

Bring the Kids Home Focus Area Medicaid RPTC Admissions

Program Performance Accountability

1. Who are our customers?

Customers of the Bring the Kids Home (BTKH) Focus Area include all children and youth 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 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?

A primary goal of BTKH is to reduce the number of children and youth receiving Medicaid funded services outside of Alaska in Residential Psychiatric Treatment Centers (RPTC). One way to achieve this goal is to shift youth from out-of-state RPTC to in-state RPTC and to lower levels of care.

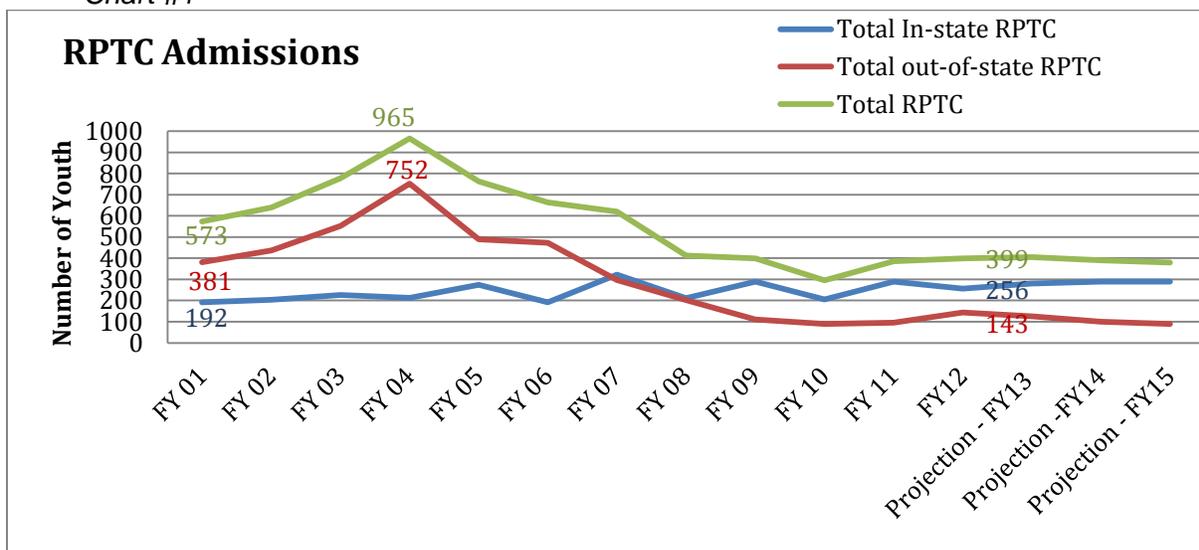
Two measures will track BTKH success: the first measure (chart 1) tracks youth admitted to RPTC both inside Alaska and out-of-state. This monitors our success at decreasing over-reliance on out-of-state RPTC. The second measure (chart 2), tracks youth served in RPTC (in-state and out-of-state) as compared to youth with SED served in community behavioral health services. This measure allows us to better understand how the system is performing in terms of the percent of youth in community services.

3. How are we doing?

Chart 1 illustrates the dramatic changes in RPTC admissions since BTKH began:

- Total RPTC Admissions dropped 59% from FY04 – FY12
- Out-of-state RPTC Admissions dropped 80.9% from FY04 – FY12
- In-state RPTC Admissions increased 33.4% from FY01 to FY12

Chart #1



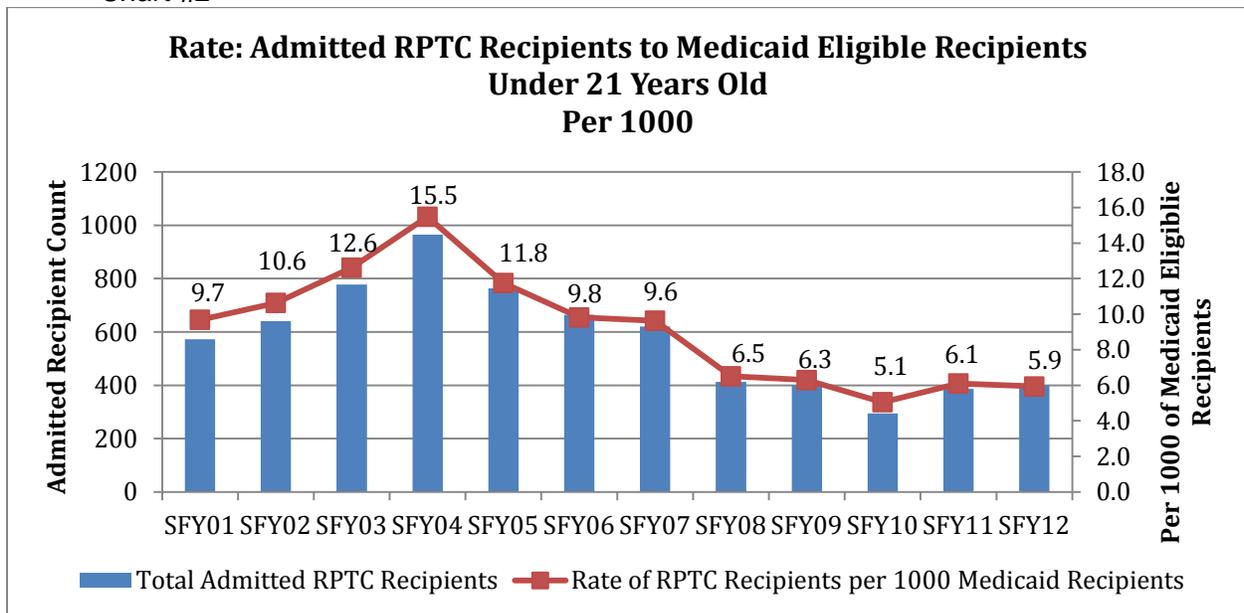
Source: Medicaid Management Information Systems (MMIS). New admissions to RPTC: does not include children admitted a previous year and served during the current year.

Chart 2 shows the number of children admitted to RPTC (both in Alaska and outside of Alaska) and the rate of admissions per 1,000 Medicaid eligible recipients. Medicaid eligible recipients for children and youth increased over 13% from FY2000 to FY2012. While the count of youth admitted to RPTC's appears to be on the rise for the past two fiscal years, this is mitigated when the overall admission/served rate is compared to total Medicaid eligible youth; the finding would indicate an overall decline of clients per 1,000 rate.

SFY 2012, 5.9 per 1,000 youth admitted to RPTCs in-state and OOS is compared to:

- SFY '11, 6.1 per 1,000 youth
- SFY '10, 5.1 per 1,000 youth
- SFY '09, 6.3 per 1,000 youth
- SFY '08, 6.5 per 1,000 youth
- SFY '07, 9.6 per 1,000 youth
- SFY '06, 9.8 per 1,000 youth
- SFY '05, 11.8 per 1,000 youth
- SFY '04, 15.5 per 1,000 youth
- SFY '03, 12.6 per 1,000 youth
- SFY '02, 10.6 per 1,000 youth
- SFY '01, 9.7 per 1,000 youth

Chart #2



Source: DBH Div. of Behavioral Health/Policy & Planning/Research Unit " Bring the Kids Home Initiative: Indicators for SFY2012"

4. What is the story behind the curve?

Between FY98 and FY04, Alaska began relying on out-of-state residential psychiatric treatment centers (RPTCs) to serve youth experiencing severe emotional disorders. Out-of-state placements grew by 802% (from 83 to 749 children and youth) and by FY04, the State of Alaska paid almost \$40 million for out-of-state RPTC. A number of factors contributed to this:

- 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.

In FY04, 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. BTKH efforts resulted in an 80.9% decrease in new admissions to out-of-state Medicaid RPTC between FY04 and FY2=12. Overall RPTC admissions decreased by 59% between FY04 and FY12. Important factors contributing to this included:

- Alaska statute 47.07.032 clarified that DHSS must determine that in-state RPTC services are unavailable before approving out-of-state RPTC. A new RPTC review process helped to divert referrals to in-state resources.
- Peer navigation, parenting skill training, parent support and enhanced care coordination was funded in order to help children and youth remain at/return to home.
- Some new in-state RPTC beds were developed (fewer than were being utilized for children and youth from Alaska).
- Less restrictive in-state services were expanded (treatment foster and group care, crisis stabilization, outpatient services, individualized services funding).
- DHSS increased support for implementation of best practices and technical assistance.
- Flexible funding was made available to pay for individualized needs to keep children in community settings.

These strategies contributed to the steep decline in out-of-state RPTC admissions until FY10. However, between FY10 and FY12, out-of-state RPTC admissions increased (90 to 143 youth) as did *overall* RPTC admissions (295 to 399 youth). A number of factors contributed to these increases:

- One in-state RPTC had been operating only some of the beds that they had available. During FY12, this agency was able to operate a larger number of their licensed beds.
- Most youth moving to out-of-state RPTC have co-occurring needs such as a fetal alcohol spectrum disorder, autism or an intellectual disability *and* histories of complex trauma, abuse, or neglect, *and* parental substance abuse and mental health problems.
- Neither the developmental disabilities providers nor the mental health providers have sufficient training in specialized strategies such as applied behavioral analysis and neither system has sufficient in-home and family-based services.
- Congregate residential services are not available through the developmental disabilities system and individualized services can take over a year to develop.

- Mental health residential providers often exclude youth with an intellectual disability.
- There is a lack of “ownership” for children and youth whose needs fall between systems.
- Some children and youth do not qualify for services until their needs become severe (fetal alcohol spectrum disorder or autism with an IQ above 70).
- Workforce challenges magnify the difficulty of serving complex youth: even when a bed is available, the workforce required to staff the bed may not be available.
- Individualized Service Agreement (ISA) funds were significantly over budget for FY10. This led to changes to increase accountability and improve tracking. However, these changes also significantly decreased utilization of ISA during FY11 and FY12: many providers are no longer using ISA and are less able to provide these individualized services.
- There continue to be service gaps in rural areas of the State for intensive outpatient and brief stabilization services. It is difficult for Alaska Native youth to receive services from local providers of the same culture in their homes and communities.

As a result of these factors, and others, during FY12 there was an increase to out-of-state RPTC admissions and to overall RPTC admissions. BTKH activities are working to drive RPTC admissions down through technical assistance and training, a focus on work with families, and refinements of RPTC admission and continued stay criteria as well as other strategies. By the end of FY13, we anticipate that the number of children and youth in out-of-state RPTC will stabilize or begin to decrease.

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
- Denali Commission
- 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

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)

flexible 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 including 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

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

improved postsecondary progress through TIP⁹ and early implementation data in Alaska is showing strong outcomes.

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 are 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.
- Streamline administration of individualized funding while maintaining accountability for funding use and outcomes.
- 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.

⁹ Theory and Research Underpinnings Supporting the Transition to Independence Process (TIP) Model; <http://www.tipstars.org/TIPModelEvidence.aspx>

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