

## Department of Health & Social Services Bring the Kids Home: Annual Report Fiscal Year 2006

### *Executive Summary*

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

- **Between 1998 – 2004, Out-of-state placements for children with severe emotional disturbances in residential psychiatric treatment centers (RPTC) grew by nearly 800%.** During this time, the children’s behavioral health system in Alaska became increasingly reliant on institutional care for treatment of severely emotionally disturbed youth (SED). At any given time, approximately 350-400 children were being served in out-of-state placements. Alaska Native children represented 49% of the custody children in out-of-state placements and 22% of the non-custody children in out-of-state placements.
- **The Family Impact:** For many of the children and families who received out-of-state mental health care, access to care came at a price: disruption of family relationships and cultural identity, disconnection of parents and family from participation in the youth’s treatment, and difficulties with transitions/re-integration into home, school and community.
- **The System Impact:** Over-utilization of out-of-state care also comes at a price for the system: state resources support highly restrictive out-of-state residential treatment resources instead of building in-state capacity. Developing capacity means investing in the Alaskan workforce and building in-state resources: in-home, in-school/community, therapeutic foster/group care, *and* residential services for Alaskan children.

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

- The Department of Health and Social Services initiated the “Bring the Kids Home” (BTKH) Project to return children served in out-of state facilities to in-state residential or community-based care and to prevent children from moving into higher levels of care. The following long-term goals were 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'06**

As noted above, overall admissions<sup>1</sup> to RPTC per year showed a steady **increase** from SFY 98-04. However, between SFY 2005 and 2006:

- The distinct number of In-State Custody RPTC recipients “admitted” during SFY 06 **decreased by 28%**.
- The distinct number of In-State Non-Custody RPTC recipients “admitted” during SFY 06, **decreased by 31.4 %**
- The distinct number of Out-of-State Non-Custody RPTC recipients “admitted” during SFY 06, **decreased by 7.5%**.
- The distinct number of total RPTC admissions for SFY '06 **decreased by 13%**.

Between SFY 1998 and 2004 the overall total<sup>2</sup> of SED youth receiving out-of-state RPTC care per year also steadily increased - **on average 46.7%** per year. The RPTC population as a whole showed a steady increase from SFY 98-04 with an **average annual increase of 24.8%**.

However, for SFY05 and SFY06:

- There was an **average decrease of .6% in** the number of OOS RPTC distinct recipients
- The average annual increase in the number of RPTC distinct recipients was **3.45%- the smallest annual increase since the inception of Medicaid data.**

Between SFY 2005 and 2006:

- The overall total of OOS RPTC recipients increased by only 4.5%: **less than 10% of the average increase between 98 and 04.**
- The overall total of RPTC recipients increased only **3.1%- the smallest increase since the inception of Medicaid data.**

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 2005 and 2006:

- Out-of-State RPTC Medicaid expenditures **increased by only 4.4%**.
- In-State RPTC Medicaid expenditures **increased by 3.5%**.
- Total RPTC Medicaid expenditures increased by only **4.7%- the smallest annual increase since 1998**. This was despite an 18% increase in the payment rate to providers during FY06.

These figures demonstrate the tapering of expenditures that reflects one of the goals of BTKH: to reduce over-reliance on out-of-state care and increase investment in in-state services and capacity at lower levels of care. During FY07, we anticipate that this tapering will continue and result in a slight decrease in the cost of out-of-state RPTC care.

<sup>1</sup> Includes only children admitted to an RPTC during the State fiscal year: provides an unduplicated total of admissions to RPTC for the year.

<sup>2</sup> Includes all children served in an RPTC during the reporting year, including those admitted during a previous year. This is an unduplicated total of clients served in RTPC for the year.

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

Between SFY 1998 and 2004 the children's behavioral health system in Alaska became 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. During that period 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 were being served in out-of-state placements, ranging in age from six to seventeen, (average age between 14 and 15). Alaska Native children were over-represented in the population of children in custody and represented 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 to in-state residential or community-based care and to prevent children from moving into higher levels of care. The project is reinvesting funding going to out-of-state care to in-state services and developing the capacity to serve children closer to home. With financial support from DHSS and the AMHTA, and the support of stakeholders this initiative continues to build 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 all four levels of the system of care be addressed concurrently: community, regional, in-state, and out-of-state care. Further, the project includes policy development, management of authorization, utilization, and enhanced care coordination, workforce development, funding, expansion of facilities and infrastructure, and expansion of service capacity.

In order to accommodate the scope of the BTKH Project, seven strategies for change are being used to facilitate the organization and implementation 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: Remove barriers in policy, regulation and financing that reduce the capacity of the system of care to serve children and families.
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 2006: By Strategy***

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

- 1. Scope:** The BTKH Project planning processes have recognized that successful implementation requires a broad scope of activity and a system wide approach: a community-based, regional, state, and out-of state level of change within the service delivery system.
- 2. Activities:** 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.
- 3. Stakeholders:** A broad group of stakeholders must be at the table to guide this system change effort. During 06 special efforts were made to engage tribal entities as partners. This was effective and tribal representatives participate in work groups and at each quarterly planning meeting.

#### **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. Strategies for Family Voice:**

- System changes impact families and youth receiving mental health care directly and personally. For this reason, through the BTKH initiative, family voice is built into planning and monitoring. During FY06, the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse worked with consumer groups to increase the voice of families and youth in the decision process, sharing their perception of what worked and what didn't work in the system, and their ideas for future changes.
- A “parent night” started in FY05 continued during FY06, providing a forum to discuss parent/youth issues and concerns at each BTKH quarterly planning meeting. Family members and children participate through these avenues.
- Travel stipends and teleconferencing capacity are available to support participation.

#### **Strategy 3: Examine financing & policy issues - Remove barriers in policy, regulation and financing that reduce the capacity of the system of care to serve children and families.**

During FY06 there were numerous efforts related to financing and policy. Some of these were financed through AMHTA and others were Department initiatives. Some of the most notable are described below:

**1. Individualized Funding:** Mechanisms were developed to allow “Individualized Service Agreements” (ISA) with Community Mental Health Centers. Funded through the AMHTA, the purpose of ISA is to ensure that SED youth who meet residential LOC are served as close to home as possible, by providing clinically necessary services to prevent institutional care. ISA’s are the mechanisms through which funds will be allocated to provide services to youth that cannot be reimbursed through Medicaid fee-for-service, private insurance, grant funded services, Behavioral Rehabilitation Services (BRS) financing, or for youth who are not covered by Medicaid.

**2. School Behavioral Health:**

- DHSS and the Dept. of Education and Early Childhood Education (DEED) signed a joint agreement around educational services for custody children and youth placed in RPTC care.
- DHSS and DEED continued discussions toward developing a Memorandum of Agreement to 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.
- School-based behavioral health services became available for students with behavioral health issues identified in their Individual Education Plans. Services are constructed avoid duplication between school and the services of the BH provider network.

**3. BRS:**

- DBH and Office of Children Services worked with the Office of Rate Review to conduct a formal rate review of the OCS Behavioral Rehabilitation Services (BRS). The rate study included levels II, III and IV as well as RPTC (level V).
- New BRS regulations were written collaboratively by DBH and OCS. These allow access to existing unused beds in OCS/BRS residential facilities for non-custody clients. This made available approximately 54 new in-state residential treatment beds for non-custody children. These were adopted by the Department and will be implemented in FY07.

**4. Residential Psychiatric Treatment Center Management:**

- The DBH Policy & Planning Section worked with the Department on amending the “Out-of-state” Regulations to change enrollment and enhance DBH’s ability to negotiate costs. Essentially, changes give the DBH regulatory authority to manage and authorize out-of-state providers.
- DHSS/DBH 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.
- The RPTC Placement Criteria Policy were rewritten to reflect Alaska Statute 47.07.032 to ensure that out-of-state psychiatric hospital or residential psychiatric treatment center services covered by the State are consistent with the person's clinical diagnosis and appropriately address the person's needs and that these services are unavailable in the state.
- Additional policies related to RPTC placements were revised to 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.**

The DBH and Trust planning process developed 7 indicators in which to measure the progress and effectiveness of the Bring the Kids Home Project. (See “Project Outcome Indicators”, below). These indicators are essential to ensure and track successful implementation.

For each indicator, aggressive target goals were set which reflected the strong desire of the stakeholder group for immediate system change rather than a thorough assessment of achievable/appropriate goals. The goals did not take into account the pace at which comprehensive system change could be achieved, nor did they reflect goals based on nationally acceptable rates for such indicators as “recidivism” or “satisfaction with services”.

While the indicators illustrate the success of the initiative in stopping the hemorrhage of Alaskan children to out-of-state RPTC care and clearly show progress, they do not meet the target goals initially set. During FY08, new yearly targets will be identified based on realistic goals and to reflect the actual pace of at which system change can be accomplished. These goals will continue to be aggressive and to require sustained effort to achieve, but will be based on more accurate reflections of achievable progress.

**Strategy 5: Home & community-based services - 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.**

Successful implementation requires in-state capacity to serve children in residential placements *and* in their homes and communities. Funding has been made available through the Trust, DHSS, and the Denali Commission for operational and capital capacity enhancements.

**1. Capacity Enhancements:**

- Operational Projects: A request for proposals was distributed for FY06, FY07 and FY08 to develop therapeutic alternatives for youth with SED. For FY06 \$1,050,000 was awarded for ten grant projects. There was a focus on developing residential options for the most severe children. Accomplishments included creating new beds and services, increasing the capacity to treat children with difficult presentations/challenging diagnoses and implementing best practices.
- Capital Projects: Capital funding has been provided by the Denali Commission, the Division of Behavioral Health and the Mental Health Trust Authority. The primary objective is to develop residential alternatives and to increase the capacity to serve youth with an SED within Alaska. These funds have developed/will develop a range of new in-state residential capacity:
  - i. Therapeutic foster and group homes (generally 5 beds or fewer) in several communities.
  - ii. A level IV residential facility
  - iii. A level V residential facility
  - iv. A transitional living facility
- MATSU Pilot Project: During FY06 DHSS planned a pilot project in the MATSU area to target children accessing out-of-state RPTC care or approved for such care. The pilot

project will integrate services across systems by providing enhanced care management for children and families. A solicitation is being developed for this project and funding is being identified.

**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.**

Development of a skilled workforce is an underlying foundation of the BTKH initiative. As new programs and new facilities are developed, staff must be available to work with children with challenging behaviors and complex needs and their families. The workforce sub-committee is charged with a plan to develop workforce resources in Alaska. The workforce sub-committee met February 15, 2006. Three small groups were formed, including 1) Training and Education; 2) Competencies; and 3) Stakeholder Input and Funding.

**1. Training and Education Group:**

- This group focused on the implementation of the Residential Services Certificate Program. The Center for Human Development developed five courses with a clear focus on kids and residential care as a trial. Final university approval for the courses was received in February 2007. Courses provide a combination of on-site intensive learning, distance education, a 90 minute annual training for supervisors and a 30 hour, 6 week practicum. Scholarships, which pay 75 percent of tuition, fees and books, are available.
- The advisory board recommended an in-house practicum and sampling visitations to other facilities to broaden student's experience; and use of a variety of strategies to market the program to encourage participation.
- Subcommittee members met with university faculty February 23, 2007 to brief them on training implications related to prevention and early intervention; role of alternative or traditional healing; role of the individual, family, community and culture in services delivery; team-oriented service delivery; community development; evidence-based practice.

**2. The Competencies Group:** This group articulated specific competencies for the Residential Services Certificate Program. A preliminary list of core competencies that can be infused across the board into Alaska's workforce development system has been developed.

**3. The Stakeholder Input and Funding Group:** This group did not meet as a full group; instead some members were actively involved in activities to interface BTKH within the Alaska Mental Health Trust Authority's new focus area on workforce development. Trust funds will be used as seed money and a springboard for long-term programming. The Trust intends to convene public and private funders to develop a coordinated, sustainable leverage plan by May 2007.

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

BTKH planning process identified issues related to policy development, management of authorization, utilization, and enhanced care coordination. Development of new and supportive policies and practices is a major factor in successful implementation of BTKH initiative.

**1. Resource Committees:** DBH is collaborating with OCS and DJJ to develop Resource Committees to staff youth in acute care, and others. Resource committees will develop in-state treatment options for custody and non-custody children in acute care (and others), insuring that

the appropriate treatment services are matched with the client's clinical needs, as close to their community and family as possible.

**2. Level of Care:** 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. During FY06 this tool was piloted for children in acute care settings and those youth being referred for ISA funds.

**3. Utilization Review:** The Division of Behavioral Health (DBH) within the Dept. of Health and Social Services (DHSS) created three Utilization Review positions during FY05 (AMHTA Funding). During FY06, an additional two positions were created within DBH. These positions coordinate review of children referred to OOS care and ensure that in-state resources are used prior to a child's approval for an out-of-state RPTC. They also review children referred for step down. These positions are engaged in the following activities:

- Collaboration with acute care facilities to identify in state resources for those youth being referred to out-of-state RPTCs.
- Develop/maintain a Diversion Database to gather clinical and demographic information pertaining to youth admitted into inpatient settings.

**4. BTKH Coordination:** During FY06 the Division of Juvenile Justice and the Office of Children's Services each identified funding for a "Bring the Kids Home" coordination position. By the end of FY06, position descriptions were developed and the positions will be filled in FY07. These positions were designed to work with the DBH utilization review team and to act as BTKH lead for the two divisions.

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

As noted above, Strategy 4 specifically targeted development of Performance and QA Measures. Seven indicators were defined to measure progress of the BTKH Initiative on identified priority areas. For each indicator an aggressive goal was selected. These seven indicators are presented below, with modification as indicated. Target goals will be adjusted during FY08 based on more informed estimates of target goals.

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***Indicator 1: Client Shift- A reduction in the total number of SED children / youth admitted to out-of-state RPTC care by 90 percent by SFY 2012 (15% per year)<sup>3</sup>***

#### **Findings: (Reference Table 1-3)**

The RPTC population as a whole has also showed steady increase from SFY 98-04. Between SFY 2005 and 2006:

- The distinct number of In-State Custody RPTC recipients "admitted" during SFY 06 **decreased** by 28%.
- The distinct number of In-State Non-Custody RPTC recipients "admitted" during SFY 06, **decreased** by 31.4 %
- The distinct number of Out-of-State Non-Custody RPTC recipients "admitted" during SFY 06, **decreased** by 7.5%.

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<sup>3</sup> This indicator has been modified during this reporting period. The previous indicator #1 read: **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)**

- The distinct number of total RPTC admissions for SFY '06 decreased by 13%.

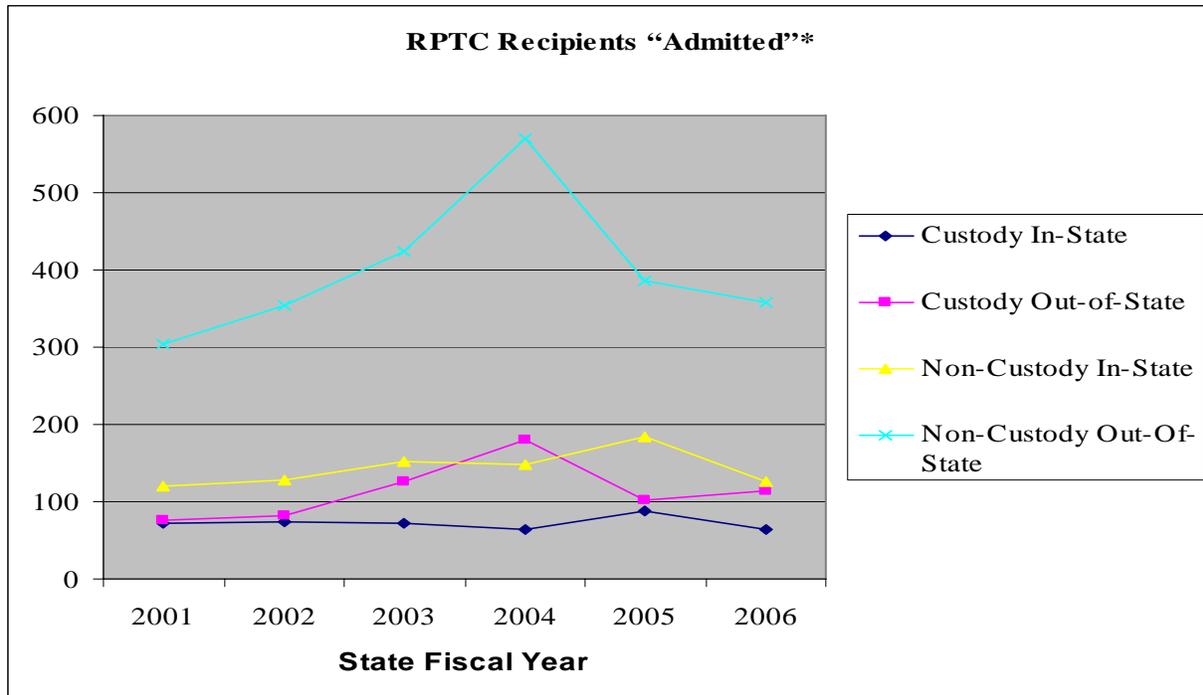
**Table 1**

Unduplicated Count of Medicaid RPTC Recipients "Admitted"*						
	2001	2002	2003	2004	2005	2006
In-State Custody	72	75	73	65	89	64
Out-of-State Custody	77	82	127	181	102	115
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In-State Non-Custody	120	128	153	148	185	127
Out-of-State Non-Custody	304	355	425	571	387	358
<b>Total</b>	<b>573</b>	<b>640</b>	<b>778</b>	<b>965</b>	<b>763</b>	<b>664</b>

**Table 2**

Percentage of Increase (Decrease) between SFY - Distinct RPTC Medicaid Recipients "Admitted"						
	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05	SFY 06
Custody In-State		4.17%	(2.67%)	(10.95%)	36.9%	(28%)
Custody Out-of-State		6.5%	54.9%	42.5%	(43.6%)	12.7%
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Non-Custody In-State		6.7%	19.5%	(3.3%)	25%	(31.4%)
Non-Custody Out-of-State		16.7%	19.7%	34.4%	(32.2%)	(7.5%)
<b>Total</b>		11.7%	21.6%	24.0%	(20.9%)	(13%)

**Table 3**



**Findings: (Reference Table 4-6)**

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**. The RPTC population as a whole has also showed steady increase from SFY 98-04, an average annual increase of 24.8%. However:

- There was an **average annual decrease of .6% in** number of distinct OOS RPTC recipients for FY05 and FY06.
- There was an average **annual increase of 3.45%** in the number of distinct RPTC recipients for FY05 and FY06 - **the smallest annual increase since the inception of Medicaid data.**

Between SFY 2005 and 2006:

- The distinct number of OOS RPTC recipients increased by only 4.5%: **less than 10% of the average increase between 98 and 04.**
- The distinct number of RPTC recipients increased only **3.1%: the smallest increase since the inception of Medicaid data.**

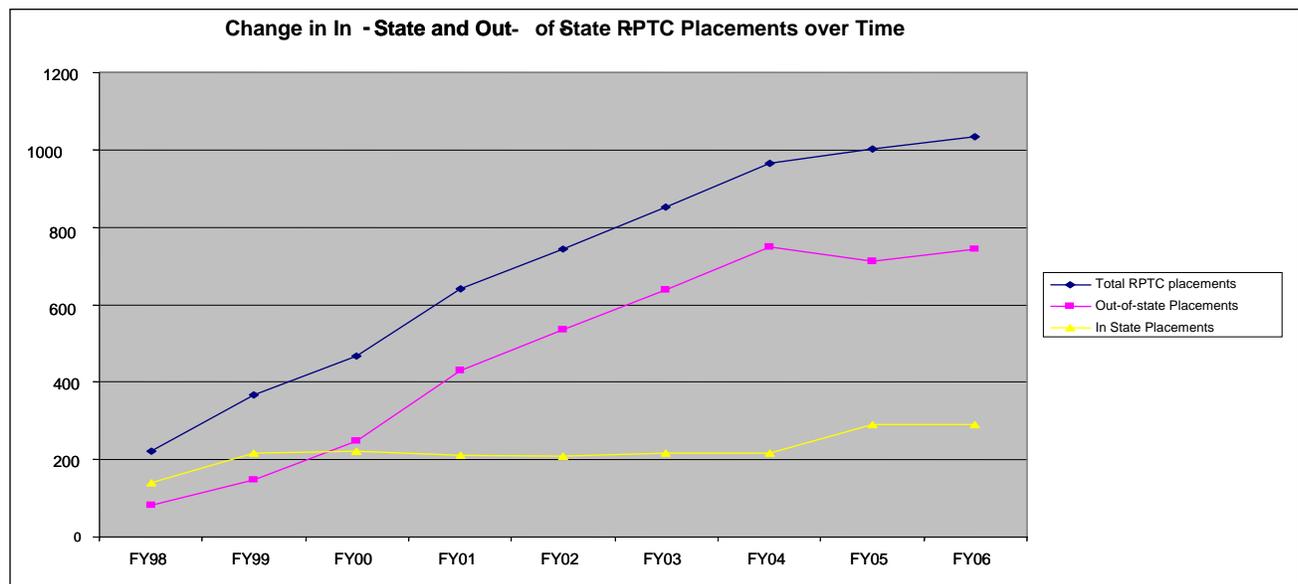
**Table 4**

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	SFY 06
<b>Out-of-state</b>	83	149	247	429	536	637	749	711	743
<b>In State</b>	139	217	221	211	208	215	216	291	290
<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>	<b>1,033</b>

**Table 5**

Percentage of Increase (Decrease) between SFY 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	SFY 06
<b>Out-of-state</b>		67.4%	65.8%	73.7%	24.9%	18.8%	17.6%	(5.1%)	4.5%
<b>In State</b>		56.1%	1.8%	(4.5%)	(1.4%)	3.4%	0.4%	34.7%	(0.3%)
<b>Total</b>		<b>64.9%</b>	<b>27.9%</b>	<b>36.8%</b>	<b>16.3%</b>	<b>14.5%</b>	<b>13.3%</b>	<b>3.8%</b>	<b>3.1%</b>

**Table 6**



**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 7-10)

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 2005 and 2006:

- Out-of-State RPTC Medicaid expenditures **increased by only 4.4%**.
- In-State RPTC Medicaid expenditures **increased by 3.5%**.
- Total RPTC Medicaid expenditures increased by **4.7%**- the smallest annual increase since 1998.

**Table 7**

<b>RPTC Medicaid Claims Payments by Custody Status</b>									
	<b>SFY 1998</b>	<b>SFY 1999</b>	<b>SFY 2000</b>	<b>SFY 2001</b>	<b>SFY 2002</b>	<b>SFY 2003</b>	<b>SFY 2004</b>	<b>SFY 2005</b>	<b>SFY 2006</b>
<b>Custody In-State</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	\$ 4,286,893
<b>Custody Out-of-State</b>	401,489	1,290,044	1,450,504	2,245,852	2,877,001	3,381,025	2,949,086	3,807,682	\$ 4,750,807
<b>Non-Custody In-State</b>	774,714	2,485,103	3,318,245	4,268,054	5,752,895	6,297,200	7,429,806	10,003,184	\$10,010,219
<b>Non-Custody Out-of-State</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	\$35,258,084
<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>	<b>\$54,306,003</b>

**Table 8**

<b>Percentage of Increase (Decrease) Between SFY- Medicaid RPTC Claims Payments</b>									
	<b>SFY 1998</b>	<b>SFY 1999</b>	<b>SFY 2000</b>	<b>SFY 2001</b>	<b>SFY 2002</b>	<b>SFY 2003</b>	<b>SFY 2004</b>	<b>SFY 2005</b>	<b>SFY 2006</b>
<b>In State</b>	-	99.2%	11.8%	31.1%	12.0%	9.4%	14.3%	19.8%	3.5%
<b>OOS</b>	-	95.3%	93.7%	78.3%	23.5%	42.1%	22.3%	1.1%	4.4%
<b>Total</b>	-	97.3%	50.7%	60.0%	19.8%	32.4%	20.3%	5.5%	4.7%

**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.**

**Findings:** (Reference Table 9-10)

- For Out-of-State Custody placements in an RPTC, the average length of stay was 294 days, **a reduction of 2.6% from SFY 05**.
- For Out-Of-State Non-Custody placements in an RPTC, the average length of stay was 297 days, **a reduction of 3.9% from SFY 05**.
- For In-State Non-Custody placements, **there was a marked increase of 46.8%**<sup>4</sup>

<sup>4</sup> There is some question about this increase and it will be verified/discounted in future reports.

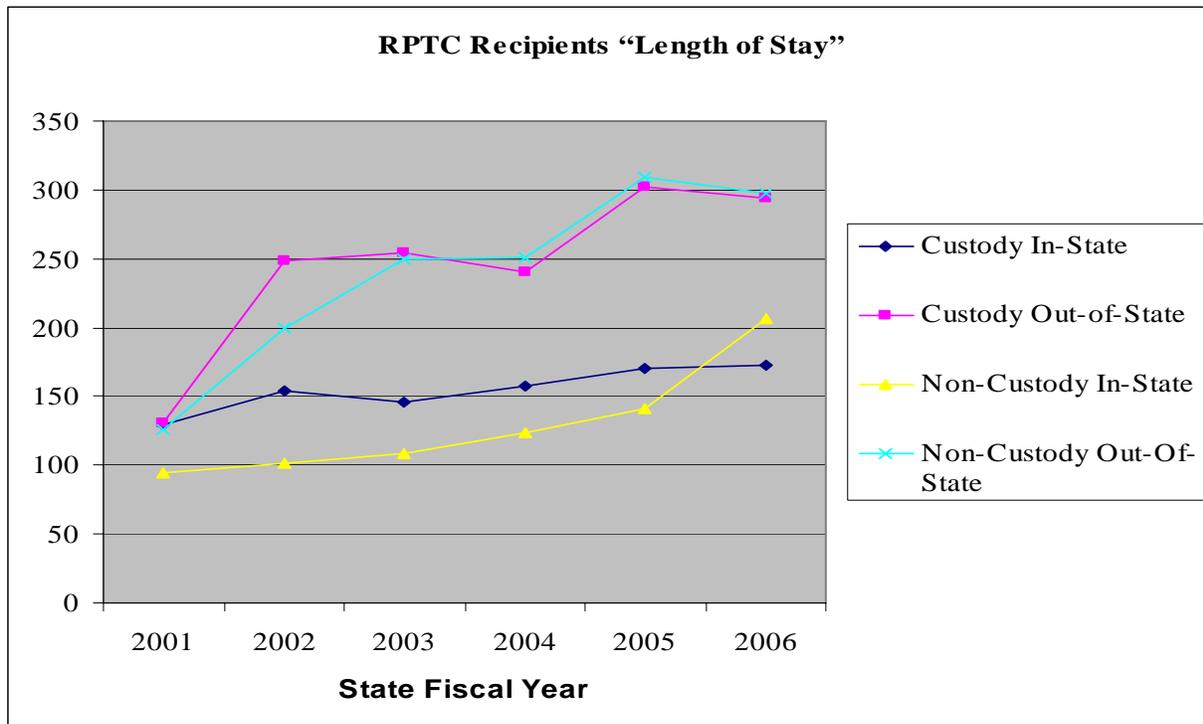
**Table 9**

Average Length of Stay ( in days)							
Custody	IO	01	02	03	04	05	06
Custody	In-State	129.5	154	146	158	170	173
Custody	Out-Of-State	131.4	249	255	240	302	294
Non-Custody	In-State	94.0	101	108	124	141	207
Non-Custody	Out-Of-State	126.3	200	250	251	309	297

**Table 10**

Percentage of Increase (Decrease) between SFY- Average Length of Stay						
	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05	SFY 06
<b>Custody In-State</b>		18.9%	(5.2%)	8.2%	7.6%	1.8%
<b>Custody Out-of-State</b>		89.5%	2.4%	(5.9%)	25.8%	(2.6%)
<b>Non-Custody In-State</b>		7.4%	6.9%	14.8%	13.7%	46.8%
<b>Non-Custody Out-of-State</b>		58.4%	25%	0.4%	23.1%	(3.9%)

**Table 11**



*Note:*

*Count represents claims received from admission to discharge.*

*Numbers for Acute care are currently under review.*

**Indicator 4: Service Capacity – Increase in the number of in-state residential beds for children/youth by 60 percent by SFY 12. (10 percent per year).<sup>5</sup>**

**Findings:** (Reference Table 12)

**Table 12**

	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09
In-state Bed Capacity (below RPTC) (Existing & Projected)				530	530	530	535	589	716	880
In-state Bed Capacity (RPTC) (Existing & Projected)				123	123	123	123	183	183	275
<b>TOTAL In-State Beds</b>				<b>653</b>	<b>653</b>	<b>653</b>	<b>658</b>	<b>772</b>	<b>899</b>	<b>1155</b>

**Indicator 5: Recidivism: Decrease in the number of children/youth returning to RPTC and acute hospitalization 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)<sup>6</sup>**

**Findings:** (Reference Table 13-17)

- For SFY '06, the over-all recidivism rate was 14.3%, for a readmission to an RPTC within 365 days of the date of discharge.
- The recidivism rate for Non-Custody In-State placements has experienced a steady decline: from '04 (26%), '05 (17%), and '06 (12%).
- For the SFY '04-'06, the greatest risk of readmission to an RPTC occurs within 31-180 days from discharge (44.2%), followed by 1-30 days (30.9%).

**Table 13 (Recidivism: Summary Table)**

	Discharges by SFY	Readmissions Following Discharge within...			Total Readmits	%	
		1-30 days	31 – 180 days	181 – 365 days			
All Placements (Custody / Non-Custody)	<b>SFY 04</b>	458*	30 (32%)	39 (42%)	24 (26%)	93 (100%)	20%*
	<b>SFY 05</b>	445*	21 (37.5%)	24 (42.8%)	11 (19.6%)	56 (100%)	12.5%*
	<b>SFY 06</b>	424*	14 (22.9%)	30 (49.1%)	17 (27.8)	61 (100%)	14.3%*
	<b>Total</b>	1,327*	65 (30.9%)	93 (44.2%)	52 (24.7%)	210 (100%)	15.8%*

<sup>5</sup> This indicator has been modified during this reporting period. The previous indicator #4 read: *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).*

<sup>6</sup> This indicator has been modified during this reporting period. The previous indicator #5 read: *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*

**Table 14 (Recidivism TOTAL)**

Custody Status	Placement	Discharges by SFY		Readmissions			Total Readmits	%
				Following Discharge within...				
				1-30 days	31 – 180 days	181 – 365 days		
Custody	In-State	<b>SFY 04</b>	51	4	2	1	7	13%
		<b>SFY 05</b>	73	4	2	2	8	11%
		<b>SFY 06</b>	56	1	8	3	12	21%
Custody	OOS	<b>SFY 04</b>	39	2	7	2	11	28%
		<b>SFY 05</b>	32	1	4	1	6	19%
		<b>SFY 06</b>	52	3	4	4	11	21%
Non-Custody	In-State	<b>SFY 04</b>	106	12	10	6	28	26%
		<b>SFY 05</b>	92	10	5	1	16	17%
		<b>SFY 06</b>	81	2	5	3	10	12%
Non-Custody	OOS	<b>SFY 04</b>	262	12	20	15	47	18%
		<b>SFY 05</b>	248	6	13	7	26	10%
		<b>SFY 06</b>	235	8	13	7	28	12%
<b>Total</b>			1327					

**Table 15 (Recidivism: SFY 04)**

Custody Status	Placement	Discharges by SFY		Readmissions			Total Readmits	%
				Following Discharge within...				
				1-30 days	31 – 180 days	181 – 365 days		
Custody	In-State	<b>SFY 04</b>	51	4	2	1	7	13%
Custody	OOS	<b>SFY 04</b>	39	2	7	2	11	28%
Non-Custody	In-State	<b>SFY 04</b>	106	12	10	6	28	26%
Non-Custody	OOS	<b>SFY 04</b>	262	12	20	15	47	18%
<b>Total</b>			458*	30 (32%)	39 (42%)	24 (26%)	93 (100%)	20%*

**Table 16 (Recidivism: SFY 05)**

Custody Status	Placement	Discharges by SFY		Readmissions			Total Readmits	%
				Following Discharge within...				
				1-30 days	31 – 180 days	181 – 365 days		
Custody	In-State	<b>SFY 05</b>	73	4	2	2	8	11%
Custody	OOS	<b>SFY 05</b>	32	1	4	1	6	19%
Non-Custody	In-State	<b>SFY 05</b>	92	10	5	1	16	17%
Non-Custody	OOS	<b>SFY 05</b>	248	6	13	7	26	10%
<b>Total</b>			445*	21 (37.5%)	24 (42.8%)	11 (19.6%)	56 (100%)	12.5%*

**Table 17 (Recidivism: SFY 06)**

Custody Status	Placement	Discharges by SFY		Readmissions			Total Readmits	%
				Following Discharge within...				
				1-30 days	31 – 180 days	181 – 365 days		
Custody	In-State	<b>SFY 06</b>	56	1	8	3	12	21%
Custody	OOS	<b>SFY 06</b>	52	3	4	4	11	21%
Non-Custody	In-State	<b>SFY 06</b>	81	2	5	3	10	12%
Non-Custody	OOS	<b>SFY 06</b>	235	8	13	7	28	12%
<b>Total</b>			424*	14 (22.9%)	30 (49.1%)	17 (27.8)	61 (100%)	14.3%*

**NOTE:**

1. The data for Indicator #5 reflects RPTC re-admissions, and does not include admits to acute level of care.
2. This data does not include lateral transfers from one RPTC facility to another.

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**Indicator 6: Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered.<sup>7</sup>**

The DHSS / Behavioral Health have implemented a *Performance Management System*<sup>8</sup>. The goal is to develop an outcomes measurement and management capacity that will provide accountability and consistency in the evaluation and effectiveness of behavioral health services. It is the intent of the BTKH planning effort to include residential services into the *Performance Management System*.

<sup>7</sup> This indicator has been modified during this reporting period. The previous indicator #6 read: *Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered*

<sup>8</sup> [http://www.hss.state.ak.us/dbh/perform\\_measure/perfmeasuredefault.htm](http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm)

During SFY 08, the DHSS / Behavioral Health will be implementing the *Behavioral Health Consumer Survey (BHCS)*<sup>9</sup> as the instrument to measure the client satisfaction of RPTC services. The administration and management of this process will follow the administration and implementation schedule as defined in the current *Performance Measures System Policy* (located at: [http://www.hss.state.ak.us/dbh/perform\\_measure/perfmeasuredefault.htm](http://www.hss.state.ak.us/dbh/perform_measure/perfmeasuredefault.htm) ).

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***Indicator 7: Functional Improvement – Eighty five percent of children and youth show functional improvement in one or more life domain areas at discharge and one year after discharge.***<sup>10</sup>

It is the intent of DHSS / Behavioral Health to apply the current mechanisms within the *Performance Management System* to measure the functional improvement of children and youth who have received services through an RPTC. Specifically, the *Client Status Review of Life Domains (CSR)* will be utilized to measure overall functional improvement, as well as, multiple specific life domains. During SFY 08, the DHSS / Behavioral Health staff will identify the necessary steps for the implementation and management of the project tasks associated with this component of this indicator.

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<sup>9</sup> As part of a statewide effort to evaluate and improve behavioral health services, the Division of Behavioral Health (DBH), The Alaska Mental Health Trust Authority (AMHTA), and the Alaska Mental Health Board (AMHB) developed the *Performance Measures Project* initiated July 1, 2002. The Mental Health Statistics Improvement Program (MHSIP)<sup>9</sup> was selected as the consumer survey. In 2006, the MHSIP was adapted into the *Behavioral Health Consumer Survey (BHCS)*.

<sup>10</sup> This indicator has been modified during this reporting period. The previous indicator #7 read: *Functional Improvement – Eighty five percent of children show functional improvement in one or more life domain areas one year after discharge*