

State of Alaska  
Department of Health and Social Services  
Division of Behavioral Health  
and

*The* TRUST

The Alaska Mental Health Trust Authority

# Bring the Kids Home Annual Report

December, 2005



**Frank H. Murkowski**  
Governor  
State of Alaska

**Karleen K. Jackson**  
Commissioner  
Department of Health and Social Services

**Christy Willer**  
Director  
Division of Behavioral Health

[www.hss.state.ak.us/dbh](http://www.hss.state.ak.us/dbh)

## Executive Summary

### Overview of the Problem

- Between 1998 – 2004, the children’s behavioral health system in Alaska has become increasingly reliant on institutional care - Residential Psychiatric Treatment Center (RPTC) care for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC care grew by nearly 800%.
- At any given time, approximately 350-400 children are being served in out of state placements. Alaska Native children represent 49% of the custody children sent to out of state placements and 22% of the non-custody children sent to out of state placements.

### The Bring the Kids Home Project

- The Department of Health and Social Services initiated the “Bring the Kids Home” (BTKH) Project to return children being served in out-of state facilities back to in-state residential or community-based care. The following long-term goals have been developed to guide the direction of the BTKH project:
  - Build/develop and sustain the community-based and residential capacity to serve children with all intensities of need within the service delivery system in Alaska.
  - Develop an integrated, seamless service system in Alaska that will allow children and youth to be served in the most culturally competent, least restrictive setting, as close as possible to home as determined to be safe and appropriate.
  - Significantly reduce the existing numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.

### Bring the Kids Home (BTKH) Project Highlights for SFY’05

Between SFY 1998 and 2004 the distinct number of SED youth receiving out-of-state RPTC care has steadily increased- on average 46.7% per year. During the same time period the distinct number of in-state RPTC recipients has remained relatively flat, showing little change. The RPTC population as a whole has also showed steady increase from SFY 98-04, an average annual increase of 24.8%. Between SFY 2004 and 2005:

- The distinct number of RPTC recipients increased only 3.8%- the smallest increase since the inception of Medicaid data.
- The distinct number of Out-of-State RPTC Medicaid recipients **decreased 5.1%**- the first decrease in the OOS RPTC population since 1998.
- The distinct number of In-State Medicaid RPTC recipients increased 34.7%.
- After years of steady increases, the out-of-state, non-custody Medicaid RPTC population decreased 6.6% between SFY 2004 and 2005.
- After years of remaining relatively flat, the in-state, non-custody population had a 48.2% increase in the number of distinct recipients.

Between SFY 1998 and 2004 out-of-state RPTC Medicaid expenditures experienced an average annual increase of 59.2% and an overall increase of over 1300%. During the same

time period in-state RPTC Medicaid expenditures increase a little more than 300% and realized smaller average annual increases of 29.6%.

Between SFY 2004 and 2005:

- Out-of-State RPTC Medicaid expenditures **increased by only 1.1%**- the smallest annual increase since 1998.
- In-State RPTC Medicaid expenditures **increased by 19.8%**.
- Total RPTC Medicaid expenditures increased by 5.5%- the smallest annual increase since 1998.
- RPTC Custody expenditures for the out-of-state custody population experienced a small decrease of 1.3% from SFY 2004 to SFY 2005. Whereas this may seem minor, this decrease in out-of-state expenditures is significant considering the explosive annual historical increases. In-state Non-Custody expenditures increase 34.6% during the same time period.

## ***Overview of the Problem***

Over the past seven years the children's behavioral health system in Alaska has become increasingly reliant on institutional care - inpatient hospital and Residential Psychiatric Treatment Center (RPTC) care - especially out-of-state RPTC care, for treatment of severely emotionally disturbed youth. In the past six years, acute care admissions increased by one-third and total days of inpatient care increased by 90%. Out-of-state placements in RPTC care grew by nearly 700% and in-state RPTC care grew by 145% from FY'98-FY'03. At any given time, approximately 400-500 children are being served in out of state placements, ranging in age from six to seventeen, (average age between 14 and 15). Alaska Native children are over-represented in the population of children in custody and represent 49% of the custody children sent to out of state placements and 22% of the non-custody children sent to out of state placements.

## ***The Bring the Kids Home Project***

The Department of Health and Social Services initiated the "Bring the Kids Home" (BTKH) Project to return children being served in out-of state facilities back to in-state residential or community-based care. The Division of Behavioral Health (DBH) and the Alaska Mental Health Trust Authority (AMHTA) are collaborating in project management of the BTKH. The project intends to reinvest funding now going to out-of-state care to in-state services and develops the capacity to serve children closer to home. With financial support, this initiative will focus on successfully building upon the existing infrastructure to treat youth in their own community, region and state. The following long-term goals have been developed to guide the direction of the BTKH project:

- Build/develop and sustain the community-based and residential capacity to serve children with all intensities of need within the service delivery system in Alaska.
- Develop an integrated, seamless service system in Alaska that will allow children and youth to be served in the most culturally competent, least restrictive setting, as close as possible to home as determined to be safe and appropriate.
- Significantly reduce the existing numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.

## ***Strategies for Change***

The scope of this project requires that four levels of the system of care must be addressed concurrently: community, regional, in-state, and out-of-state care. Further, there are additional issues that are applicable to the overall system of care i.e. policy development, management of authorization, utilization, and enhanced care coordination, workforce development, funding strategies, expansion of facilities and infrastructure, and expansion of services. In order to accommodate the scope of the BTKH Project, seven strategies for change have been identified and will be used to facilitate the organization of the project.

1. Theory of change Articulate and communicate a formal theory of change and continue ongoing communication.
2. Strong family voice Develop a strong family and youth voice in policy development, advocacy, family education and support, and quality control/assurance and evaluation.
3. Examine financing & policy issues
4. Performance & QA measures Ensure that strong performance measurement/continuous quality improvement procedures are in place.
5. Home & community-based services (DBH SED Yth) Develop a wide range of accessible home and community-based services that reduce the need for kids to enter residential care and ease transition back into the community for those in out of home care.
6. Work force development Build the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders.
7. Assessment & Care Coordination Develop “gate keeping” policies and practices and implement regional networks to divert kids from psychiatric residential care.

### ***Bring the Kids Home (BTKH) Project Highlights for 2005***

The project highlights for 2005 are reported in relationship to the related general strategies. The focus of this past year activities have been strongly aligned with the management infrastructure that must be in place in order to implement major system changes. For that reason, many of the activities described are related to policy-procedural-regulation development and facility and service enhancements.

#### **General Strategies**

##### **Strategy 1: Theory of change Articulate and communicate a formal theory of change and continue ongoing communication.**

1. The BTKH Project planning processes have recognized that successful implementation requires an acknowledgement of a broad scope of activity that involves a system wide approach: a community-based, regional, state, and out-of-state level of change within the service delivery system.
2. The BTKH Project recognizes that successful implementation acknowledges issues that are applicable to the overall system of care i.e. policy development, management of authorization, utilization, and enhanced care coordination, workforce development, funding strategies, expansion of facilities and infrastructure, and expansion of services.

##### **Strategy 2: Strong family voice Develop a strong family and youth voice in policy development, advocacy, family education and support, and quality control/assurance and evaluation.**

1. DBH and the AMHTA have attended workshops given by the Disability Law Center to the target audience of consumers and their families. Through this medium, DBH and the AMHTA were able to initiate contact with parents of youth in RPTCs. DBH held a meeting with parents to elicit feedback regarding the

current service delivery system and their ideas for necessary services that would allow their children to be served as close to home as possible. The ideas they shared are being incorporated into the planning for individualized funding mechanisms. In addition, through the connections made at these meetings, DBH and the AMHTA were able to secure consumer representation for the BTKH committees. At the last AMHTA quarterly meeting, a parents night was held to discuss related issues. Consumer turn out was good, and it was decided that these quarterly meetings for consumers and their families should continue.

### **Strategy 3: Examine financing & policy issues**

1. DBH has initiated a planning initiative to define and implement *Individualized Service Agreements*. Funded through the AMHTA, the purpose of Individualized Service Agreements (ISA) is to ensure that SED youth are being served as close to their community as possible, providing clinically necessary services to prevent institutional care. ISA's are the mechanisms through which funds will be withdrawn to provide services to youth that cannot be reimbursed through Medicaid fee-for-service or Behavioral Rehabilitation Services (BRS) financing.
2. DHSS and the Dept. of Education and Early Childhood Education (DEED) are developing a Memorandum of Agreement (MOA) that will add non-custody children to the established practice of reviewing custody youth with intensive behavioral health needs, on regional and out-of-state placement committees.
3. The DBH and Office of Children Services are working with the *Office of Rate Review* in conducting a formal rate review of the OCS Behavioral Rehabilitation Services (BRS). These are residential facilities that are often referred to as "Level II- IV". This rate study will also include RPTC facilities as well. The facility reviews began on 10/24/05, with an estimated completion date of 12/15/05.
4. In collaboration between the DBH, the Office of Program Review, and the Department of Education, school-based behavioral health regulations have been developed. These services will be available for students with Individual Education Plan's, in which behavioral health issues are identified as impediments to their successful educational experience. These services have been constructed in such a manner that different levels of school staff may function as a provider, and ensure that there are not duplicative efforts between school services and existing services of the BH provider network.
5. The Behavioral Rehabilitation Services regulations have been written as a collaboration between DBH and OCS. These regulations are the primary mechanism to begin to access unused beds in OCS/BRS residential facilities for non-custody clients. This will effectively make available approximately 54 beds to the statewide BTKH initiative to increase treatment bed capacity. The BRS regulations have been adopted by the Department, and are in final legal review.
6. The DBH *Policy & Planning Section* has been working with the Department on amending the "Out of State" Regulations. Adjustments to these regulations will change enrollment of out-of-state providers, and enhance DBH's ability to

negotiate costs. Essentially this gives the DBH regulatory authority to manage and authorize out of state providers.

7. DHSS/DBH has negotiated with their contractor First Health Services, to provide two additional Care Coordinators to monitor length of stay and ensure timely discharge of youth from RPTCs.
8. The RPTC Placement Criteria Policy has been rewritten to reflect **Alaska Statute 47.07.032** which asserts that the department may not grant assistance for inpatient psychiatric services to a person under 21 years of age who is in an out-of-state psychiatric hospital facility or an out-of-state residential psychiatric treatment center unless the department determines that the assistance is for psychiatric hospital or residential psychiatric treatment center services that are consistent with the person's clinical diagnosis and appropriately address the person's needs and that these services are unavailable in the state
9. Additional policies related to RPTC placements have been revised that support BTKH. These include policies that address: documentation of medical necessity for services; individualized treatment plans that document specific and measurable treatment objectives and address progress toward goal achievement; specific and detailed discharge plans; family therapy requirements for ages 18-22; certificate of need requirements; enrollment requirements; and therapeutic transitional discharge days.

**Strategy 4: Performance & QA measures Ensure that strong performance measurement/continuous quality improvement procedures are in place.**

1. The DBH and Trust planning process has developed 7 indicators in which to measure the progress and effectiveness of the *Bring the Kids Home Project*.

**Strategy 5: Home & community-based services (DBH SED Yth) Develop a wide range of accessible home and community-based services that reduce the need for kids to enter residential care and ease transition back into the community for those in out of home care.**

1. A Request for Proposals was distributed in the summer of 2005 for Bring the Kids Home: *Home and Community Based Capacity Enhancements*, supported by the Division of Behavioral Health, Mental Health Trust Authority and the Denali Commission. The primary objective of this grant was to provide operational funding for therapeutic alternatives for youth experiencing SED close to their homes and communities. Approximately \$1,050,000 was awarded to ten applicants, proposing to serve up to a total of 193 children and youth in the community. This increased capacity is expected to be available in the spring of 2006.
2. DHSS is in the process of soliciting for further projects to assist in the BTKH Initiative by the end of FY06, including \$188,000.00 for Therapeutic Foster Homes; \$486,000.00 for Home and Community Based Capacity Enhancements and

\$1,250,000.00 for a residential psychiatric facility. These efforts are funded through a combination of the state, AMHTA and the Denali Commission.

3. Juneau Youth Services (JYS), in partnership with the Southeast Area Regional Hospital Corporation (SEARHC) received \$90,000 for planning and design and \$1.5 million of capital funding for their proposed 15-bed Residential Treatment Center. Principal funding was supported through the Denali Commission.
4. The DHSS Children's policy team (CPT) is in the process of developing a pilot project for the MATSU area that will target a subpopulation of children either accessing out of state RPTC care or approved for such care. The pilot project goal is to integrate services across systems by braiding funding and providing enhanced care management to this subpopulation of children and their families. The CPT is in the process of finalizing a letter of interest for this project that is anticipated to be issued in January. Next steps will include an RFP through which a single agency will be identified and an individual service agreement will be issued.

**Strategy 6: Work force development Build the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders.**

1. The workforce development sub-committee met five times by teleconference and once in a face-to-face meeting to draft a workforce development position paper (See Appendix A). The position paper outlines the major working principles that must be in place to improve the workforce serving children and youth in Alaska. Areas covered include 1) standard practice in Alaska; 2) Alaska's workforce development system; and 3) coordination with the overall *Bring/Keep the Kids Home Initiative*.
2. During the April 4 face-to-face meeting, participants developed eight workforce development strategies, some of which are currently being implemented. These strategies include:
  - a. Secure stakeholder input and participation in promoting, implementing and evaluating the desired system of workforce development (targeted approaches).
  - b. Develop matrix of currently available/planned workforce development activities (e.g. university education, training, technical assistance, professional organizations, information, recruitment and retention, pay and benefits) and identify opportunities to collaborate and leverage resources.
  - c. Support the development, implementation and evaluation of the Certificate in Residential Treatment Services (CRTS), the Training Academy and other university Behavioral Health programs, and coordinate with other training centers for articulation into university programs (including arranging for credit/alignment with the Bring the Kids Home agenda).
  - d. Articulate core competencies which can then be infused across the board into Alaska's workforce development system.

- e. Articulate specific competencies for bringing and keeping the kids home and translate into Alaska’s workforce development system.
  - f. Identify and secure sources of funds to offset training costs to families, youth and providers (across all staff levels).
  - g. Develop and conduct training events followed up by protracted training and technical assistance (e.g. FAS/CODI models).
  - h. Conduct “backwards assessment” to determine what could have been done to keep kids home, assess what’s working as kids come home (one kid at a time) and translate into workforce development learning opportunities.
3. Assistance in developing a University of Alaska distance-delivered certificate program focused on residential services to a) increase the number of trained, entry-level staff employed in residential environments and b) increase the demonstrated skill level of the trained employees. Planning activities included a) two full-days with national consultants; b) learning about national view on best practices and evidence-based practices; c) developing draft-set of competencies; d) developing draft-curriculum and fit with assorted University of Alaska programs; and e) reviewing ways to deliver just-in-time training.
  4. Participation in planning the September 28-29 Behavioral Health Workforce Development Summit to ensure the inclusion of speakers and topics relevant to the Bring/Keep the Kids Home Initiative. In addition, the draft position paper and workforce development were presented for audience feedback during one of the Summit sessions.
  5. Participation in teleconferences with staff of the National Technical Assistance Center for Children’s Mental Health at Georgetown University to 1) identify workforce development strategies being used in other states and 2) determine applicability to Alaska.

**Strategy 7: Assessment & Care Coordination Develop “gate keeping” policies and practices and implement regional networks to divert kids from psychiatric residential care.**

1. DBH is collaborating with OCS and DJJ in the development of Regional Resource Placement Committees. It is the intent of this planning to expand the role of these placement committees to provide gate keeping functions for custody and non-custody children, insuring that the appropriate level of care is matched with the client’s clinical needs, as close to their community and family as possible.
2. In collaboration with The Division of Health Care Services, DBH has contracted with McKesson Corporation in the use of a *Level of Care Assessment*, referenced as “*InterQual*”. The population includes adults, adolescents, and children for chemical dependency, mental health, and co-occurring disorders. Two pilot sites have been selected for initial application of the Level of Care Assessment: (1) children in acute care settings, and (2) adults in the DET program, both of which will be implemented in early 2006.

3. The Division of Behavioral Health (DBH) within the Dept. of Health and Social Services (DHSS) has created three Utilization Review positions (supported by funding from the Alaska Mental Health Trust Authority (MHTA)). These positions ensure that all in-state resources are used prior to a young person being placed in an out-of-state RPTC. These positions have been hired and are engaged in the following activities:
  - Engaged with acute care facilities to ensure clinical appropriateness of those youth being referred to RPTC level of care.
  - Developed a database to track youth referred from acute care facilities to RPTCs and other lower levels of care.

### ***Project Outcome Indicators***

Early in the planning process of the BTKH Initiative, measuring progress was valued and given priority in the development of strategies for project implementation. This priority was defined in *Strategy 4: Performance and QA Measures*. From this strategy, seven indicators were defined by identified priority areas of the service delivery system in order to measure progress of the BTKH Initiative. The indicators are presented in their original form.

The DBH *Policy and Planning* section is tasked with generating reports on these indicators, accounting for multiple challenges. As part of the implementation on reporting, *Policy & Planning* conducted an analysis and review of each indicator, respective of available data sources, the parameters and relevance of each indicator, and the most appropriate reporting methodology.<sup>1</sup> Using a foundation of *Continuous Quality Improvement*, it is anticipated that *Policy and Planning* will be working with the “data workgroup” on refining the indicators over time, as well as, developing a more comprehensive method of measurement for the service delivery system.

***Indicator 1:*** *Client Shift- A reduction in the total number of SED children / youth placed in out-of-state RPTC care by 90 percent by SFY 2012 (15% per year)*

### **Findings:**

(Reference Table 1-3)

Between SFY 1998 and 2004 the distinct number of SED youth receiving out-of-state RPTC care has steadily increased- on average 46.7% per year. During the same time period the distinct number of in-state RPTC recipients has remained relatively flat, showing little change. The RPTC population as a whole has also showed steady increase from SFY 98-04, an average annual increase of 24.8%. Between SFY 2004 and 2005:

- The distinct number of RPTC recipients increased only 3.8%- the smallest increase since the inception of Medicaid data.
- The distinct number of Out-of-State RPTC Medicaid recipients **decreased 5.1%**- the first decrease in the OOS RPTC population since 1998.
- The distinct number of In-State Medicaid RPTC recipients increased 34.7%.

(Reference Table 4-5)

---

<sup>1</sup> Addendum A: “Data Definitions and Feasibility Review”.

- After years of steady increases, the out-of-state, non-custody Medicaid RPTC population decreased 6% between SFY 2004 and 2005.
- After years of remaining relatively flat, the in-state, non-custody population had a 48.2% increase in the number of distinct recipients.

Table 1<sup>2</sup>

Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year								
	SFY 98	SFY 99	SFY 00	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05
<b>Out of State</b>	83	149	247	429	536	637	749	711
<b>In State</b>	139	217	221	211	208	215	216	291
<b>Total</b>	<b>222</b>	<b>366</b>	<b>468</b>	<b>640</b>	<b>744</b>	<b>852</b>	<b>965</b>	<b>1,002</b>

Table 2

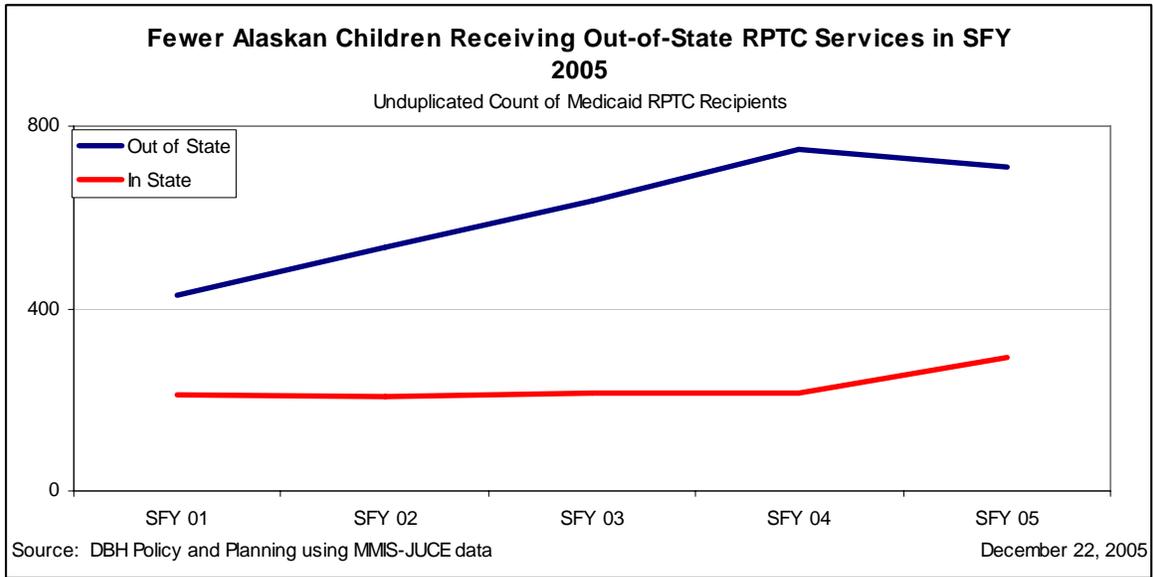


Table 3

Percentage of Increase (Decrease) between SFY- Distinct RPTC Medicaid Recipients								
	SFY 98	SFY 99	SFY 00	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05
<b>Total</b>	0.0%	64.9%	27.9%	36.8%	16.3%	14.5%	13.3%	3.8%
<b>Out of State</b>	0.0%	79.5%	65.8%	73.7%	24.9%	18.8%	17.6%	-3.7%
<b>In State</b>	0.0%	56.1%	1.8%	-4.5%	-1.4%	3.4%	0.5%	30.1%

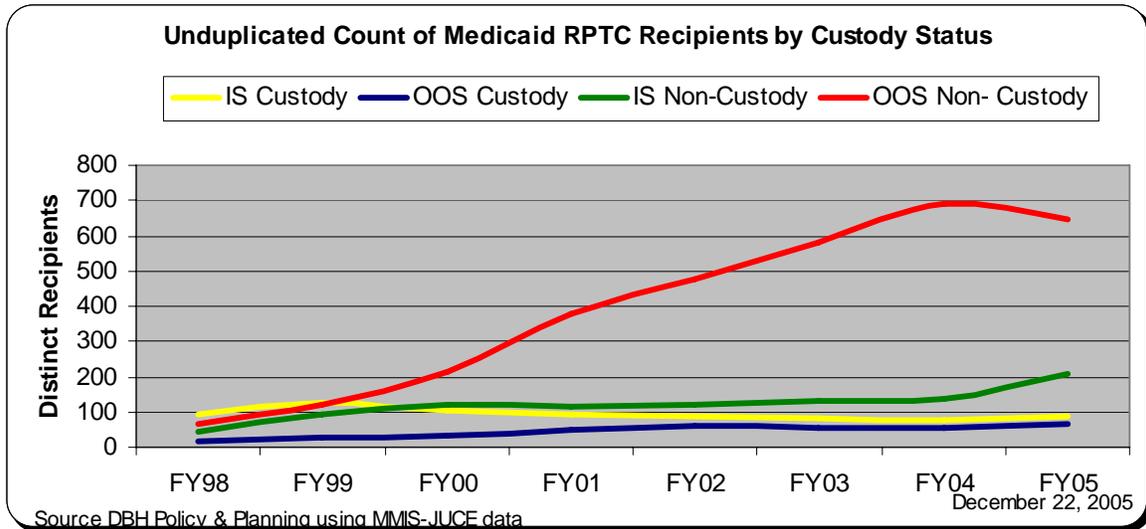
Table 4

Unduplicated Count of Medicaid RPTC Recipients by Custody Status								
	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05
IS Custody	94	124	102	95	86	81	77	85
OOS Custody	17	28	34	49	58	57	56	64

<sup>2</sup> Prepared by DBH Policy & planning: source MMIS-JUCE (122/22/05)

IS Non-Custody	45	93	119	116	122	134	139	206
OOS Non-Custody	66	121	213	380	478	580	693	647
<b>Total</b>	<b>222</b>	<b>366</b>	<b>468</b>	<b>640</b>	<b>744</b>	<b>852</b>	<b>965</b>	<b>1,002</b>

**Table 5**



**Indicator 2:** Funding Shift- Ninety percent reduction in Medicaid / General Fund match dollars from out-of-state services to SED children / youth with a corresponding increase in Medicaid / General Fund match dollars for in-state services by SFY 12. (15 percent per year)

**Findings:**

(Reference Table 6-8)

Between SFY 1998 and 2004 out-of-state RPTC Medicaid expenditures experienced an average annual increase of 59.2% and an overall increase of over 1300%. During the same time period in-state RPTC Medicaid expenditures increase a little more than 300% and realized smaller average annual increases of 29.6%. Between SFY 2004 and 2005:

- Out-of-State RPTC Medicaid expenditures **increased by only 1.1%**- the smallest annual increase since 1998.
- In-State RPTC Medicaid expenditures **increased by 19.8%**.
- Total RPTC Medicaid expenditures increased by 5.5%- the smallest annual increase since 1998.

(Reference Tables 9-11)

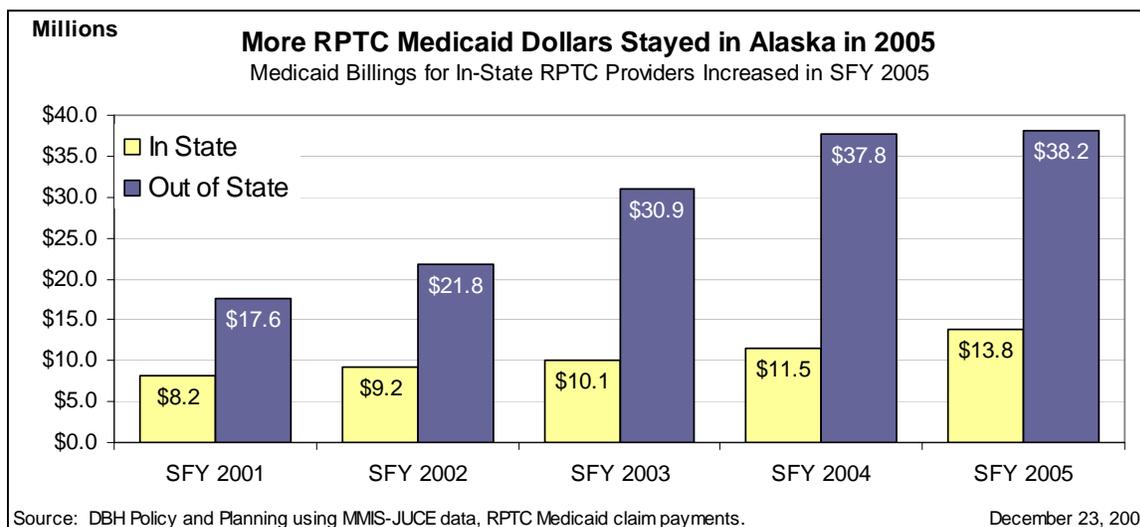
- RPTC Custody expenditures for the out-of-state custody population experienced a small decrease of 1.3% from SFY 2004 to SFY 2005. Whereas this may seem minor, this decrease in out-of-state expenditures is significant considering the explosive annual historical increases. In-state Non-Custody expenditures increase 34.6% during the same time period.

**Table 6**

RPTC Medicaid Claims Payments								
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005

<b>In State</b>	2,823,582	5,623,347	6,286,219	8,242,948	9,229,970	10,093,200	11,532,083	13,812,640
<b>OOS</b>	2,609,857	5,098,190	9,873,606	17,609,108	21,752,228	30,915,287	37,794,191	38,202,707
<b>Total</b>	<b>5,433,439</b>	<b>10,721,537</b>	<b>16,159,825</b>	<b>25,852,056</b>	<b>30,982,198</b>	<b>41,008,487</b>	<b>49,326,274</b>	<b>52,015,347</b>

**Table 7**



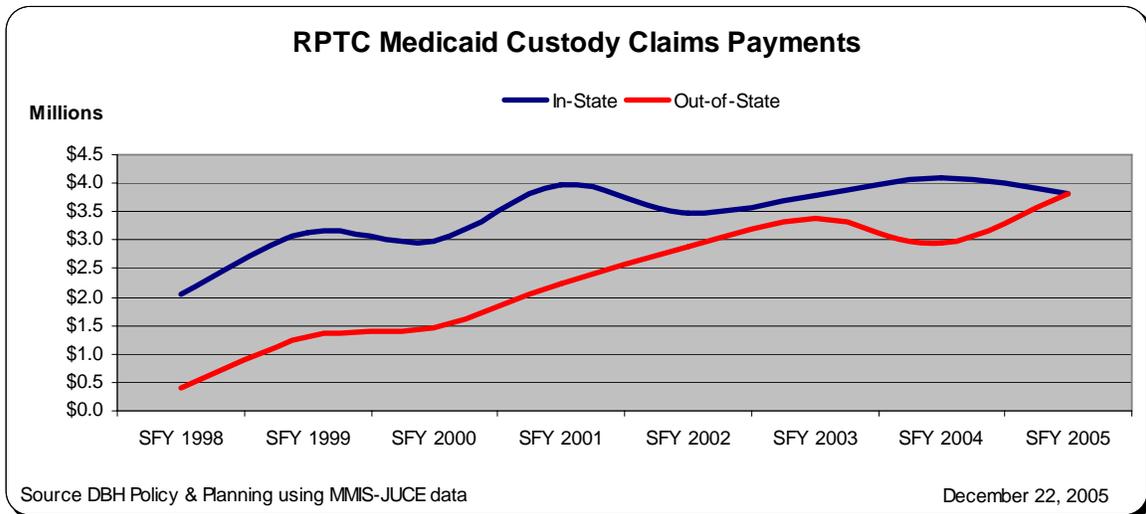
**Table 8**

Percentage of Increase Between SFY- Medicaid RTPC Claims Payments								
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005
<b>Total</b>	-	97.3%	50.7%	60.0%	19.8%	32.4%	20.3%	5.5%
<b>In State</b>	-	99.2%	11.8%	31.1%	12.0%	9.4%	14.3%	19.8%
<b>OOS</b>	-	95.3%	93.7%	78.3%	23.5%	42.1%	22.3%	1.1%

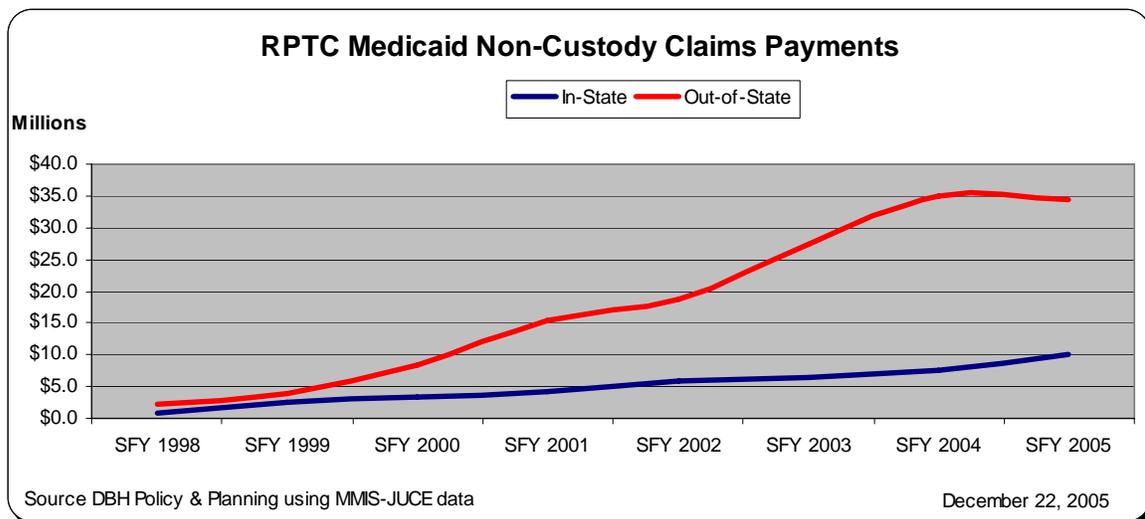
**Table 9**

RTPC Medicaid Claims Payments by Custody Status								
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005
<b>IS Custody</b>	2,048,868	3,138,245	2,967,974	3,974,894	3,477,075	3,796,000	4,102,277	3,809,456
<b>OOS Custody</b>	401,489	1,290,044	1,450,504	2,245,852	2,877,001	3,381,025	2,949,086	3,807,682
<b>IS Non-Custody</b>	774,714	2,485,103	3,318,245	4,268,054	5,752,895	6,297,200	7,429,806	10,003,184
<b>OOS Non-Custody</b>	2,208,368	3,808,145	8,423,102	15,363,256	18,875,227	27,534,262	34,844,953	34,395,025
<b>Total</b>	<b>5,433,439</b>	<b>10,721,537</b>	<b>16,159,825</b>	<b>25,852,056</b>	<b>30,982,198</b>	<b>41,008,487</b>	<b>49,326,122</b>	<b>52,015,347</b>

**Table 10**



**Table 11**



**Indicator 3:** *Length of Stay- Reduction in the average length of stay for in-state and out-of-state residential institutions by 50 percent by SFY 2012.*

This indicator is being reported on in two different ways: “service days” and “average length of stay”.

**Service Days**

**Findings:**

(Reference Tables 12 - 18)

- Out of State aggregate bed days increase by only three tenths of a percent between SFY 04 and 05, compared to an increase of 17.6% between SFY 03 and 04.

- In-State aggregate bed days increased by 10.2% between SFY 2003 and 2004, and 22.5% between SFY 2004 and 2005, and indicator that RPTC bed utilization is beginning to shift from out of state providers back to Alaskan providers.
- Average Bed days per recipient increased 4.3% for the Out of state population between SFY 2004 and 2005, and showed no change between SFY 2003 and 2004. An indication that the children with the longest lengths of stays, and likely the most severe diagnosis are remaining out of state.
- Aggregate Bed Days per recipient decrease 5.7% between SFY 2004 and 2005, an possible indication that less severe children with shorter length of stay are returning to in-state care or stepping down to lower levels of in-state care.

Note:

While the aggregate number out of state bed days and the unduplicated count of out of state recipients has decreased, the average number of out of state bed days per recipient has increased. The average “bed days” calculation divides unduplicated out of state recipients by total out of state bed days during a fiscal year. With a reduction in both the numerator and denominator of this calculation, the question is raised: “why are the average bed days per recipient increasing?” The answer is children in out of state care are the most severe SED children with the longest lengths of stay- some with length of stay of more than four years. The children returned to Alaska during SFY 2005 did not have the longest lengths of stay of that out of state population, but rather shorter lengths of stay. To reduce the average bed days per recipient, the children with the longest out of state stays would need to be returned to Alaska to have the greatest impact.

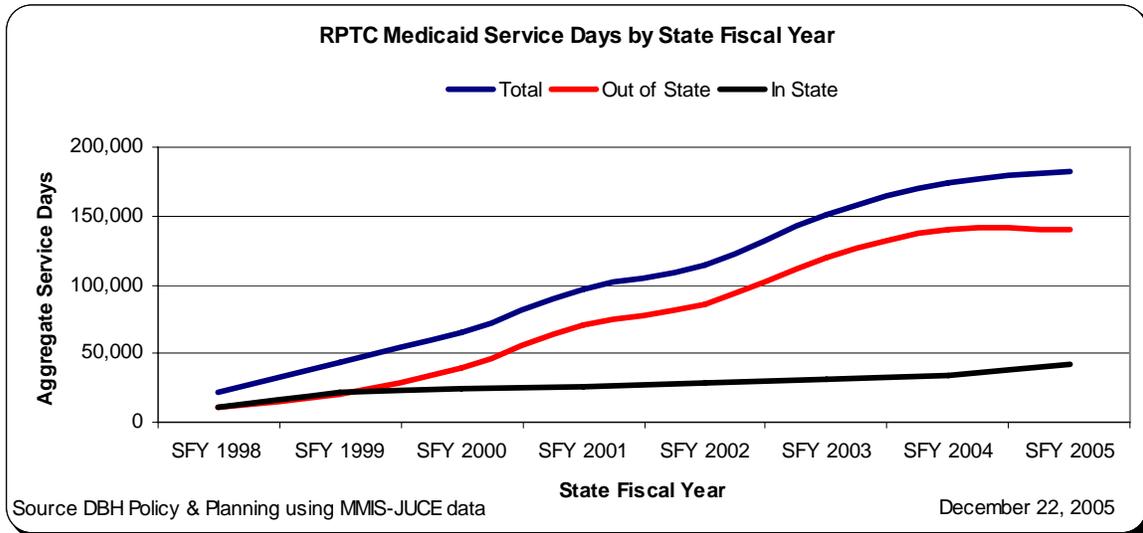
With this issue known, other indicators around the BTKH Initiative will assist in targeting the most severe children and aim at returning them closer to their community of origin which will also reduce the average bed days. For example, the data will allow for identification of children with multi-year stays. That data cross referenced with the child’s home zip code and diagnosis data would provide information to care coordinators on the level of care the child needs and where that level of care could be accessed in Alaska, better informing placement of the children returning to Alaska.

**Table 12**

Aggregate RPTC Medicaid Bed Days <sup>3</sup>								
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005
<b>Out of State</b>	10,733	20,652	39,693	70,398	85,829	119,152	140,087	140,536
<b>In State</b>	11,353	22,341	24,971	25,870	28,788	31,268	34,449	42,197
<b>Total</b>	<b>22,086</b>	<b>42,993</b>	<b>64,664</b>	<b>96,268</b>	<b>114,617</b>	<b>150,420</b>	<b>174,536</b>	<b>182,733</b>

**Table 13**

<sup>3</sup> Note: Aggregate bed days represent the total number of days children received RPTC care during a state fiscal year.

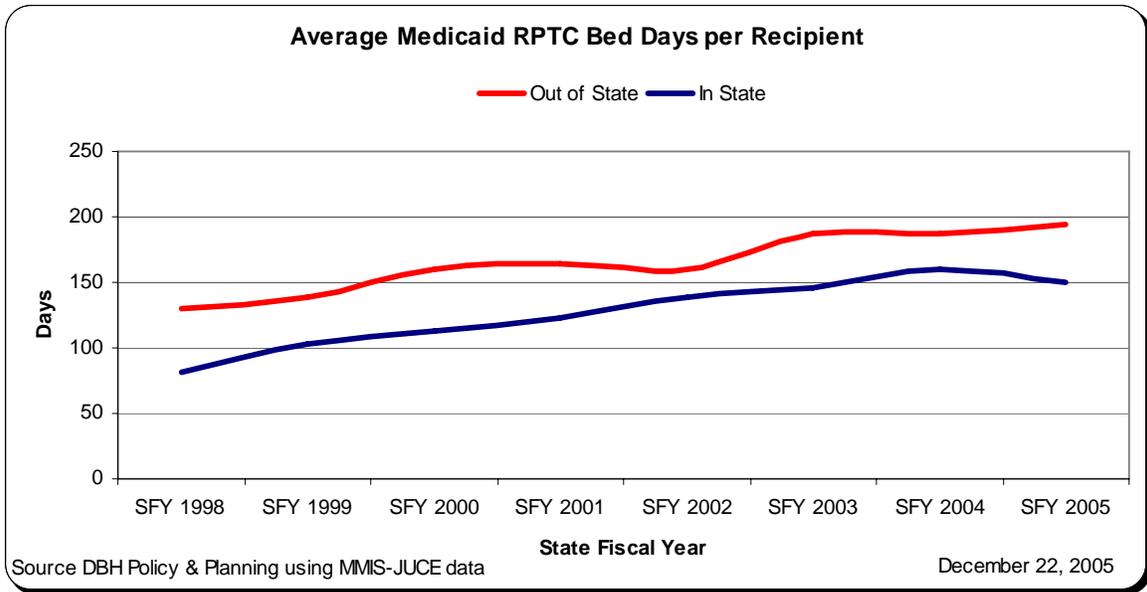


**Table 14**

Average Medicaid RPTC Bed Days per Recipient <sup>4</sup>								
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005
Out of State	129	139	161	164	160	187	187	198
In State	82	103	113	123	138	145	159	145
<b>Total</b>	<b>99</b>	<b>117</b>	<b>138</b>	<b>150</b>	<b>154</b>	<b>177</b>	<b>181</b>	<b>182</b>

<sup>4</sup> The average bed days per recipient calculation is not intended to measure length of stay admit to discharge across fiscal years, but rather measures the **average number of beds per recipient during a state fiscal year.**

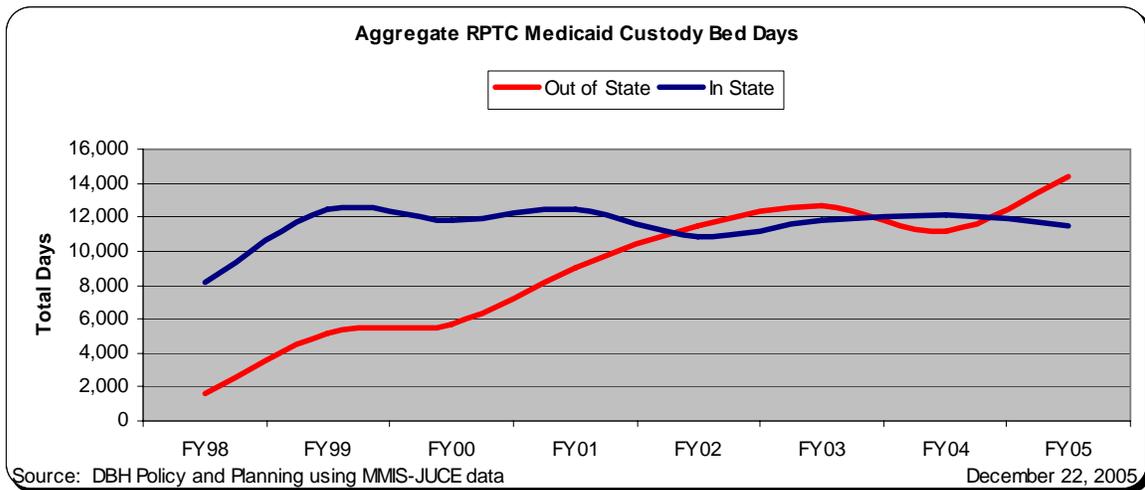
**Table 15**



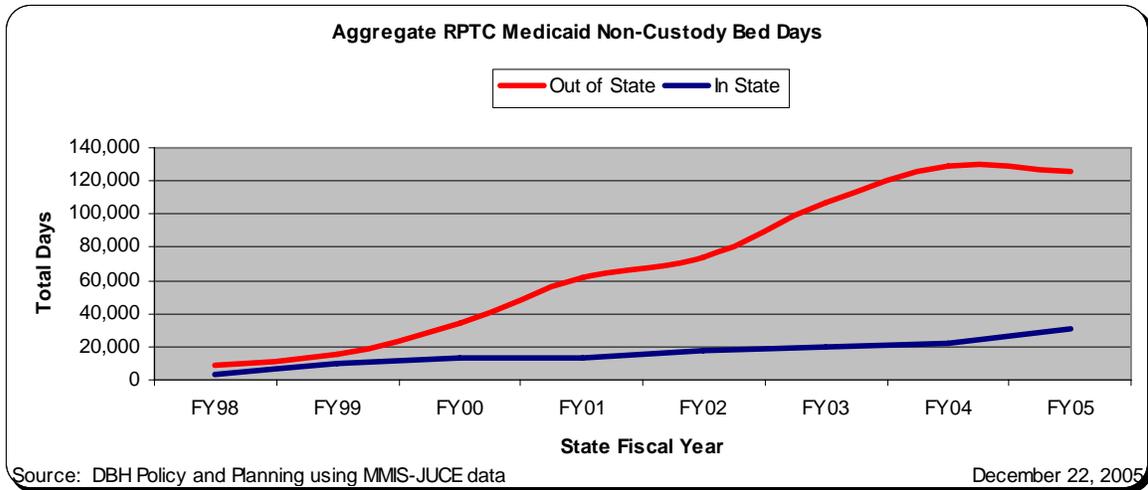
**Table 16**

Aggregate RPTC Medicaid Bed Days by Custody Status								
	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05
<b>OOS Custody</b>	1,595	5,110	5,712	9,005	11,509	12,669	11,160	14,410
<b>IS Custody</b>	8,213	12,450	11,782	12,407	10,824	11,761	12,098	11,501
<b>OOS Non-Custody</b>	9,138	15,542	33,981	61,393	74,320	106,483	128,927	126,126
<b>IS Non-Custody</b>	3,140	9,891	13,189	13,463	17,964	19,507	22,351	30,696
<b>Totals</b>	<b>22,086</b>	<b>42,993</b>	<b>64,664</b>	<b>96,268</b>	<b>114,617</b>	<b>150,420</b>	<b>174,536</b>	<b>182,733</b>

**Table 17**



**Table 18**



**Average Length of Stay**

The intent of this indicator is to measure the period of time between an admission and a discharge from RPTC care. As stakeholders have indicated the service days reporting useful, reporting around length of stay- admit to discharge will augment the historically reported bed day data.

Policy and Planning- Research has developed methodology which provides for reporting average length of stay- admit to discharge by either year of admission or year of discharge. Additional work continues in future analysis to explicate the differences in length of stay by additional variables, such as diagnosis.

The methodology includes only recipients with both an admission date and corresponding discharge date. Once identified and compiled, the difference in days between the admission and discharge (length of stay) is calculated for each recipient. The sum of the length of stay is calculated and divided by the total number of admission or discharges, depending on how the data is reported- by year of admission or year of discharge. The number of admission or discharges is not a distinct count and may contain duplicate recipients.

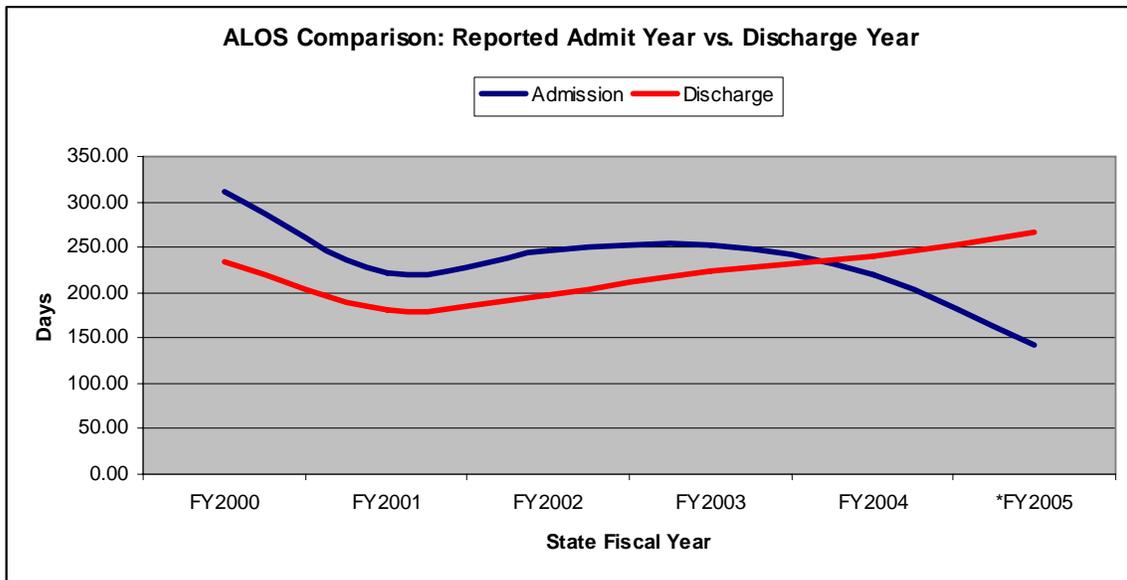
**Table 19**

BY ADMIT DATE						
	FY2000	FY2001	FY2002	FY2003	FY2004	*FY2005
Distinct Recipient Count	137	400	413	472	462	242
Total Discharges	140	469	489	546	529	281
Total Length of Stay	43,481	104,447	120,197	137,287	116,754	39,892
<b>Average Length of Stay</b>	<b>310.58</b>	<b>222.70</b>	<b>245.80</b>	<b>251.44</b>	<b>220.71</b>	<b>141.96</b>
Longest Stay in days	1080	1696	1234	1034	744	407
Shortest Stay	3	1	1	2	1	1
Mode (most commonly occurring)	283	175	3	182	204	13
Median (middle of the distribution)	310	175	187	213	204	143

**Table 20**

BY DISCHARGE DATE						
	FY2000	FY2001	FY2002	FY2003	FY2004	*FY2005
Distinct Recipient Count	16	295	404	406	499	492
Total Discharges	16	338	458	442	570	545
Total Length of Stay	3,728	61,274	90,374	98,610	136,881	145,514
<b>Average Length of Stay</b>	<b>233</b>	<b>181.284</b>	<b>197.32</b>	<b>223.09</b>	<b>240.14</b>	<b>266.99</b>
Longest Stay in days	1002	846	802	1080	1059	1696
Shortest Stay	3	1	1	2	1	0
Mode (most commonly occurring)	5	175	146	109	213	204
Median (middle of the distribution)	192	158.5	168.5	183.5	205	210

**Table 21**



**Indicator 4:** *Service Capacity – Increase in the number of children /youth receiving home and community based services in communities or regions of meaningful ties by 60 percent by SFY 12 (10 percent per year).*

**Findings:**

(Reference Table 22- 23)

- There was a 16.6% decrease in the number of children receiving OOS RPTC care from Anchorage Region
- There was a 12.5% decrease in the number of children receiving OOS RPRC care from Southeast Alaska.

Note: Haines and Yakutat for the first time ever had a child receiving OOS RPTC care. This reporting shows how we can identify and align children with community based

services. For example, with JYS coming online soon, we are able to id children who would be closer to home by receiving services there.

**Table 22**

Unduplicated Count of OOS RPTC Recipients by Community of Origin								
	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05
Aleutians East	1	2	1				1	1
Aleutians West						1		2
Anchorage	30	69	124	199	250	295	355	296
Bethel		1		3	13	17	16	14
Bristol Bay					1			4
Denali				2	1	1		
Dillingham				1	2	4	5	4
Fairbanks North Star	6	10	16	40	47	67	74	74
Haines								1
Juneau	18	16	20	32	39	34	40	37
Kenai Peninsula	10	14	16	28	45	53	53	60
Ketchikan Gateway	1	4	7	5	3	3	7	7
Kodiak Island	1	1	1	5	9	13	18	15
Lake & Peninsula			1	1		1	2	
Matanuska-Susitna	9	19	31	48	45	58	76	86
Nome			1	5	6	8	10	11
North Slope	1	1	7	12	14	13	12	20
Northwest Arctic				4	9	12	17	15
Prince of Wales	2	1	2	5	5	8	11	7
Sitka			3	6	3	7	5	4
Skagway-Angoon			1	2	1	1	1	2
Southeast Fairbanks				2	3	1	2	4
Unknown	1	4	7	12	16	14	12	17
Valdez/Cordova	1	5	5	6	6	3	9	7
Wade Hampton		2	2	3	7	8	7	7
Wrangell-Petersburg					4	8	8	4
Yakutat								1
Yukon-Koyukuk			2	8	7	7	8	11
<b>Grand Total</b>	<b>81</b>	<b>149</b>	<b>247</b>	<b>429</b>	<b>536</b>	<b>637</b>	<b>749</b>	<b>711</b>

Note:

Unduplicated Counts by Community of Origin utilized federal classification of geographic census areas to designate community of origin categories based on recipient zip codes. This mechanism allows for clustering of RPTC recipients by urban and rural geographic regions in Alaska

**Table 23**

Unduplicated Medicaid RPTC Recipient Count by Region								
	FY98	FY99	FY00	FY01	FY02	FY03	FY04	FY05
<b>Anchorage</b>	30	69	124	199	250	295	355	296
<b>Fairbanks</b>	6	10	16	42	50	68	76	78
<b>Kenai Peninsula</b>	10	14	16	28	45	53	53	60

<b>Matanuska- Susitna</b>	9	19	31	48	45	58	76	86
<b>Southeast</b>	21	21	33	50	55	61	72	63
<b>Other</b>	4	12	20	50	75	88	105	111
<b>Unknown</b>	1	4	7	12	16	14	12	17
<b>Totals</b>	<b>81</b>	<b>149</b>	<b>247</b>	<b>429</b>	<b>536</b>	<b>637</b>	<b>749</b>	<b>711</b>

Note:

- Unduplicated OOS counts by region is a collapsed iteration of the community of origin data which regionalizes the RPTC recipients.
- Other includes Yukon-Koyokuk, Wade Hampton, Valdez/Cordova, Northwest Arctic, North Slope, Nome, Bethel, Kodiak Island, Aleutians East and West, Dillingham, and Denali.
- Unknown represents recipients with a non resident zip code.

**Indicator 5:** *Effectiveness: Decrease in the number of children/youth returning to residential care by 75% by SFY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)*

To effectively report on this measure, assumes and requires that the current service delivery system is structured in a manner that allows for discrete “levels of care”. In this respect, the challenges with the level of care definitions aligning with current data elements are problematic.<sup>5</sup> Policy and Planning Research is currently evaluating the capacity to report recidivism figures. Preliminary analysis around reporting this indicator appears promising. Research Analysts will soon test the methodology and report findings. The projected time line- less than 3 months (3/06).

**Indicator 6:** *Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered.*

The Policy and Planning- Research Team is currently evaluating the use of the MHSIP survey and discussing best options for dissemination techniques, development of work plan, and evaluating the correlation of questions to the population.<sup>6</sup> The proposed timeline for implementation is less than three months (3/05), and the timeline for meaningful and comparative analysis is projected to be less than one year. In addition, the targeted population of the BTKH project included custody and non custody. In order to adequately report on this indicator, the issue of standardizing an outcomes instrument needs to be resolved. This has implications for the need to standardize assessment instruments between the DBH and facilities that are currently operated by the Office of Children’s Services.

The recommendation of Policy and Planning- Research is to develop and pilot the instrument at the RPTC level and expand the instrument to the instate residential population.

<sup>5</sup> For a detailed discussion reference Appendix B.

<sup>6</sup> For a detailed discussion reference Appendix B.

***Indicator 7: Functional Improvement – Eighty five percent of children show functional improvement in one or more life domain areas one year after discharge.***

The *Policy and Planning* research analysts are working with the OISPP consultant to evaluate and recommend an instrument appropriate for the population.<sup>7</sup> In addition, the targeted population of the BTKH project included custody and non custody. In order to adequately report on this indicator, the issue of standardizing an outcomes instrument needs to be resolved. This has implications for the need to standardize assessment instruments between the DBH and facilities that are currently operated by the Office of Children's Services.

The recommendation of Policy and Planning- Research is to develop and pilot the instrument at the RPTC level and expand the instrument to the instate residential population.

---

<sup>7</sup> For a detailed discussion reference Appendix B.

## Appendix A

### **BRING THE KIDS HOME INDICATORS DATA DEFINITIONS AND FEASIBILITY REVIEW**

The Bring the Kids Home Master Planning Document defines the context and scope necessary to focus efforts and resources designed to change the service provisions for the SED youth population in Alaska (This document is subject to revisions as the BTKH effort unfolds.) To monitor the effectiveness of the Initiative, the Alaska Mental Health Trust, Providers and DBH have collaborated efforts to define seven outcomes which will serve as performance measures for the Initiative. Policy and Planning recommends the following changes to the indicators so they can be measured. Concurrently, Policy & Planning will look at ways to increase the capacity to report and include lower levels of care around the indicators.

- 1) Client Shift – A reduction in the total number of SED children/youth being sent out of state by 90 percent by SFY 12 (15 percent per year).**

**Measurement:** How do we measure the client shift by state fiscal year?

- Track change (reduction) in the OOS population beginning at implementation and compare the change to historical baseline data.

**Methodology:** Recipient counts are distinct. A distinct count considers a record only once regardless of frequency. Populations are measured by distinct counts of individuals receiving services during a fiscal year.

- 2) Funding Shift - Ninety percent reduction in Medicaid/General Fund match dollars from out-of-state services to SED children/youth with a corresponding increase in Medicaid/General Fund match dollars for in-state services by SFY 12. (15 percent per year).**

**Measurement:** How do measure the funding shift by state fiscal year?

- Track change (reduction) in OOS Medicaid RPTC expenditures beginning at implementation and compare to historical expenditure data.
- Track change (increase) of in-state RPTC expenditures and compare to historical expenditure data.

**Methodology:** Funding shift measures RPTC expenditures related to in state and out-of-state care. The 'payment\_amount' field from the MMIS is summed to arrive at total expenditures. Payment amount is the computed amount due a provider for a claim transaction.

Note: At this time we are unable to track the corresponding increase of in-state expenditures relating to lower levels of care as these levels of care are not defined.

**3) Length of Stay – Reduction in the average length of stay for in-state and out-of-state residential institutions by 50 percent by SFY12.**

**Measurement: How have we measured average length of stay by state fiscal year?**

- Track average out of state bed days per recipient by fiscal year.
- Track average in state bed days per recipient by fiscal year.
- Track number of out of state RPTC bed days.
- Track number of in state RPTC bed days.

**Methodology:** This is a calculated field which is reported by state fiscal year (SFY). The calculation is as follows:

**Step one: Calculate number of RPTC service days within SFY**

Number of RPTC service days = Service Through Date – Service From Date

**Step two: Sum number of RPTC service days within SFY**

Total RPTC service days = sum of RPTC service days

**Step three: Calculate average length of stay within SFY**

Average length of stay = total RPTC service days / unduplicated count of recipients

Service days are the difference between the service from date and the service through date. The difference is reported in days.

Note: The AMHTA has indicated the intent of this indicator is to measure the period of time between an admission and a discharge from RPTC care. To augment the data historically reported around this indicator, Policy & Planning Research & Analysis is developing the capacity to report average length of stay based on admission and discharge dates based on the following methodology:

All RPTC admissions with a corresponding discharge will be reported based on fiscal year of admission. Length of stay will be reporting in days. There will be a lag when moving closer to the present as discharges for recipients have not occurred. Expect to be able to report ALOS within 3 months, likely sooner.

Additionally- the impetus behind the indicators is to enable timely tracking and monitoring of the efficacy of efforts around BTKH. The admission to discharge analysis for measuring ALOS will likely have a lag in excess of a year creating an untimely indicator of ALOS. Utilizing the data historically reporting around this indicator will allow for near immediate tracking of ALOS within a SFY.

**4) Service Capacity – Increase in the number of children /youth receiving home and community based services in communities or regions of meaningful ties by 60 percent by SFY 12 (10 percent per year).**

**Measurement: How do we measure increased service capacity?**

- Track distinct count of OOS recipients by community of origin by SFY
- Track distinct count of in state recipients by community of origin by SFY

This performance indicator does not consider a variety of dynamic and undefined variables, and as written does not measure service capacity but rather intends to measure service utilization at lower levels. Whereas the three previous indicators aim to exclusively evaluate change in the RPTC population, this indicator moves beyond that population to include all lower levels of care which have not yet been completely defined. Once defined the biggest challenge begins- to identify how existing Medicaid data can consistently and accurately define these children. As many of the risk factors the RPTC population present are not apparent in the data, it is difficult, if not impossible to accurately and consistently define at which level a child is or should be receiving service with existing Medicaid data.

Until a more effective solution is identified, tested and validated, the Policy and Planning Research Team recommends a solution which truly measures service capacity:

- 1- Account for all in-state beds at various levels as defined in the ‘Expansion of Services & Facilities- Proposed Implementation Schedule & Timeline by Fiscal Year’ document;
- 2- Utilize the community of origin data for all custody and non-custody children which are captured at the regional resource committee to inform the venue and appropriate level of the service capacity enhancements.
- 3- Use the ‘Expansion of Services & Facilities- Proposed Implementation Schedule & Timeline by Fiscal Year’ document as a guide for future expansions;

**5) Effectiveness: Decrease in the number of children/youth returning to residential care by 75% by SFY 12. Defined as children/youth returning within one year to the same or higher level of residential care (12.5% per year)**

**Proposed re-write:**

**Decrease in the number of children returning to RPTC care by 75% by SFY 12. Defined as children returning within one year to RPTC care.**

As stated earlier, the challenges with the level of care definitions aligning with current data elements also pertain to this indicator. Policy and Planning Research is currently evaluating the capacity to report recidivism figures. Preliminary analysis around reporting this indicator appears promising- Analyst will soon test the methodology and report findings. Time line- less than 3 months.

**6) Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered.**

Policy and Planning- Research is currently evaluating the use of the MHSIP survey and discussing best options for dissemination techniques, development of workplan, and evaluating the correlation of questions to the population. The timeline for implementation- less than three months; Timeline for meaningful and comparative analysis- less than one year.

Note: the targeted population of BTKH project included custody and non custody and if we are looking at standardizing an outcomes instrument need to span the dynamics of custody and non- custody.

The recommendation of Policy and Planning- Research is to develop and pilot the instrument at the RPTC level and expand the instrument to the residential population.

Successfully contacting consumers one year after discharge has historically been a difficult and time consuming effort with very dismal results. Policy and Planning- Research is evaluating various ways to successfully contact consumers one year after discharge. Some options include using other state data resources such as the PFD, DMV and or Fish and Game databases.

**7) Functional Improvement – Eighty five percent of children show functional improvement in one or more life domain areas one year after discharge.**

The life domain areas need to be more clearly defined so an appropriate instrument / survey may be selected and evaluated. Policy and Planning Research is working with the OISPP consultant to evaluate and recommend an instrument appropriate for the population.

Note: the targeted population of BTKH project included custody and non custody and if we are looking at standardizing an outcomes instrument need to span the dynamics of custody and non- custody.

The recommendation of Policy and Planning- Research is to develop and pilot the instrument at the RPTC level and expand the instrument to the residential population.

Successfully contacting consumers one year after discharge has historically been a difficult and time consuming effort with very dismal results. Policy and Planning- Research is evaluating various ways to successfully contact consumers one year after discharge. Some options include using other state data resources such as the PFD, DMV and or Fish and Game databases.

## Appendix B

**OISPP Internal Meeting: December 13 & 14, 2005**

**RE: BTKH Indicators. Client Satisfaction and Functional Improvement**

**Participants: Mike Bellevue- Research Analyst, Dave Meiners- Research Analyst, Chuck McGee- WICHE Consultant**

### **Purpose:**

The purpose of this meeting was to discuss and recommend to the Policy & Planning Section Chief an appropriate instrument which would facilitate reporting on two Bring the Kids Home Indicators for which data was unavailable to allow for reporting. The two indicators are:

1. Client Satisfaction- Via annual reporting, 85% of children and families report satisfaction with services rendered.
2. Functional Improvement- 85% of children show functional improvement in one or more life domain areas one year after discharge.

Two instruments initially identified as possible sources to capture the data were discussed at length. The Client Status Review (CSR) and the Mental Health Statistics Improvement Project (MHSIP) Youth survey form. While discussing these instruments the group felt it was important to: 1- Utilize instruments currently implemented across providers and levels of care to allow for comparison; 2- Utilize instruments which would eventually be implemented across all levels of care as the behavioral health integration moves forward. The following discussion will address the indicator, instrument, methodology, deployment, communication, monitoring, timelines, reporting and review recommended for use in increasing reporting capacity around the Client Satisfaction and Functional Improvement Indicators for the BTKH Initiative.

---

### **CLIENT SATISFACTION**

---

#### **Indicator**

The indicator benchmarks the level of satisfaction with services rendered at 85% for children and families. The group felt this was high given no baseline data has been evaluated. At this time, the Research Group recommends no changes to the indicator, however, depending on baseline data a recommendation to lower the level of satisfaction could be made. It is important to have realistic and measurable indicators- an evaluation of the baseline data may unveil the need to make changes to the benchmark of 85%. Additionally, all other indicators around levels of reported satisfaction benchmark 75%. Consistency is also a concern.

#### **Instrument**

The group reviewed multiple instruments which sampled consumer satisfaction and analyzed how the survey questions corresponded with the population being surveyed and whether the instrument could be used across multiple levels of care and populations. The MHSIP Youth Survey, MHSIP Children and Families Survey, and the NRI / MHSIP

Inpatient Consumer Survey were compared to determine an appropriate instrument for use in measuring the indicator.

The idea is to have one instrument which is utilized across all levels of care and aligns appropriately with all populations- children, youth, and adults. More importantly is the ability to compare the results of the survey to other populations, other states, and other sectors and levels of care within the behavioral health spectrum of services. The group selected the MHSIP youth survey to capture consumer satisfaction with services rendered.

As the MHSIP Satisfaction Survey is used across all age groups to capture consumer satisfaction among other important domains, implementing this survey initially at the RPTC level and eventually all levels of residential care is the next step in being able to capture consumer satisfaction and perceptions at all levels of care and across all populations. The survey is currently sent to all other consumer groups- it makes sense to survey the entire consumer population- in state or out-of-state.

### **Methodology**

The methodology for implementing the MHSIP-Youth Survey with RPTC providers will use the methodology established during the FY 2005 MHSIP survey deployment to mental health and substance abuse providers. In an effort to mitigate burden on providers, packets containing the survey, return envelopes and instructions will be sent along with provider instructions on survey details.

All RPTC providers will receive enough survey packets to complete a point in time survey of all active RPTC clients and discharge clients over the course of a fiscal year. Research Analysts will review RPTC Medicaid data to determine the appropriate number of survey packets to send to each provider. Providers will be asked to track the number of point in time survey and discharges over the course of the fiscal year to calculate response rates by provider.

The idea of a coercion question being added to the survey would improve the reporting by removing biases around artificial negative reporting stemming from children forced into residential care.

### **Deployment**

The supply of survey packets will be mailed to all in-state and out-of-state RPTC providers with a memo informing providers of survey administration procedures, timelines, and how to access findings from the survey. The memo utilized for the FY 2005 MHSIP survey deployment to mental health and substance abuse providers will be used to inform the RPTC providers of the aforementioned items.

### **Communication**

The initial communication to providers will be sent with survey packets. During the FY 06 MHSIP survey deployment to mental health and substance abuse providers, Behavioral Health Specialist assisted in communication to provider using existing channels of communication. This worked well when dealing with over 80 providers. The same may hold true when considering the use of Utilization Review Staff to communicate to RPTC providers. This will be further discussed.

### **Monitoring**

The MHSIP surveys contain serial numbers of the instrument. When documented, these numbers allow for tracking to a specific provider. Returned surveys will be monitored and if a low response rates seems to be developing from a specific provider, communication will commence around improving the return rate for that provider.

### **Timelines (subject to change depending on final approval)**

Finalize survey instrument	January 16, 2006
Agency Distribution to Provider	January 31, 2006
Survey Period (point in time)	February 15 - March 15, 2006
Data Entry	March 20 – April 4, 2006
Data is Analyzed	April 5 – April 21, 2006
Internal Review and Feedback	April 24 – April 26, 2006
Report Released to the World	May 1, 2006

### **Reporting**

The MHSIP has nationally recognized and endorsed instructions for cleaning, grouping, analyzing and reporting the data. As the Division is utilizing other MHSIP survey to sample consumer satisfaction and perception, the infrastructure is already in place to capture, warehouse, and report the data. The reporting has been automated through the development of syntax within SPSS software, and reporting formats and templates are already constructed.

### **Review**

All findings will be reviewed internally prior to release to stakeholders.

### **Recommendations**

Research recommends the use of this nationally recognized and federally endorsed survey instrument. The instrument is used to sample satisfaction of all other levels of care and populations served by the Division. It makes sense to extend the instrument to the RPTC population and next to the entire residential population. This will fill the population gap around the use of the MHSIP while allowing for reporting of an indicator where reporting capacity previously did not exist.

---

## **FUNCTIONAL IMPROVEMENT**

---

### **Indicator**

The indicator benchmarks the level of functional improvement around life domains at 85%. The group had some concerns with this indicator, they are as follows:

1. 85% is a very high benchmark considering the population and lack of baseline data to set a benchmark;
2. Functional improvement cannot truly be measured with the recommended instrument- the CSR, as the CSR has mostly quality of life questions.
3. Specific life domains are not defined within the indicator- there are over 16 questions on the CSR, each addressing a life domain.
4. All other performance measures around life domains benchmark improvement at 75%. DBH intends to be consistent in reporting performance measures for comparison purposes among others. Additionally the intention of OISPP is to align

performance measure and establish consistency in data, performance measures and indicators, and reporting. Connecting with consumers one year after discharge has historically resulted in sparse data insufficient for meaningful analysis.

**The recommendation is to re-write the indicator to read:**

Functional Improvement- 85% of children show improvement in one or more life domain areas between intake and subsequent intervals. (CSR instrument)

The indicator benchmarks the level of satisfaction with services rendered at 85% for children and families. The group felt this was high given no baseline data has been evaluated. At this time, the Research Group recommends no changes to the indicator, however, depending on baseline data a recommendation to lower the level of satisfaction could be made. It is important to have realistic and measurable indicators- an evaluation of the baseline data may unveil the need to make changes to the benchmark of 85%. Additionally, all other indicators around levels of reported satisfaction benchmark 75%. Consistency is also a concern.

**Methodology**

The methodology for implementing the Client Status Review with RPTC providers will utilize the existing methodology mental health and substance abuse grantees use for completing the CSR instrument. RPTC providers, both in-state and out-of-state, will be sent the CSR instrument on legal size paper along with instructions on how to administer the instrument, the frequency of administration- all intakes, 3 month follow-ups and discharges. For children currently active the CSR instrument will be administered at the 3 month interval. All new admissions will complete an intake CSR, all discharges a discharge CSR.

The scoring of the CSR will measure the change specific to individual recipients using the existing data by linking an intake CSR to subsequent CSR using the consumer case number and the provider identification number. The beginning baseline will be the individual responses on the intake CSR for a specific consumer. The change will be measured by comparing subsequent CSR for the consumer to the intake CSR. A positive change will be identified by no change or and improvement to the intake, stated differently, if the subsequent CSR is greater than or equal to the intake response to a specific question, it will be treated as an improvement.

Compliance reporting will be developed to ‘spot check’ providers who do not appear to be using the instrument so the Research Team may assist with any administration challenges the provider may be experiencing.

**Timeline**

Timelines will follow the MHSIP survey as much as possible. Consideration needs to be given to the CSR document look and feel, and consider printing times.

**Deployment**

A supply commensurate with the number of Alaskan children being served by the out-of-state providers will be mailed with a memo explaining the administration procedures, timelines, and how to access finding from the survey. Changes to improve the ability to identify unique recipients are underway. Once changes are finalized a new version will be

printed, distributed and posted to the website with consideration given to the legal size / letter size challenges the instrument has experienced since inception.

### **Communication**

The initial communication to in-state and out-of-state providers will be sent with the revised CSR instrument. The provider letter will include the administration procedures, timelines, and how to access finding from the survey, and contact information to the Research Team for technical assistance. The Research Team anticipates a high number of phone calls and questions from providers during the period immediately following the deployment of the provider letter and instrument.

### **Monitoring**

The CSR instrument captures consumer case number and facility code. The facility code will allow for tracking of submission by provider. Facility codes will need to be reviewed for accuracy and new codes developed for out-of-state providers. The facility codes for the out-of-state provider location will be filled in on the instruments sent to that specific out-of-state provider. The idea is to track submission by provider. If a particular provider is not submitting, Researchers will contact that provider to offer technical assistance around completion and submissions of the CSR.

### **Reporting**

As mentioned above, the scoring of the CSR will measure the change specific to individual recipients using the existing data by linking an intake CSR to subsequent CSR using the consumer case number and the provider identification number. The beginning baseline will be the individual responses on the intake CSR for a specific consumer. The change will be measured by comparing subsequent CSR for the consumer to the intake CSR. A positive change will be identified by no change or and improvement to the intake, stated differently, if the subsequent CSR is greater than or equal to the intake response to a specific question, it will be treated as an improvement. The report will indicate a percentage of clients with an improvement in one or more life domains. Individual life domains will be reported.

### **Review**

All findings will be reviewed internally prior to release.

### **Recommendations**

Implement the CSR instrument with in-state and out-of-state RPTC providers with some minor changes to how the instrument captures unique recipient data.

The CSR instrument captures consumer case number and facility code. When the instrument was developed, the original intent capturing these two items was to allow for the unique identification of recipients. The challenge with this methodology is that it makes it impossible to identify recipients once they cross providers or levels of care.

The recommended improvements include inclusion of a Medicaid ID number, date of birth field, and a gender field. The idea behind capturing data of birth and gender is to utilize a multi-join on gender, date of birth and provider id as a augmenting means to identify recipients without unique identifiers such as the Medicaid ID number, or when a Medicaid ID number is not included.