

Department of Health & Social Services

Bring (Keep) the Kids Home: Annual Report FY07

Executive Summary

- **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 youth with severe emotional disturbances (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 (Keep) 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.

BTKH Project Highlights for State Fiscal Year 07:

Between FY98 and FY04 the total number¹ of SED youth receiving out-of-state RPTC care per year steadily increased - on average 46.7% per year. During the same time period the distinct number of in-state residential psychiatric treatment care recipients remained relatively flat, showing little change. The RPTC population as a whole showed a steady increase from SFY 98-04 with an average annual increase of 24.8%. However between FY06 and FY07:

- There was a **decrease of 19.8%** in out-of-state RPTC recipients.
- There was an **increase of 33.8%** in in-state RPTC recipients.

¹ Includes all children served in an RPTC during the reporting year, including those admitted during a previous year. It is an unduplicated total of clients served in RTPC for the year.

- There was a **decrease of 4.8%** in total RPTC recipients.

As noted above, overall admissions² per year showed a steady **increase** from SFY 98-04. However, between FY06 and FY07:

- There was a **decrease of 36.3%** in Out-of-State Non-Custody RPTC admissions.
- There was a **decrease of 37%** in Out-of-State RPTC admissions.
- There was a **decrease of 6.6%** in total RPTC admissions.

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 FY06 and FY07:

- There was a **decrease of 8.16% in** out-of-state RPTC Medicaid expenditures.
- There was an **increase of 46.1% in** in-state RPTC Medicaid expenditures.
- There was an **increase of 6.13% in** total RPTC Medicaid expenditures.

These figures illustrate the beginning of a trend of declining out-of-state expenditures for residential care and the expansion of capacity and utilization of residential psychiatric treatment care within Alaska.

How are these gains being achieved?

Part One: Part one of this report describes the systemic restructuring and re-investment activities taking place. These are at all levels (home, community, regional, statewide) and address funding gaps, coordination and management of resources to policies, procedural and regulatory changes and other systemic changes.

Part Two: Part two of this report describes the outcome indicators monitored through BTKH and the progress made on each indicator.

² This includes only children admitted to an RPTC during the State fiscal year. It is an unduplicated total of admissions to RPTC for the year.

Part One

Overview of the Problem

Between state fiscal year 1998 and 2004 the children's behavioral health system in Alaska became increasingly reliant on inpatient hospital and Residential Psychiatric Treatment Center (RPTC) care for treatment of youth with severe emotional disturbances. During that period acute care admissions increased by one-third and total days of inpatient acute care increased by 90%. Out-of-state placements in RPTC care grew by nearly 700% and in-state RPTC care grew by 145% from FY98-FY03.

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 (Keep) the Kids Home Project

The Department of Health and Social Services initiated BTKH 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 project is reinvesting funding from out-of-state residential 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, the initiative continues to build upon the existing infrastructure to treat youth in their own communities, region and state.

Strategies for Change

Seven strategies for change 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:** Develop a wide range of accessible home and community-based services to 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, revise existing regulations and management strategies, and implement regional networks to divert kids from residential care.

FY2007 BTKH Project Highlights: by Strategy

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

I. Scope: The BTKH Project planning processes recognize that success requires a broad scope of activity and a community, regional, state, and out-of state level of change within the service delivery system.

II. 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.

III. Stakeholders: A broad group of stakeholders must be at the table to guide this system change effort. During FY07 two expansions were made to stakeholders:

- A new “Education Subcommittee” started, co-led by Commissioner Barbara Thompson from the Department of Education and Deputy Commissioner Bill Hogan from the Department of Health and Social Services.
- Continued to seek to expand parent involvement in BTKH planning.

IV. Communication: Communication within DHSS, with stakeholders, parents, and providers is essential to success. During FY07 two new strategies were implemented:

- A BTKH manager was hired for DHSS to coordinate DHSS activities.
- A “Joint Management Team” was established to include the deputy directors of Behavioral Health, Children’s Services and Juvenile Justice, the head of Policy and Planning for Behavioral Health, the head of Residential Services for the Office of Children’s Services and the new BTKH Coordinator.

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

I. Strategies for Family Voice:

- System changes impact families and youth receiving mental health care directly. Families know from personal experience what works and what does not work. For this reason, through the BTKH initiative, family voice is built into planning and monitoring.
- Travel stipends and teleconferencing capacity are available to support participation.
- During FY07, a “family voice” teleconference was started by the Mental Health Board. This provides direct on-going exchange of information and organizes parent input for the quarterly BTKH planning meetings.
- During FY07, efforts began to develop a youth advisory group and to increase structured peer support available to youth in the system.

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 FY07, financing, regulatory and policy review continued. Brief descriptions are included below:

I. Individualized Funding:

- “Individualized Service Agreements” (ISA) were implemented to ensure that youth with SED are served as close to home as possible, by providing flexible services to prevent

institutional care. ISA's are the mechanisms through which funds are allocated for services that cannot be reimbursed and/or are not covered through any other sources. ISA allow funding for a service that is specifically designed as a part of a child's mental health treatment plan. Access to ISA funding is currently available through DBH Behavioral Health providers and will be expanded to encompass OCS behavioral rehabilitation service providers during FY08.

II. School Behavioral Health:

- The Educational Subcommittee advocated for funding for two projects for FY08 to improve services for children with severe emotional disturbances in the school system: the first will facilitate transitions between residential treatment and schools and the second will develop a tool kit to help schools take advantage of regulations allowing them to provide behavioral health services for children with IEPs and a behavioral health problem that interferes with school work.

III. BRS:

- A formal rate review was conducted for OCS Behavioral Rehabilitation Services. An average 18% rate increase was recommended and implemented during FY07.
- During FY07, new regulations and BTKH funding allowed access to unused beds in BRS residential facilities for non-custody children at risk of movement into OOS care.

IV. Residential Care Management:

- During FY07, DHSS began developing site review and critical incident protocols to more intensively manage out-of-state residential psychiatric treatment centers. RPTC enrollment regulations revision began during FY07 to provide an additional tool for system management.
- During FY07 DBH solicited a new contract with increased duties for care coordination, level of care review and data collection. Qualis Health Care will start in January of 08.
- DHSS drafted a solicitation to identify a contractor to work with DHSS to integrate standards, criteria and management of the residential care system, regardless of custody status. This project will go forward aggressively during FY08.
- A new "bed needs" model was developed to track residential care resources and predict capacity needs. This model will be refined by outcomes and system planning.

V. Regulations:

- DHSS began planning for development of regulations to improve access for young children and their families to behavioral health services during FY07.
- DBH continued regulations development to integrate mental health and substance abuse services.
- DHSS applied and was accepted for a Federal demonstration project to develop a service system to care for children with a severe emotional disturbance and a fetal alcohol spectrum disorder in community settings rather than RPTC.

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

I. BTKH Indicators: Through the BTKH planning process 7 indicators were developed 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.

II. BTKH Target Goals:

- For each indicator, aggressive target goals were set which reflected the desire for immediate system improvement. Goals were not based on an assessment of the potential for system change, on national norms, or on the ability to access data for each indicator.
- While strong progress on the target goals illustrates success in reducing the movement of Alaskan children into out-of-state RPTC care, the target goals need to be modified. During FY08, new target goals will be identified where existing goals are inappropriate.
- Work continues on reporting data for the final two indicators. DBH plans to begin reporting on these during FY08.

Strategy 5: Home & Community-Based Services - Develop a wide range of accessible home and community-based services to reduce the need for residential care and to ease transition back into the community for children in out of home care.

I. BTKH Capacity Expansion Grant Program:

- The Home and Community Based Capacity expansion grant program started in FY06 to develop new home and community based services for children with a severe emotional disturbance. Through FY08, 28 competitive grants were funded in Seward, Kenai, Ketchikan, Kodiak, Kotzebue, Metlakatla, Bethel, Prince of Wales, Juneau, Anchorage, Fairbanks, and MatSu.
- These grant projects created new beds, increased services for children with difficult presentations/challenging diagnoses and implemented best practices. For FY06 and FY07 56 lower level beds were developed; 74 children were stepped down from out-of-state RPTC and 162 children were stepped down from more restrictive in-state care. The grants served approximately 500 children.
- During FY08, an independent contractor will evaluate the outcomes of the capacity expansion program. This information will guide operational system development.

II. MATSU Pilot Project:

- During 2007 DHSS started a project in MATSU to provide care management to coordinate comprehensive community services for children stepping down from RPTC or to divert children from RPTC.
- The pilot project began admitting children and families to services in October of 07 and will be fully implemented during FY08. If this model is successful, it may be expanded.

III BTKH Capital Enhancements:

- BTKH Capital funding was provided by the Denali Commission, the Division of Behavioral Health and the Mental Health Trust Authority.
- The primary objective is to develop residential alternatives to increase the capacity to serve youth with an SED within Alaska.
- Funding allocations awarded to date equal approximately \$4,679,064. Additional funding of \$1,898,186 has been approved. Projects have been funded in: Anchorage, Fairbanks, Juneau, Ketchikan, Kenai, Dillingham, Eklutna, and MatSu. Additional projects are currently under development in Anchorage, Kotzebue and Juneau. Projects have/will develop a range of new in-state residential capacity including:
 - Therapeutic foster and group homes (generally 5 beds or fewer).
 - A level IV residential facility
 - A level V residential facility with locked beds.
 - A transitional living facility
 - A 44 bed tribally run culturally competent level IV/V treatment center at Eklutna.

IV: Tribal Capacity Expansion: One BTKH goal is to enhance capacity for tribal mental health service delivery. This will increase access to culturally competent care, care closer to home/in rural hubs, and also allow access to 100% federal reimbursement for beneficiaries.

- Juneau Youth Services and Southeast Regional Health Corporation opened a new residential treatment facility. JYS estimates a savings to State GF of \$265,000 for the first 10 ½ months of start-up. JYS estimates the full year savings at approximately \$500,000.
- Other tribal projects include: *SouthCentral Foundation* - 44 bed Eklutna RPTC, *Bristol Bay Health Corporation/Bristol Bay Native Association/Family Centered Services of Alaska* - 5-bed group home, *Maniilaq* - community based & in-school services and a 5-bed group home, *Metlakatla* - new community and school based mental health program. DHSS is also working with two tribes that have federal system of care grants to improve mental health services: *Fairbanks Native Association* is in the final year of an implementation grant and *Cook Inlet Tribal Corporation & SouthCentral Foundation* have a planning grant and are partnering on an implementation proposal.

Strategy 6: Work Force Development - Build the capacity and core competencies of in-state providers to meet the needs of kids with severe behavioral health disorders. As new programs and facilities are developed, staff must be available to work with children with challenging behaviors and complex needs and their families. General recruitment, retention, education and training activities have been incorporated into the Alaska Mental Health Trust Authority's new focus area on workforce development. The sub-committees for this focus area developed the following goals and objectives, which are currently being implemented:

I. Develop strategies so that Alaska has 1,000 new qualified employees that work with Trust beneficiaries by 2015.

- Develop a comprehensive “grow your own” recruitment strategy for youth. The Alaska Health Education Center is encouraging youth to participate in career exploratory activities to increase the long-term availability of professionals in behavioral health.
- Develop comprehensive marketing strategies, including activities to recruit Alaska Natives and other minorities and non-traditional populations. A presentation was made during AFN's Elder and Youth Conference.
- Northwest Strategies was awarded the contract to conduct a comprehensive media campaign.
- Trust staff presented information on workforce development to the Alaska Workforce Investment Board to develop a partnership and enhance recruitment of a workforce to support Trust beneficiaries.

II. Develop and implement strategies to retain qualified employees, including incentives for the development of a qualified, compassionate workforce.

- Committee members are working closely with the Alaska Postsecondary Commission to work out specific details of a loan forgiveness program. Options for providing housing in rural areas are also being explored.
- Maintain ongoing activities of the Alaska Alliance for Direct Service Careers including support for website, supervisor training, Full Lives Conference and technical assistance to help providers develop individualized recruitment and retention plans. Provide technical assistance to help 8 agencies develop individualized recruitment and retention plans; several serve youth with severe behavioral health disorders.

- The wages and benefits sub-committee is developing a 1-page fact sheet and talking points for use in legislative advocacy. Particular emphasis is being placed on the impact of low wages and inadequate benefits on the lives of trust beneficiaries.

III. Develop education and training programs to meet the needs of the current and future workforce.

- Establish training cooperatives to provide and coordinate training and career development when and where the need arises. Planning for the training cooperative is well underway. A needs and resource assessment is being used to drive implementation activities.
- Children’s Residential Services Certificate Program: There are several promising developments: courses are underway, practicum sites have been developed across the State and students from a variety of communities are participating. A partnership was developed with DHSS for the new Medicaid Waiver project. This creates a career pathway for direct service professionals working with the target population (children with a severe emotional disturbance and a fetal alcohol spectrum disorder in, or at risk of placement in an RPTC).
- FASD Waiver Training: A training curriculum on the Mentoring, Modeling and Monitoring Model for youth age 14-21 with severe emotional disturbances and fetal alcohol syndrome disorders was developed during late in FY07.
- Person-Centered Planning Training: DHSS received a grant from the Centers for Medicare & Medicaid Services to provide training on person-centered planning for youth with severe emotional disturbances. The Center for Human Development will be responsible for developing the curriculum and providing training.

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

I. Utilization Review: In FY05, DBH created a Utilization Review team which is now staffed with five positions. During FY07, the team accomplished the following:

- Began reviewing all children in acute care to ensure that in-state services were accessed prior to referral to out-of-state care. During FY07, the team diverted 16 children from RPTC care through this process.
- Facilitated services for children stepping down from out-of-state care.
- Maintained a Diversion Database to gather clinical and demographic information pertaining to youth admitted into inpatient settings.
- Maintained/analyzed information related to outcomes and system management.
- Approved individualized funding to divert children from residential care.

II. BTKH Coordinators: During FY07, the Division of Juvenile Justice and the Office of Children’s Services each hired a “Bring the Kids Home” coordinator to work with the DBH utilization review team and to act as BTKH lead for the two divisions. During FY07, these positions accomplished the following:

- Participated with DBH Utilization Review Team in acute care reviews.
- Removing the barriers within their existing system and developing new and innovative ways to utilize residential and community resources.
- Identify issues that require input and expertise of other state agencies
- Develop community resources and build relationships with existing entities to enhance the existing home and community-based infrastructure.

- Program integrity functions including data collection, analysis of utilization reviews, site reviews, grievance and consumer satisfaction tracking.
- Developed individualized service agreement for use with Behavioral Rehabilitation Service Providers (to be implemented during FY08).

III. Individualized Service Agreements: During FY07 Individualized Service Agreements (ISA) were implemented to fund flexible services to maintain a child with a severe emotional disturbance in a community setting instead of a residential setting. ISA are part of an individualized plan and can be used when no other funding source exists for the item or service. The UR and BTKH Coordinators are responsible for approving ISA plans. During FY07:

- 17 providers were signed on across the State.
- 61 children were served using ISA funds.
- The average total cost per recipient was \$5,597.00. A single day in an RPTC care setting is approximately \$260. One month of RPTC care = \$7,800, not including travel.

IV. Resource Committees/Regional Networks:

- During FY07 the UR team expanded to develop and work with regional networks. During FY08, all children referred for out-of-state care will go through a regional review team to identify in-state resources, before being approved for out-of-state care.
- DBH held 5 BTKH planning summits during FY07 to collect information on community/regional needs. These summits also build collaboration between providers to serve children at risk of moving out of the community for mental health services. FY07 summits were in Bethel, Fairbanks, Juneau, Kenai and Kodiak. FY08 summits will begin in Kotzebue and expand to additional communities based on need.

V. Level of Care:

- DBH contracted with McKesson Corporation in the use of a Level of Care Assessment, referenced as “InterQual” to inform utilization of RPTC care.
- During FY06 this tool was piloted for children in acute care settings and those youth being referred for ISA funds.
- During FY07, refinements were made to the use of the tool.
- During FY08, the tool will be a required part of the clinical necessity review by the new contractor. Also, the level of care assessment will be piloted in the community and for the FASD Demonstration Waiver.

Part Two

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.

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)*³

Findings (Reference Table 1-3): The RPTC population as a whole also showed steady increase from SFY 98-04. Between SFY06 and 2007:

- The distinct number of In-State Custody RPTC recipients “admitted” during SFY07 **increased** by 10%.
- The distinct number of In-State Non-Custody RPTC recipients “admitted” during SFY07, **increased** by 98.4 %
- The distinct number of Out-of-State Non-Custody RPTC recipients “admitted” during SFY07, **decreased** by 36.3%.
- The distinct number of total Out-of-State RPTC recipients “admitted” during SFY07, decreased by 37%.
- The distinct number of total RPTC admissions for SFY07 decreased by 6.6%.

Table 1

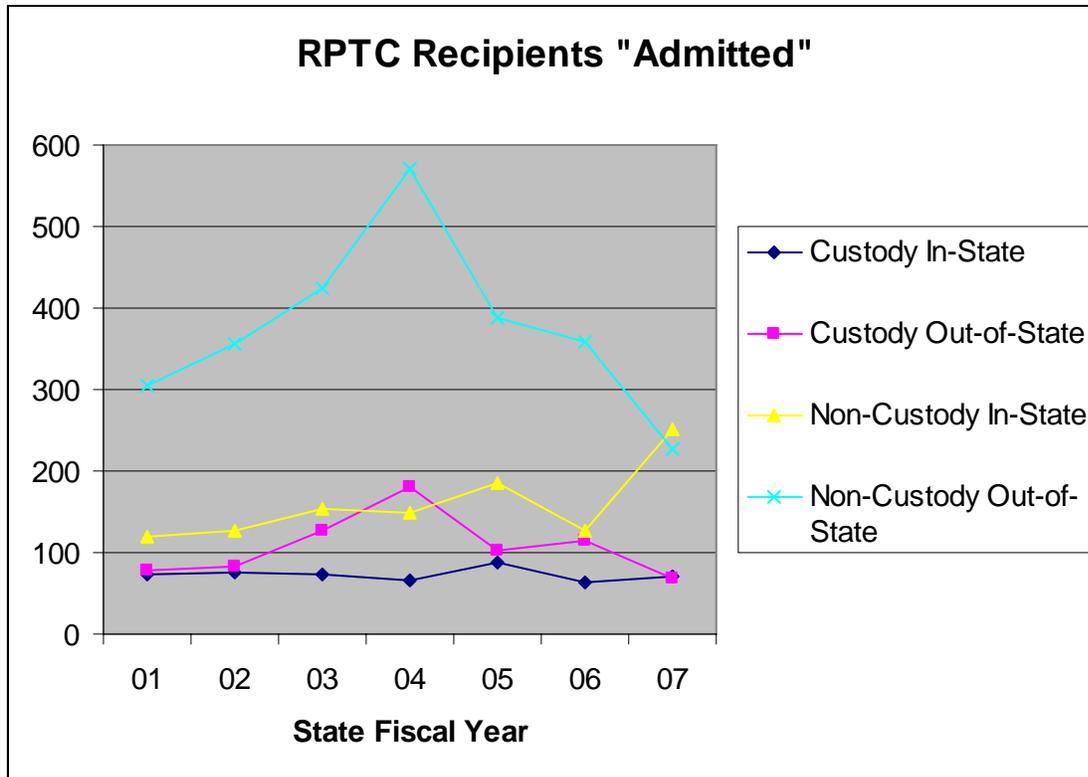
Unduplicated Count of Medicaid RPTC Recipients “Admitted”							
	2001	2002	2003	2004	2005	2006	2007
Custody In-State	72	75	73	65	89	64	71
Custody Out-of-State	77	82	127	181	102	115	69
Non-Custody In-State	120	128	153	148	185	127	252
Non-Custody Out-of-State	304	355	425	571	387	358	228
Total	573	640	778	965	763	664	620

Table 2

Percentage of Increase (Decrease) between SFY- Distinct RPTC Medicaid Recipients “Admitted”							
	SFY 01	SFY 02	SFY 03	SFY 04	SFY 05	SFY06	SFY07
Custody In-State		4.17%	(2.67%)	(10.95%)	36.9%	(28%)	10%
Custody Out-of-State		6.5%	54.9%	42.5%	(43.6%)	12.7%	(40%)
Non-Custody In-State		6.7%	19.5%	(3.3%)	25%	(31.4%)	98.4%
Non-Custody Out-of-State		16.7%	19.7%	34.4%	(32.2%)	(7.5%)	(36.3%)
Total		11.7%	21.6%	24.0%	(20.9%)	(13%)	(6.6%)

³ 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)**

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 between FY06 and FY07:

- There was a **decrease of 19.8%** in the number of distinct OOS RPTC recipients served⁴.
- There was an **increase of 33.8%** in the number of distinct RPTC recipients who received services instate. This reflects increased bed capacity and utilization.
- There was a **decrease of 4.8%** total RPTC recipients served.

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	SFY07
Out-of-state	83	149	247	429	536	637	749	711	743	596
In State	139	217	221	211	208	215	216	291	290	388
Total	222	366	468	640	744	852	965	1,002	1,033	984

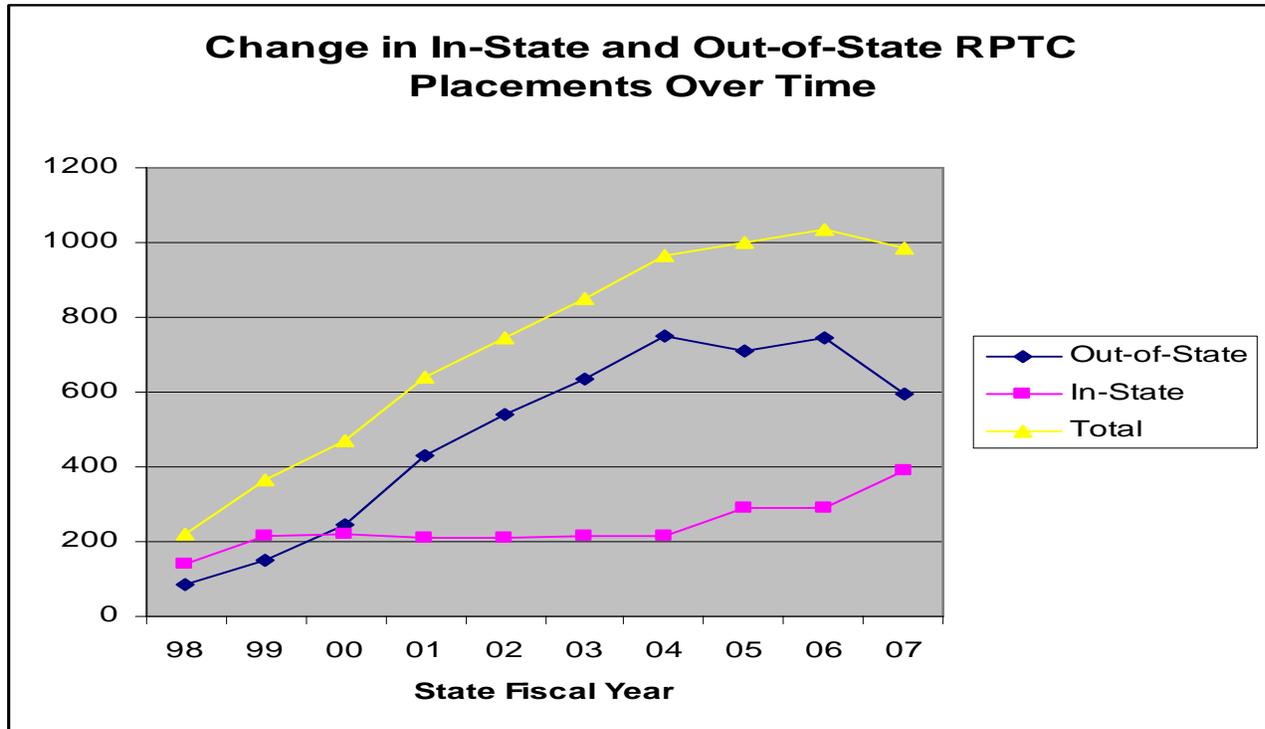
Table 5

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	SFY06	SFY07
Out-of-state		67.4%	65.8%	73.7%	24.9%	18.8%	17.6%	(5.1%)	4.5%	(19.8%)
In State		56.1%	1.8%	(4.5%)	(1.4%)	3.4%	0.4%	34.7%	(0.3%)	33.8%
Total		64.9%	27.9%	36.8%	16.3%	14.5%	13.3%	3.8%	3.1%	(4.8%)

⁴ Includes all children served in an RPTC during the reporting year, including those admitted during a previous year.

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 7-8): 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 increased more than 300% and realized smaller average annual increases of 29.6%. Between SFY 2006 and 2007⁵:

- There was a **decrease of 8.16% in** out-of-state RPTC Medicaid expenditures. *This is the first decrease in out-of-state expenditures since BTKH efforts began.*
- There was an **increase of 46.1% in** in-state RPTC Medicaid expenditures.
- There was an **increase of 6.13% in** total RPTC Medicaid expenditures.

⁵ Fiscal year 2007 expenditures were completed by DHSS Finance Management Services and include all claims incurred and paid in FY07 as well those incurred in FY07 and paid in the first quarter of FY08. SFY98 - SFY06 calculations were provided by DBH. Every attempt was made to replicate the parameters used between DBH and DHSS FMS. Parameters have now been standardized and future years will replicate the parameters used for FY07.

Table 7⁶

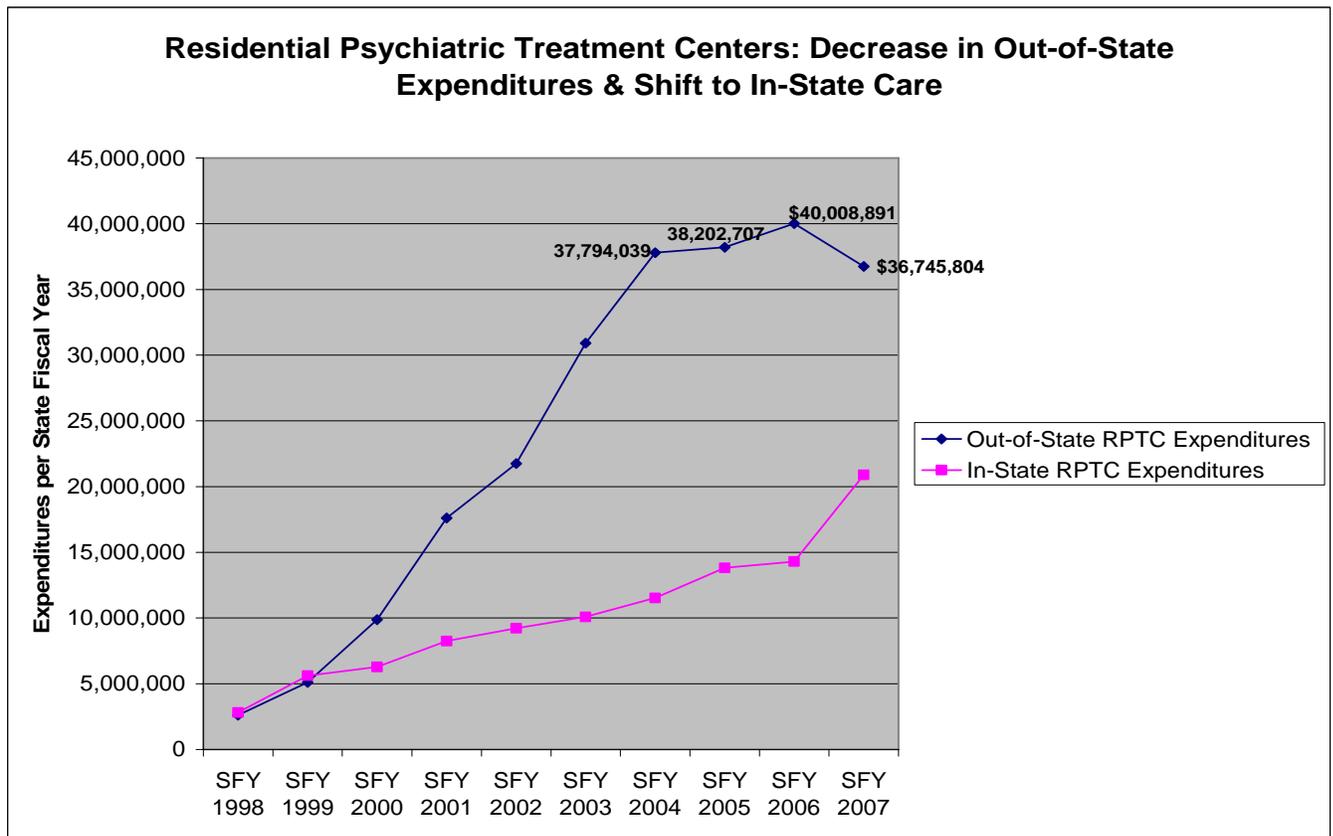
	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Out-of-State RTPC Expenditures	\$2,609,857	\$5,098,189	\$9,873,606	\$17,609,108	\$21,752,228	\$30,915,287	\$37,794,039	\$38,202,707	\$40,008,891	\$36,745,804
In-State RTPC Expenditures	\$2,823,582	\$5,623,348	\$6,286,219	\$8,242,948	\$9,229,970	\$10,093,200	\$11,532,083	\$13,812,640	\$14,297,112	\$20,888,007
Total	\$5,433,439	\$10,721,537	\$16,159,825	\$25,852,056	\$30,982,198	\$41,008,487	\$49,326,122	\$52,015,347	\$54,306,003	\$57,633,811

Table 8

Percentage of Increase (Decrease) Between SFY- Medicaid RTPC Claims Payments

	SFY 1998	SFY 1999	SFY 2000	SFY 2001	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY06	SFY07
In State	-	99.2%	11.8%	31.1%	12.0%	9.4%	14.3%	19.8%	3.5%	(8.16)%
OOS	-	95.3%	93.7%	78.3%	23.5%	42.1%	22.3%	1.1%	4.4%	46.1%
Total	-	97.3%	50.7%	60.0%	19.8%	32.4%	20.3%	5.5%	4.7%	6.13%

Table 9



⁶ Fiscal year 2007 calculations were completed by DHSS Finance Management Services and include all claims incurred and paid in FY07 as well as those incurred in FY07 and paid in the first quarter of FY08. SFY98 - SFY06 calculations were provided by DBH. Every attempt was made to replicate the parameters used between DBH and DHSS FMS. Parameters have now been standardized and future years will replicate the parameters used for FY07.

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 10-12):

- For In-State Non-Custody placements, there was a marked decrease in FY07 of 31.9% for the average length of stay.
- For Out-Of-State Non-Custody placements, there was an average increase of 12.8% in the average length of stay.
- The average length of stay for all RPTC placements decreased in FY07 by 3%.

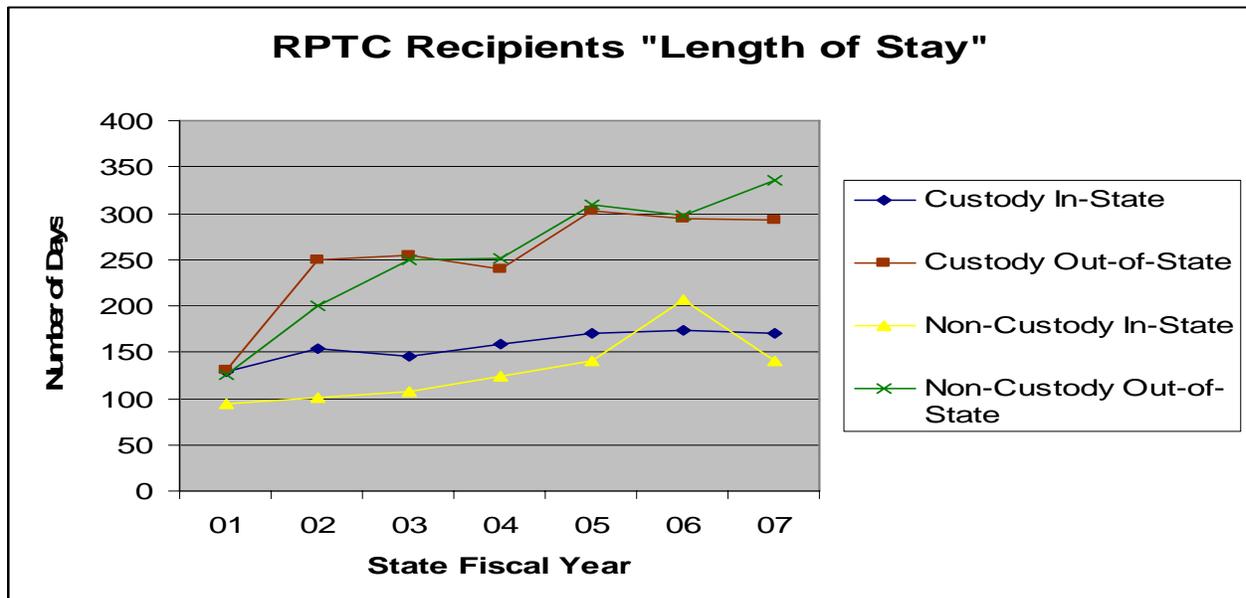
Table 10

Average Length of Stay (in days)								
Custody	IO	01	02	03	04	05	06	07
Custody	In-State	129.5	154	146	158	170	173	171
Custody	Out-Of-State	131.4	249	255	240	302	294	293
Non-Custody	In-State	94.0	101	108	124	141	207	141
Non-Custody	Out-Of-State	126.3	200	250	251	309	297	335

Table 11

Percentage of Increase (Decrease) between SFY – Average Length of Stay								
Custody	IO	01	02	03	04	05	06	07
Custody	In-State		18.9%	(5.2%)	8.2%	7.6%	1.8%	(1.16%)
Custody	Out-Of-State		89.5%	2.4%	(5.9%)	25.8%	(2.6%)	(.0034%)
Non-Custody	In-State		7.4%	6.9%	14.8%	13.7%	46.8%	(31.9%)
Non-Custody	Out-Of-State		58.4%	25%	0.4%	23.1%	(3.9%)	12.8%

Table 12



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).⁷

Findings (Reference Table 13):

Table 13

	FY03	FY04	FY05	FY06	FY07
In-state Bed Capacity (below RPTC) (Existing & Projected)	530	530	530	535	638
In-state Bed Capacity (RPTC) (Existing & Projected)	123	123	123	123	166
TOTAL In-State Beds	653	653	653	658	804

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)⁸

Findings (Reference Table 14):

- For SFY07, the over-all recidivism rate was 7.5%, for a readmission to an RPTC within 365 days of the date of discharge, down from the SFY06 recidivism rate of 14.4%
- The recidivism rate for Non-Custody In-State placements has experienced a steady decline: from '04 (26%), '05 (17%), '06 (12%), and '07 (9%).
- The recidivism rate for Non-Custody Out-of-State placements has declined from '06 (12%) to '07 (4%).
- The recidivism rate for Custody In-State placements has declined from '06 (21%) to '07 (10%).
- The recidivism rate for Custody Out-of-State placements has declined from '06 (21%) to '07 (11%).

Table 14 (Recidivism TOTAL)

Custody Status	Placement	Discharges by SFY		Readmissions Following Discharge within...			Total Readmits	%
				1-30 days	31 – 180 days	81 – 365 days		
Custody	In-State	SFY 04	51	4	2	1	7	13%
		SFY 05	73	4	2	2	8	11%
		SFY06	56	1	8	3	12	21%

⁷ 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).*

⁸ 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*

		SFY07	68	1	4	2	7	10%
Custody	OOS	SFY 04	39	2	7	2	11	28%
		SFY 05	32	1	4	1	6	19%
		SFY06	52	3	4	4	11	21%
		SFY07	55	2	4	0	6	11%
Non-Custody	In-State	SFY 04	106	12	10	6	28	26%
		SFY 05	92	10	5	1	16	17%
		SFY06	81	2	5	3	10	12%
		SFY07	194	12	6	1	19	9%
Non-Custody	OOS	SFY 04	262	12	20	15	47	18%
		SFY 05	248	6	13	7	26	10%
		SFY06	235	8	13	7	28	12%
		SFY07	239	4	5	1	10	4%

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.

Indicator 6: Client Satisfaction – Via annual reporting, 85 percent of children and families report satisfaction with services rendered.⁹

The DHSS / Behavioral Health have implemented a *Performance Management System*¹⁰. 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*.

⁹ 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*

¹⁰ 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 (BHCS¹¹)* as the instrument to measure the client satisfaction of RPTC services. The intent is to implement this indicator by January, 2008.

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).

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.¹²

The DHSS / Behavioral Health will 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. The intent is to implement this indicator by January, 2008.

¹¹ 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)¹¹ was selected as the consumer survey. In 2006, the MHSIP was adapted into the *Behavioral Health Consumer Survey (BHCS)*.

¹² 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*