health Specialist/Child State Planner will be responsible for oversight of the grants and contracts for the Partnership Project. The DBH Planning and Policy Manager will have oversight of data collection and evaluation. The BTKH Coordinator and the DBH Children's Specialist will spend up to 20% of their time on this project, the DBH Deputy Director will spend up to 10% of her time and the Policy and Planning Manager will spend up to 5% of his time.

The DBH Operations Manager was born and raised in Juneau and is a third generation Alaskan. She is a strong and capable leader and manager, serving as a critical part of the DBH leadership and management teams and has led the Division on a wide range of children's issues, adult treatment and recovery, trauma, and access to treatment. Over the course of her 11 years in DHSS, she served as the Acting Director, the Deputy Director, and the Administrator for Community Mental Health Services with Behavioral Health and the Program Officer for Out of Home Care and the Residential Care Coordinator for the Office of Children's Services. She graduated with a master's degree in Counseling Psychology from Gonzaga University and is a Licensed Professional Counselor in Alaska.

The BTKH Coordinator is a LCSW and a lifelong Alaskan. She has been with the Department of Health and Social Services for 12 years. During these years, she has represented the Department in many capacities including acting as the Alaska representative to the National Association of State Mental Health Program Directors, participating in planning and implementation two tribal

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System of Care implementation grants and two tribal Circle of Care planning projects, developing the Alaska FASD waiver project and Bring the Kids Home. She has been involved in social services and behavioral health service delivery, system management, oversight and planning in Alaska for most of the last 25 years. She has had extensive personal and professional experience in urban and rural areas, and with Alaska Native people. BTKH is housed in the DHSS Commissioner's Office and the BTKH Coordinator is responsible for oversight of BTKH planning, system development, reporting and for facilitating stakeholder and cross system improvement projects Statewide.

The DBH Children's Specialist has direct oversight for grants and contracts implementing BTKH system improvement projects such as implementing Parenting with Love and Limits, the Transition to Independence Process and other BTKH related projects. He is a Master's level behavioral health clinician and also has many years of experience in Alaska providing behavioral health services, running a behavioral health center and working in program planning, system management and system oversight. He has extensively personal and professional experience with Alaska Native people and Alaska Native culture and has worked intensively with both rural and urban programs to develop behavioral health services.

In addition, the DBH Policy & Planning Manager will manage the project evaluation plan. He is a member of the DBH senior management team and has direct management responsibilities for the Research unit and the Alaska Automated Information Management System (AKAIMS). Program oversight includes policy and regulation development, and management of the divisions Performance Management System. He served as the Project Director for the Co-Morbidity/API Replacement Project, a SAMHSA, CSAT/CMHS funded project and the SAMHSA Co-occurring State Incentive Grant (COSIG) project, resulting in the Integrated Behavioral Health Regulations and has worked for over 20 years in the mental health and substance abuse treatment settings in Montana, Washington, Iowa and Alaska. His research background include studies of families who adopted, fostered, or birthed HIV/AIDS children; community needs assessments, "Family Stress and Dysfunction," "Elder Abuse," and "Child Maltreatment"; longitudinal studies examining state funding policies and follow-up of support services for special-needs adoptions. For the Iowa Department of Human Services, he served as a research trainer addressing issues of adoption and foster care for AIDS/HIV infected children. Academically; he has served as an adjunct professor at the University of Alaska for coursework related to social work and research. He has published articles in the *Child & Adolescent Social Work Journal*, as well as multiple monographs.

Because these four highly qualified staff are available to oversee implementation of the project, DHSS will utilize a half-time contractor to complement the work of the program. This contractor will take on coordination, communication and tracking roles, work with the project sites on documentation, convene CAP meetings, and take on many administrative and support roles to ensure that the project is successful.

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### Section E: Data Collection and Performance Measurement (20 points)

DBH recognizes that data collection, management, analysis and reporting require a strong alignment of systems (program development, service delivery, and finances) with data collection. The Alaska Automated Information Management System (AKAIMS) is the data collection and reporting system for the DHSS Division of Behavioral Health, and will be used to collect client level data on all target recipients for the **Alaska's Partnership to Improve Outcomes for Adolescents and Families**. The AKAIMS is a web-based application and database that serve the dual purpose of a management information system (MIS) and an electronic medical record (EMR). As an MIS reporting tool, the system allows the Division to meet current and emerging State and Federal reporting requirements, such as state Quarterly Reporting, Treatment Episode Data Set (TEDS), Government Performance and Results Act (GPRA), both Mental Health and Substance Abuse Block Grants and the National Outcome Measurements (NOMs). As an Electronic Health Record (EHR), AKAIMS provides the ability to create a full Electronic Health Record (EHR) compliant with HIPAA and 42-CFR part II standards. The AKAIMS meets federal requirements of meaningful use certification, as of December 2011. AKAIMS has been successfully implemented with 100% of grantee provider agencies now submitting data to the division. The statewide grantee provider user network includes 96 service provider organizations, with a combined individual user group membership of over 2,000 individuals.

The AKAIMS has existing capacity to capture Government Performance and Results Act (GPRA) related data. Provider organizations will submit these required data via the online access of AKAIMS, according to the stipulated timelines. The DBH will report demographics (gender, age, race, and ethnicity) data on all clients served, and on the following GPRA performance measures: abstinence from use, housing status, employment status, criminal justice system involvement, access to services, retention in services and social connectedness. Data will be collected at baseline (i.e., the client's entry into the project), three months post-baseline, discharge, and six months post-baseline. The DBH, in collaboration with providers will monitor and ensure a 6-month follow-up rate of 80 percent (i.e., grantees will be expected to complete a face-to-face 6-month follow-up interview with 80 percent of all clients served at intake). Upon collection of the data, all data will be submitted via the Services Accountability Improvement System (SAIS), CSAT's online data-entry and reporting repository.

Data collection and reporting will include the development of a formal tracking process to monitor and receive semi-annual progress and performance information on infrastructure development. Reports will be generated to assess the DBH's progress as compared to both the target outcomes established and a common set of infrastructure measures (developed post-award) for the project.

Alaska's **Partnership to improve Outcomes for Adolescents and Families** includes training of staff on the evidence based practice models of PLL and TIP. Each training event will include data collection on overall satisfaction with the quality and application of event information, using a customer satisfaction tool provided by CSAT. Data will be collected at the end of each event and 30 days post-event from all participants.

#### *Data Driven Quality Improvement:*

Describe the data-driven quality improvement process by which sub-population disparities in access/use/outcomes will be tracked, assessed, and reduced. The AKAIMS system can report on the following:

- Client enrollment, demographics, and characteristics;

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- Admission, assessment, and discharge; and
- Services provided, including type, amount, and individual service provider.
- Measurement of outcomes and quality of services.

The DBH research unit will collaborate with AKAIMS system programmers in the development of reports specific to the identification and monitoring of sub-populations with disparities in access, service utilization and outcomes. Targeted analysis and reporting will include quality of behavioral health services, and outcomes. As this information is identified, it will be applied to the mechanisms in place for the overall project management. DHSS will share project data at the CAP, at quarterly BTKH meetings, and at the bi-yearly Change Agent Conference. Internally, project data will be shared at the DHSS Joint Management Team and with the Senior Leadership Team. Analysis and policy changes, as well as project refinements will be communicated and applied within the affected area of practice. Reference section below on “Use of Data for Project Management.”

### *Local Performance Assessment:*

The DBH has implemented a business practice of continuous quality improvement and defined as a *Performance Management System*, which guides policy and decision-making for improving the behavioral health treatment system. The DBH *Performance Management System* seeks to improve the quality of life of Alaskans through the right service to the right person at the right time, using the Results Based Accountability (RBA) framework of (a) Quantity: How much did we do? (b) Quality: How well did we do it? and (c) Outcome: Is anybody better off? The DBH has developed formal feedback loops via processes and policies on the application of data to monitor the treatment system, in collaboration with grantee providers. This includes the development of a performance “scorecard”, with targeted performance measures.

The framework of the Performance Management System will be applied to the “local performance assessment”. In particular, the current DBH practice of site reviews will serve to provide the functional structure in conducting “local performance assessments”; combining site reviews with data to improve management of the grant project, as well as, determining the degree to which the goals, objectives and outcomes are being achieved. Additional outcome and process questions will be included.

### *Use of Data for Project Management:*

The DBH has implemented a business practice of continuous quality improvement and defined as a *Performance Management System*, which guides policy and decision-making for improving the behavioral health treatment system. The DBH *Performance Management System* seeks to improve the quality of life of Alaskans through the right service to the right person at the right time, using the Results Based Accountability (RBA) framework of (a) Quantity: How much did we do? (b) Quality: How well did we do it? and (c) Outcome: Is anybody better off? The DBH has developed formal feedback loops via processes and policies on the application of data to monitor the treatment system, in collaboration with grantee providers. This includes the development of a performance “scorecard,” with targeted performance measures in the following areas: acute care volume; access to treatment; volume of emergency medical services; engagement & retention; treatment quality and outcomes. The reporting capability is available online through the AKAIMS report manager, to all grantee providers and includes quarterly individual provider agency, regional and statewide reporting, across multiple years. This includes measures for adults, youth, and children accessing behavioral health services.

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The framework of the DBH Performance Management System will be applied to Alaska's **Partnership to improve Outcomes for Adolescents and Families**. In similar fashion, the communication mechanisms through formal and structured planning and reporting meetings, guidance documents, and directives will be applied as well.

DHSS will share project data at the CAP, at quarterly BTKH meetings, and at the bi-yearly Change Agent Conference. Internally, project data will be shared at the DHSS Joint Management Team and with the Senior Leadership Team. In addition, the SharePoint site will house project reports and data. Data gathered will include both clinical indicators of change and achievement of grant deliverables and contract deliverables. DHSS will work with the practice developers and the Community Providers to ensure that project tasks are clearly articulated and measurable and that a timeline is developed for planned activities and goals.