Bring the Kids Home Focus Area

In-State Services for Children and Youth with Severe Emotional Disturbances (SED)

System Change

What is system change?

System change is the development of sustainable organizational capacity that results in Trust Beneficiaries living healthier lives.

The goal of the Bring the Kids Home (BTKH) focus area is to develop and improve an integrated mental health service system in Alaska, so that children and youth are served in the most culturally competent, least restrictive setting, as close to home as determined to be safe and appropriate. The efforts to create the BTKH focus area were led by the Department of Health and Social Services (DHSS) in partnership with the Alaska Mental Health Trust Authority and with an extensive stakeholder group.

Funding strategies include using a mix of general fund dollars with Alaska Mental Health Trust Authority funds for startup, with a shift to long-term general funding by fiscal year 2013. These strategies are aimed to reduce dependence upon Medicaid funded out-of-state residential care; increase home and community based services and natural supports; invest in earlier intervention; and seek partnerships for system development.

Bring the Kids Home (BTKH) System Change: Building In-State Service Delivery System for Children and Youth with SED

During BTKH, the Trust and the Department of Health and Social Services collaborated with multiple stakeholders to implement strategies to address the deficiencies of the service delivery system for youth in Alaska. In addition, other system development projects impacted the in-state service delivery system. Some system change results are described below:

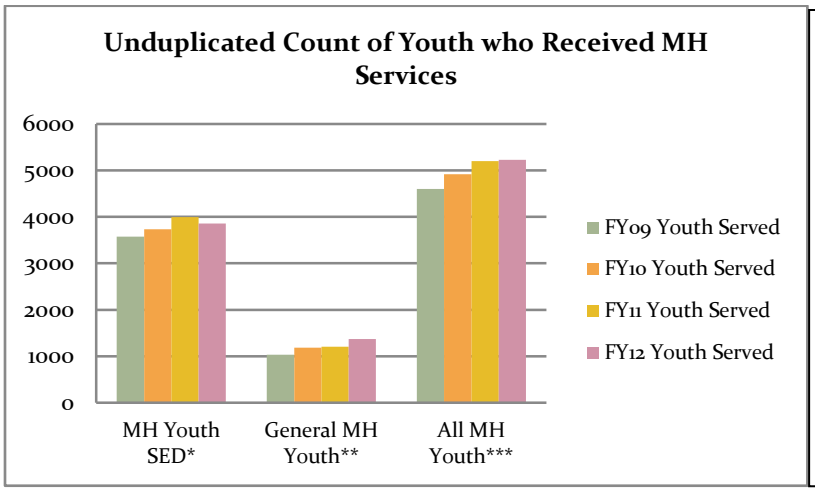
Increased utilization of in-state mental health services for children and youth.

Chart 1 shows increased utilization of mental health services by youth with SED and increased "general mental health" service utilization. This may suggests services are reaching children and youth earlier and reflect expanded service access due to BTKH efforts. However, the decreased number of youth with SED who accessed mental health services between FY11 and FY 12 should be monitored. Given a decline in youth with SED counts (FY 12), with a corresponding increase of total youth served (.6% increase), this change could simply reflect the shift of youth with SED to lower levels of services. Regardless, the small decline does not meet the threshold of statistical significance.

Chart 2 shows decreased utilization of substance use disorder (SUD) services for youth. This may reflect reduced service capacity or decreased need or some other factor. Data from the "Youth Risk Behavior Survey" does show that fewer youth are using tobacco, alcohol and drugs[1]. SUD service utilization trends needs to be monitored. BTKH data clearly shows that children who reach the RPTC level of care have significant risk factors related to substance abuse. A 2011 report on RPTC admissions found that 77 % had a family history of substance abuse and 34 % reported a co-morbidity of substance abuse.[2]

[1] http://www.hss.state.ak.us/dph/chronic/school/YRBS results.htm
[2] DBH "A Client Profile Snapshot: In-State & Out-of-State RPTC Admissions, Updated May 2011"

Chart 1



KEY

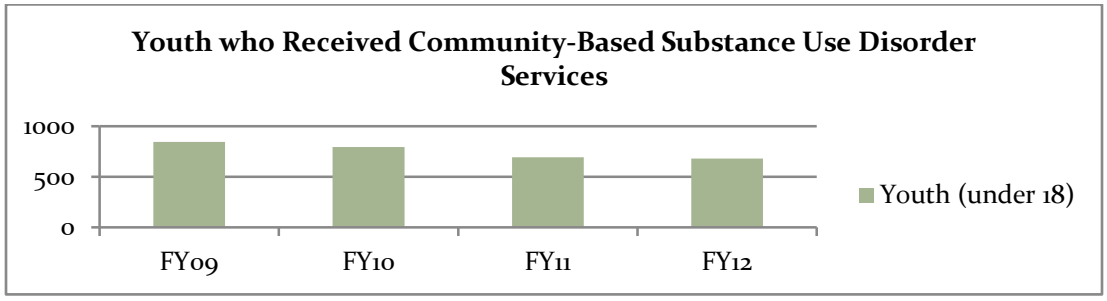
* MH Youth SED: Youth with Serious Emotional Disturbance (SED) receiving mental health (MH) services. Includes individuals with co-occurring MH & substance use disorders.

** General MH Youth: Youth without SED receiving MH services: includes co-occurring disorders.

*** All MH Youth: All youth receiving MH services; includes co-occurring disorders.

Data source: DHSS FY2012 Budget Overview. Reflects individuals receiving services in a fiscal year.

Chart 2



Data source: Division of Behavioral Health MMIS data – from "DHSS FY2012 Budget Overview"

Increased delivery of home-based and family treatment services.

Data shows that most children in RPTC have families who have experienced problems such as parental substance abuse, mental illness, abuse or neglect. As a result, there is a clear need for family treatment to help children return home successfully.

However, chart #3 and chart #4 show that few children are receiving family services and that limited services are being delivered: *to be effective, even a "brief" family therapy model would include one or more sessions per week for 3 to 6 months (12 to 48 hours).*

Chart 3

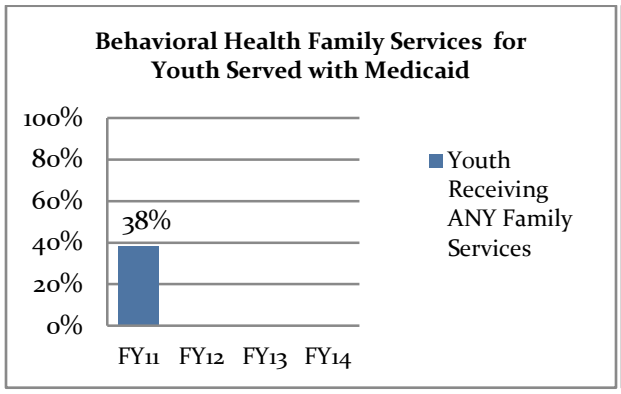
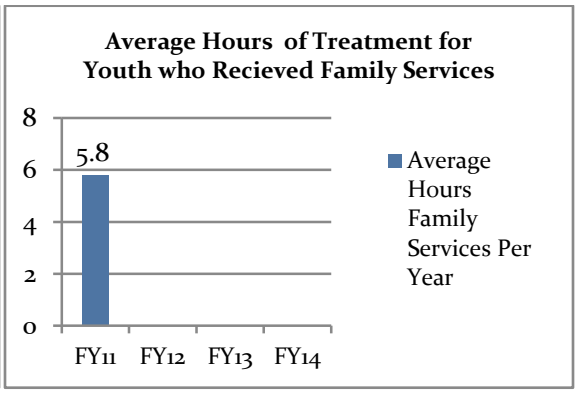


Chart 4



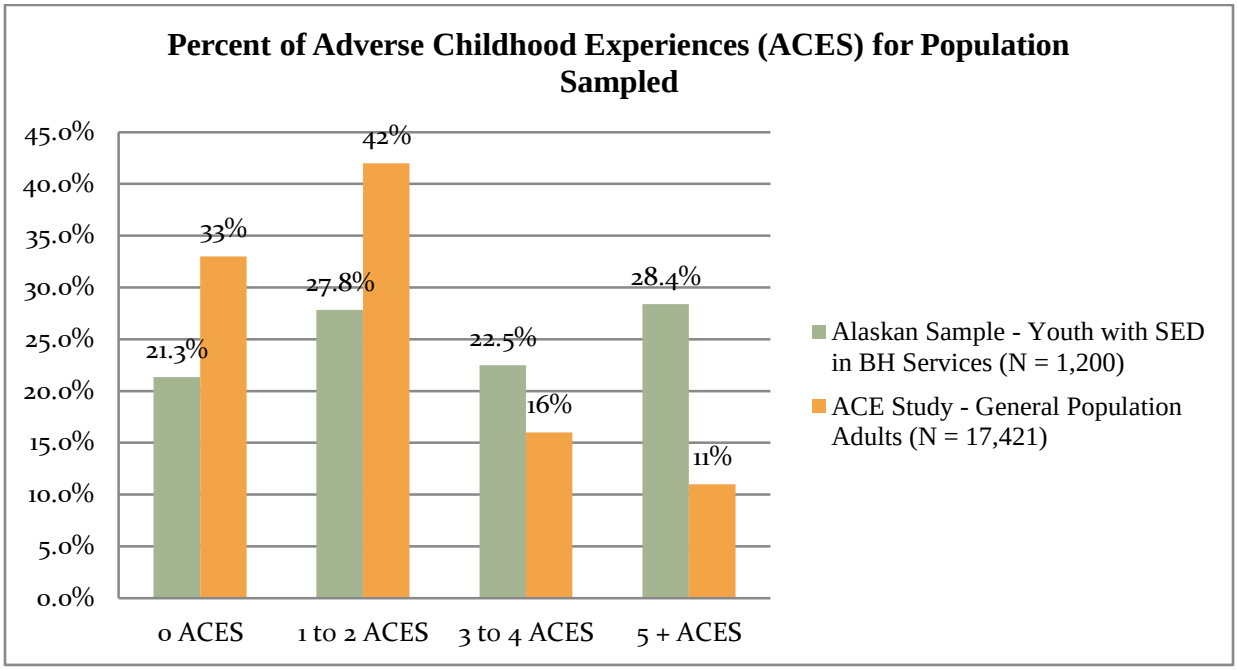
Data source: MMIS Data for youth receiving any "family service" including: family therapy, family skill development or other service to a family.

Maximize clinical utility and application of the Alaska Screening Tool and the Client Status Review to inform treatment and show meaningful outcomes.

The Alaska Screening Tool (AST) is a standardized instrument required of all clients entering Behavioral Health treatment services. Building on the Adverse Childhood Experiences Study, (ACES) the AST includes "accumulated adverse experiences". The correlation between ACES and many chronic conditions has been established in the more than fifty peer reviewed articles that have been published. The graded relationship between the number of ACES and many chronic conditions strongly suggest that a reduction in ACES would lead to a reduction in other adverse outcomes.

The DBH has taken steps to incentivize providers to implement and maximize the clinical utility of the AST through regulation reimbursement and prescription of using the AST to inform the assessment and subsequent treatment. An example of emerging reporting is presented.

"AST Adverse Experience for BH Clients vs. General Population"



Data Sources:
Alaskan Youth with SED - AKAIMS: Date range between 7/23/2011 and 7/23/2012
General Population of Adults – ACE Study
http://acestudy.org/yahoo_site_admin/assets/docs/ARV1N1.127150541.pdf

Implementation of policy and regulation changes to support in-home and community-based service expansion. Examples of system changes post-BTKH include:

1. An enhanced review process is in place for children referred to out-of-state RPTC: all children must first access in-state resources as appropriate.
2. A flexible funding pool developed for services to divert or step youth down from residential care.
3. A start-up grant program is in place to improve in-state service capacity for best practices, Medicaid billing, etc.
4. A demonstration waiver resulted in strategies to divert children with severe emotional disturbances and fetal alcohol spectrum disorders from RPTC to community services.
5. RPTC admitting and continued stay criteria have been rewritten. Phase II will include tightening up of this criteria.

6. RPTC requirements for family therapy and for discharge planning were increased.
7. Prior authorization criteria for acute care were refined to more accurately place children. (Acute care is the most frequent entry point into RPTC).
8. DHSS staff was assigned to work with Acute Care to facilitate in-state service delivery.
9. Medicaid rates for services delivered in the home were increased.
10. Work started towards integration of the residential treatment systems for children in DHSS custody with the Behavioral Health residential treatment system.
11. The Complex Behaviors Collaborative was implemented to develop services for children and youth with co-occurring mental health and developmental challenges in their homes and communities. A DHSS/provider work group was established to work on system issues.
12. Work started towards new regulations to expand behavioral health services for young children in order to prevent development of severe disorders.

Expanding collaboration to improve behavioral health service systems. Examples:

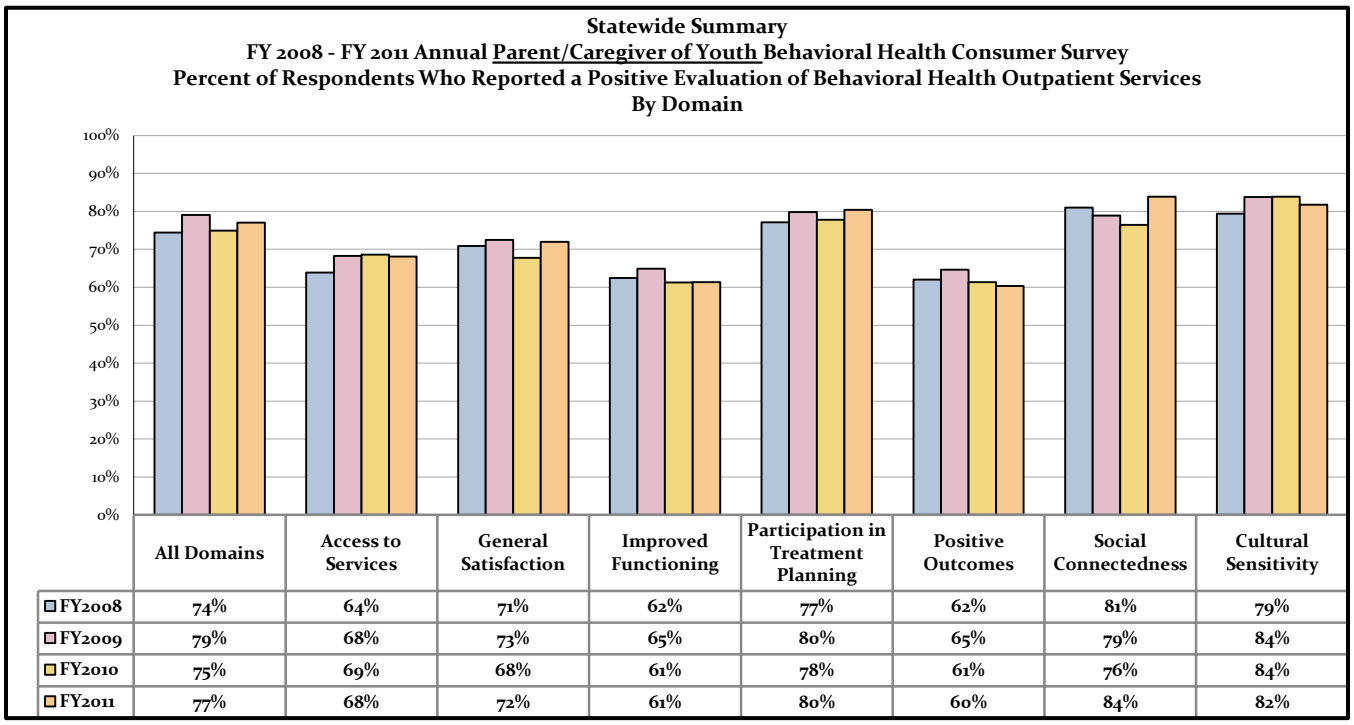
1. The "Alliance for Education and Behavioral Health" was established to work on expanding access to school-based behavioral health services.
2. The Tribal Behavioral Health BTKH work group and the DHSS "tribal team" were formed with a new position (funded by BTKH) to coordinate work.
3. The BTKH stakeholder group was established to provide input into policy, funding and system development work. Planning for long-term collaboration to monitor system functioning after BTKH is starting.
4. The *Family Voice* grant through the Alaska Mental Health Board was established to increase family and youth voice in planning and system development.
5. Peer navigation was developed to provide services and supports to parents and youth by peers. A *Youth Move* group was formed to increase youth voice in system development and planning.
6. A transition-age youth work group meets as needed to address issues such as housing and supports for youth of transition age.

Implementation of mechanisms to monitor system performance over time.

DHSS has developed a robust ability to evaluate system functioning and outcomes. This includes use of the results based accountability (RBA) framework to monitor the impact of projects and initiatives. The Division of Behavioral Health has established a number of broad data points (beyond the BTKH specific data) in order to monitor system functioning over time. Specific RBA performance measures have been developed in the following categories for children and youth: Acute Care Volume; Access to Treatment; Emergency Medical Services Volume; Engagement & Retention; and Treatment Outcomes. This includes monitoring client satisfaction and outcomes (Charts 4 and 5).

As a part of this, DHSS will establish an on-going review process for BTKH related performance measures once the initiative has ended: this may involve a yearly data review and planning session for the children's system of care, as part of a DBH Change Agent meeting.

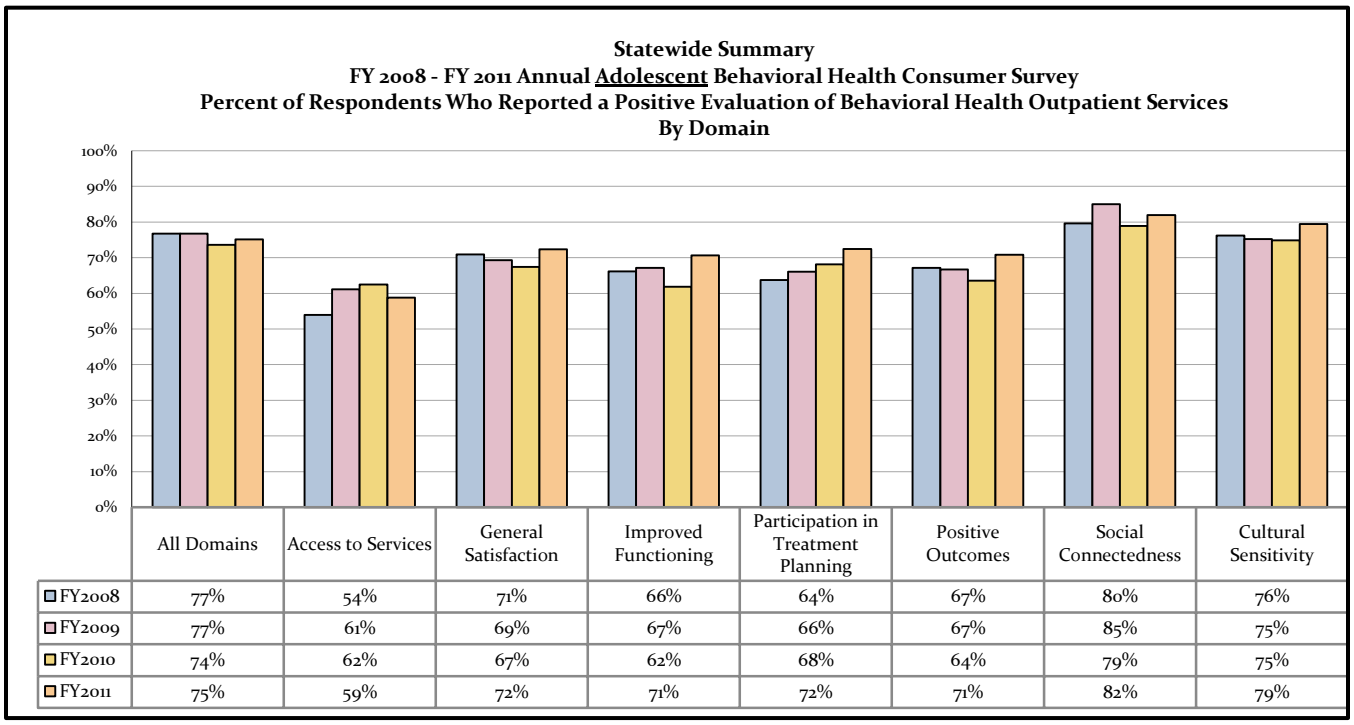
Chart 4



	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Cultural Sensitivity
FY2008	74%	64%	71%	62%	77%	62%	81%	79%
FY2009	79%	68%	73%	65%	80%	65%	79%	84%
FY2010	75%	69%	68%	61%	78%	61%	76%	84%
FY2011	77%	68%	72%	61%	80%	60%	84%	82%

Data Source: Division of Behavioral Health "FY2008 – FY2011 Annual Behavioral Health Consumer Survey Return Rates and Client Evaluation of Outpatient Services, Statewide Report Card" June 1, 2012

Chart 5



	All Domains	Access to Services	General Satisfaction	Improved Functioning	Participation in Treatment Planning	Positive Outcomes	Social Connectedness	Cultural Sensitivity
FY2008	77%	54%	71%	66%	64%	67%	80%	76%
FY2009	77%	61%	69%	67%	66%	67%	85%	75%
FY2010	74%	62%	67%	62%	68%	64%	79%	75%
FY2011	75%	59%	72%	71%	72%	71%	82%	79%

Data Source: Division of Behavioral Health "FY2008 – FY2011 Annual Behavioral Health Consumer Survey Return Rates and Client Evaluation of Outpatient Services, Statewide Report Card" June 1, 2012

How do Trust beneficiaries benefit from this system change?

The following actions result in an improved and connected in-state service continuum for children with, or at risk for, severe emotional disturbances

- Increase in-state capacity for all levels of care
- Decrease utilization of out-of-state residential care
- Increase capacity and funding for home-based services
- Expand and utilize best practices
- Refine policy and regulations to support the system changes
- Improve the quality and accessibility of services provided
- Create new mechanisms to monitor system access, outcomes and service utilization
- Cross-system communication - Improve integration among the systems serving Trust beneficiaries to provide better links with community health care services.

What is the story?

As early as 1998, several factors were contributing to a less than ideal service delivery system for children in Alaska. First, a shift to use of Medicaid to fund behavioral health services allowed access to federal match resources. However, many in-state providers did not have the expertise or infrastructure to effectively access Medicaid. And Denali Kid Care expanded access to Medicaid, bringing more non-custody youth into behavioral health services. Since Medicaid is less flexible than grant funding, this made it more difficult to implement individualized, community-based behavioral health plans. Several other factors also challenged the capacity of the in-state system:

- Inadequate gate keeping and resource referral functions for behavioral health residential care,
- limitations in behavioral health funding and service delivery gaps,
- workforce issues, and
- few mechanisms to support collaboration between providers or across state divisions.

Thus, there was an increasing reliance on out-of-state residential treatment centers as families sought services for their children. This resulted in Trust beneficiaries ending up in out-of-state RPTC beds, including many who might have been effectively served at a lower level of care or at an in-state RPTC had the resources been available or, had the family been aware of the resources. Because of these factors, the Bring the Kids Home partners joined to implement a strategy to mitigate the deficiencies of the service delivery system for youth in Alaska.

What stakeholders and key partners have contributed to system change?

The Trust collaborated with the Department of Health and Social Services and multiple statewide stakeholders to implement this strategy. The BTKH accomplishments were the result of strong partnerships between different individuals and organizations including: State Planning Boards (Alaska Mental Health Board, Substance Abuse Directors Association, Governor's Council, Traumatic Brain Injury Board), youth and parent advocates, providers, tribal organizations, schools and the Department of Education and other community organizations and individuals.