

Bring the Kids Home Focus Area RPTC Medicaid Expenditures Payments

Program Performance Accountability

1. Who are our customers?

Customers of the Bring the Kids Home (BTKH) Focus Area include all children in Alaska with, and at risk for, severe emotional disturbances. The goal of the Bring the Kids Home 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.

2. How can we measure if our customers are better off?

By tracking the expenditures for out-of-state RPTC as compared to in-state and overall RPTC, we can determine how successful BTKH has been at changing treatment patterns and resource utilization. Shifting expenditures from out-of-state RPTC to in-state RPTC and to services at lower levels of care has increased in-state capacity, supported implementation of best practices and decreased the overall number of children in RPTC.

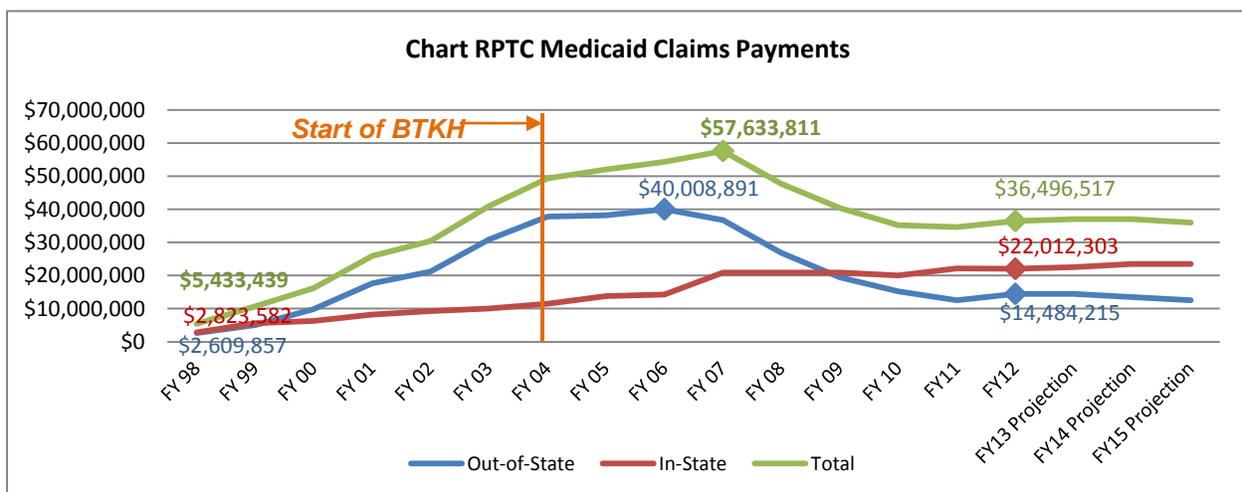
3. How are we doing?

Cross year comparison:

- Total RPTC Medicaid expenditures for FY12 are 37% lower than SFY07.
- Out-of-state Medicaid expenditures for FY12 are 64% lower than the high year of FY06.

Current year:

- Between FY11 and FY12, out-of-state RPTC Medicaid expenditures increased by 14%.
- Between FY11 and FY12, in-state RPTC Medicaid expenditures decreased by .7%.
- Between FY11 and FY12, total RPTC Medicaid expenditures increased by 5%.



The above graph shows in-state and out-of-state Medicaid claims payments between FY 1998 and FY 2012.

Source of data: Medicaid Management Information Systems (MMIS). Performance Measure is tracking number of kids at RPTC level and does not include lower level care patients.

4. What is the story behind the curve?

Between FY 1998 and FY 2004, the Alaska service system began relying on out-of-state residential psychiatric treatment centers (RPTCs) to serve youth experiencing severe emotional disorders, and out-of-state placements grew by 802% (from 83 to 749 children). As a result, out-of-state Medicaid claims payments increased quickly. For FY 2004, the State of Alaska paid almost \$40 million for Alaskan children with severe emotional disturbances to receive services in out-of-state RPTCs.

A number of factors contributed to the increase in reliance on out-of-state residential psychiatric treatment center services, including:

- Lack of gate-keeping and resource coordination
- Limited in-state Residential Psychiatric Treatment Center (RPTC) bed capacity
- Lack of clearly articulated best practice guiding principles for the behavioral health system, and poor integration of desirable principles into the regulations, policies, procedures, and practices of the Alaska behavioral health system.
- Workforce issues employee turnover in beneficiary-related service positions,
- Service gaps including insufficient in-home services and family therapy, and inadequate access to services in rural areas and for youth who have challenging presentations.
- Lack of support for performance improvement and implementation of best practices
- Resource issues including lack of adjustment for market changes for Medicaid rates, limitations on access to existing beds and lack of funding for individualized needs.
- Little incentive or support for coordination across systems

As a result of these factors, children were not able to access in-state services and were placed into out-of-state RPTC too frequently. In FY2004, the Bring the Kids Home (BTKH) focus area was initiated by the Trust, in partnership with the Department of Health and Social Services and stakeholders. The focus area and its partners aimed to raise the bar by shifting resources from supporting out-of-state RPTC to instead supporting expanded in-state services.

Between FY2004 and FY 2006, the impact of BTKH on RPTC placement patterns resulted in turning the curve in terms of decreased out-of-state Medicaid RPTC expenditures. Strategies that contributed to this progress included:

- Articulating the Bring the Kids Home Guiding Principles and beginning to build these into the behavioral health system at the State level and at the Provider level.
- Alaska statute 47.07.032 clarified that before approving out-of-state RPTC placement, the Department of Health and Social Services is required to determine that the services are unavailable in the state. This resulted in a new process for review of out-of-state RPTC referrals and helped to divert many RPTC referrals to in-state resources.
- Improving access to existing in-state beds at RPTC and at other levels,
- Creating new beds (as needed) at all levels of care,
- Creating non-residential services to help youth stay at home,
- Providing services earlier to prevent the need for RPTC level of care,
- Helping youth and families access in-state services effectively,
- Monitoring out-of-state referrals to ensure full utilization of in-state resources,
- Changing the Medicaid RPTC eligibility review process for non-custody youth,
- Providing support for implementing best practices.

Out-of-state RPTC Medicaid expenditures are dependent upon three things:

1. The rate paid for the RPTC beds: for FY2012, there was no change in the cost of beds.
2. The number of youth served: for FY12 there was an increase to the overall number of youth served and there was an increase to the number of youth admitted to RPTC.

3. The average length of stay (LOS) for the youth served. During FY12, the LOS for out-of-state RPTC decreased and the length-of-stay for in-state RPTC increased. Acuity level impacts the length of stay, so this may be reflecting the fact that more children with challenging presentations are remaining in-state for care.

Given these factors, we project that for FY13 the Medicaid expenditures for out-of-state RPTC may either slightly increase or remain about the same. Many youth out-of-state have co-occurring conditions and all have extreme behaviors. In-state providers continue to experience workforce challenges which limit their capacity to serve highly complex youth, and in addition, are using tools such as the Individualized Service Agreement less frequently due to administrative changes in the process.

During FY13, the “Complex Behaviors Collaborative” and other efforts within DHSS to increase access to in-state services for children with co-occurring conditions will help to stop children from leaving the state and will assist some children to remain home. However, the increased number of children admitted during FY12 is likely to impact expenditures for FY13 as children finish treatment out-of-state.

During FY14 and FY15, we anticipate that efforts to develop services for children with complex and co-occurring presentations as well as increased skill in using trauma informed services, improvements around ISA management, and efforts to reach children and families more effectively and earlier will begin to pay off and the number of youth receiving out-of-state RPTC services will again decline and this will drive a decrease in Medicaid expenditures for RPTC.

5. Who are key partners that have a role in turning the curve?

- Alaska Mental Health Trust Authority
- Trust Statutory Partner Advisory Boards
- Family & Youth Advocate Agencies
- Behavioral Health Providers
- Other Community Providers
- Tribal Entities
- Department of Health and Social Services
- Department of Education
- School Districts

6. What works to turn the curve?

The Surgeon General's Report on Mental Illness (USDHHS, 1999) was a children's mental health landmark report on the future direction for service delivery. Eight recommendations were set forth in the Surgeon General's report:

- Continue to build a science base;
- Overcome stigma;
- Improve public awareness of effective treatment;
- Ensure the supply of mental health service providers;
- Ensure delivery of state-of-the-art treatments;
- Tailor treatment to age, gender, race, and culture;
- Facilitate entry into treatment; and
- Reduce financial barriers to treatment

These recommendations guide BTKH planning, and in addition, a variety of evidence-based strategies have informed BTKH. For youth with serious emotional disturbance and complex needs, research has consistently supported better outcomes from a wraparound process than from alternative services¹. One required component of wraparound is access to flexible funding. Family and youth advocates support access to flexible funding, and child welfare research has demonstrated greater rates of reunification with access to flexible

¹ Summary of the Wraparound Evidence Base: April 2010 Update; Bruns, Eric and Suter, Jesse C.
[http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-\(evidence-base\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-(evidence-base).pdf)

funding². BTKH Individualized Service Agreements were developed as an avenue to provide these individualized services.

Reducing system barriers and enhancing collaboration is also essential. A 2004 paper by the National Association of State Mental Health Program Directors outlined strategies to improve services for individuals with co-occurring developmental and behavioral health challenges. Strategies included cross system communication, data development and tracking, use of best practices, and use of a universal assessment tool³. DHSS is working internally and with providers to improve collaboration and services for youth who span these systems.

Most children in out-of-state RPTC have families who have experienced serious challenges such as substance abuse, mental health problems, domestic violence, abuse or neglect. To keep children at home, families must have access to effective parenting strategies, a support network and to resource navigation. Alaska has adopted a *Family Peer Support* model with services through the Alaska Youth and Family Network (AYFN). The family movement has developed of two roles for families in systems of care: *Families as Service Coordinators* and the *Family as Faculty*⁴. This is currently being practiced by AYFN through *Parenting with Love and Logic*[®] classes which provide practical training to raise responsible children, enjoy parenting and make changes in children's behavior⁵. In addition to peer services; families require intensive clinical and in-home services. *Parenting with Love and Limits*[®] (PLL) is an evidence-based treatment for children with severe disturbances and their families that is being implemented in Alaska. PLL outcome studies have found lower recidivism and better improvement for PLL as compared to control group youth and families⁶. DHSS is also developing a 'home grown' strategy to support performance improvement for family therapy and in-home services in order to achieve statewide system improvement.

The lack of school-based services also undermines youth success in community settings. When children cannot remain in school and require parental supervision during work hours, family stress increases and this can ultimately result in an out-of-home placement. The Center for Mental Health Services (CMS) identified three key school-based behavioral health practices:⁷ using clinicians and student support providers, focusing on wraparound and case management services, and providing school wide prevention and early intervention programs. *Positive Behavioral Intervention and Supports* is a model that includes these CMS key practices and that is being supported through BTKH and through the education and school districts.

Most youth in RPTC have a history of complex trauma. The *Attachment, Self-Regulation and Competency Clinical Services* (ARC) framework is recognized as a promising practice. ARC is being practiced in Anchorage to address interventions and improve outcomes for youth exposed to complex trauma⁸. In addition, trauma informed treatment strategies are being implemented in residential and community-based settings and in Juvenile Justice facilities.

Young people with behavioral health challenges often experience homelessness, unemployment, poverty and reliance on emergency health and mental health services as they move into adulthood. The *Transition to Independence Process* (TIP) is an evidence-supported practice to assist young people with severe disturbances to transition to adulthood with better outcomes. Six outcome studies have demonstrated improved postsecondary progress through TIP⁹ and early implementation data in Alaska is showing strong outcomes.

² Children's Bureau, 2010b; Wulczyn & Martin, 2001; Wulczyn, Zeidman, & Svirsky, 1997

³ National Association of Mental Health Program Directors "Serving Individuals with Co-Occurring Developmental Disabilities and Mental Illnesses: System Barriers and Strategies for Reform, 2004".

http://www.nasmhpd.org/general_files/publications/MIDD%20report102704FINAL.pdf

⁴ Osher, deFur, Nava, Spencer, & Toth-Dennis, 1999

⁵ See Love and Logic website: <http://www.loveandlogic.com/>

⁶ Professional Issues in Criminal Justice, Vol 6, Reducing Adolescent Oppositional and Conduct Disorders: An Experimental Design Using the Parenting with Love and Limits[®] Model, Scott P. Sells, Kristin Winokur Early, Thomas E. Smith, 2011

⁷ Burns & Goldman, 1999

⁸ Kinniburgh, Blaustein, Spinazzola & van der Kolk 2005, Psychiatric Annals

⁹ Theory and Research Underpinnings Supporting the Transition to Independence Process (TIP) Model;

<http://www.tipstars.org/TIPModelEvidence.aspx>

A history of adverse events results in risk taking behaviors in adolescence and adulthood including alcoholism and drug abuse, suicide attempts, and multiple sexual partners¹⁰. As adults, children exposed to adverse events have higher risks for heart disease, stroke, diabetes, mental illness and other chronic health problems. Early Childhood Mental Health Consultation (ECMHC) is a best practice to intervene with young children in their family, day care and early learning settings. ECHC is being piloted in several sites using BTKH funding.

DHSS is using a “tribal team” approach that provides DHSS staff support, training tools and contractors to assist tribal behavioral health agencies to implement strategies to expand access to Medicaid and increase local service delivery. This is an expansion of on-going TA that DHSS has provided through Health Care Services and outcomes are still being monitored for this practice.

7. What do we propose to do to turn the curve?

In order to continue to reduce out-of-state RPTC placements, Alaska must have behavioral health services that are collaborative, individualized and able to work with youth with co-occurring conditions, complex trauma, and with aggressive and challenging presentations. Services must also engage families effectively and develop the resources and resilience needed for children to return to or remain in their homes. In addition, services must reach children and families before needs become complex and out-of-home placement is indicated. The following activities will help achieve these goals:

- RPTC admitting and continued stay criteria have been rewritten. Phase II will include tightening up of this criteria.
- Continue work to align service delivery with BTKH guiding principles.
- Continue implementation of the Complex Behaviors Collaborative.
- Continue best practice improvement work around trauma informed care.
- Expand access to peer navigation and support services.
- Expand access to family therapy and intensive in-home treatment.
- Expand best practices for youth of transition age.
- Refine the use of ISA to effectively divert residential placements.
- Continue to increase Medicaid-funded culturally competent behavioral health services in rural communities.
- Continue collaboration to expand best practices in the schools.
- Expand best practices for young children with behavioral health problems.
- Intervene with young children with behavioral health and their families in early learning and day care settings through the TACSEI project

¹⁰ See Adverse Childhood Experiences Study website: <http://www.acestudy.org/>