FAMILY STABILIZATION AND SUPPORT SERVICES

FY12				FY13			
MHTAAR Increment	General Fund Increment	Fed Increment	Total	MHTAAR Increment	General Fund Increment	Federal Increment	Total
$638	$638	$0	$1, 276	$688	$558	$0	$1,246

Proposal 1- Parenting with Love and Limits and Intensive Family Therapy (Com BH outpx): Most of the youth admitted to out-of-state Residential Psychiatric Treatment Centers come from families with multiple needs (family history of substance abuse = 70%; family history of mental illness: 64%; child experienced physical abuse = 64%)[1]. 66% of children leaving out-of-state RPTC return to their parents or another relative. Family problems present a barrier in getting/keeping children in their homes and impact the long-term outcomes for youth.

This project will provide start-up grants to implement Parenting with Love and Limits (PLL). PLL is an evidence-based family therapy for children with mental health and substance use problems and for children with juvenile justice involvement. PLL is manualized and is ideal for a start-up of a high quality intervention for youth with highly problematic behaviors and challenging family situations. These funds may also cover training and technical assistance for other intensive family therapy and in-home treatment modalities statewide.

For FY11 continue existing grant (Seward, Kenai & Homer) and solicit a two-year grant in Anchorage.
For FY12 continue on-going grants ($200K each) and solicit two-year grant for Fairbanks. $400 MHTAAR increment required
For FY13, continue on-going grants and solicit two-year grant to rural hub ($250K each). $450 MHTAAR increment required

Proposal 2 - Enhanced Care Coordination (Com BH outpx)**:** Youth in out-of-state RPTC have complex treatment needs: aggression is the primary referral reason for 56%. 76% of the youth have experienced multiple traumas and 64% have experienced physical abuse. 60% have 1 or more co-morbidity (developmental or physical disability, etc). Most of these youth are from Anchorage (51%). FY09 data shows that 78% of the youth were admitted to out-of-state residential psychiatric treatment from an acute care placement[2]. These youth continue to have difficulty accessing in-state services and stabilizing in their home settings.

This project will replicate an existing pilot project in MATSU designed to ensure that coordinated, comprehensive services are provided to high-risk families who have children with severe emotional disturbances in/at risk of RPTC placement. Results from the pilot are encouraging and suggest replication may be an effective strategy. This project will include two key services: enhanced care coordination for families and 24-hour support and technical assistance for providers. The target population will be families and youth from the Anchorage area, at risk of RPTC placement or returning from an RPTC placement. Priority is for children with aggressive behaviors, co-occurring disorders, or for families with multi-system involvement (OCS, DJJ, Adult Justice, PA).

For FY11 continue existing grant and solicit for an Anchorage grantee.
For FY12, continue existing grants and expand to Fairbanks. $400 GF increment required
For FY13, evaluate sustainability. Address gaps and if needed, fund rural pilot project. ($200 GF existing funding) + $200 GF increment required

[1] See "RPTC Admissions Summary Draft" & "RPTC Discharged Recipient Summary Draft" at http://www.hss.state.ak.us/commissioner/btkh/reports.htm
[2] See "RPTC Admissions Summary Draft" & "RPTC Discharged Recipient Summary Draft" at http://www.hss.state.ak.us/commissioner/btkh/reports.htm

Proposal 3 - Peer/Parent Navigation: Most children in out-of-state RPTC come from families with multiple needs (family history of substance abuse = 70%; family history of mental illness: 64%; child experienced physical abuse = 64%). 66% return to their parents or another relative on leaving out-of-state RPTC[3]. Family problems present a barrier in getting/keeping children in their homes and result in poor long-term outcomes for youth. Many of these families are not familiar with the Alaska behavioral health system. Some of them may have negative experiences with State service systems, and many of them do not have basic skills to parent children with behavioral health disorders. Peer navigation services are not sustainable through Medicaid or other non-grant sources; however, they have proven effective: for FY08 and FY09, over 90% of children served who were at risk of out-of-home placement stayed in their own communities[4].

Project will develop peer navigation and support services for children at risk of/returning from RPTC or residential placements. Currently peer/parent navigation is primarily available in Anchorage. Peer/parent navigation uses trained parents whose children have been in behavioral health services in Alaska provide support to other parents and trained youth to provide support to other youth. It also provides skill training and assistance to parents in understanding and accessing behavioral health and other services. This is a non-clinical service which works in conjunction with other supports.

For FY11 expand peer/parent navigation and support to two additional communities and add a rural pilot project.
For FY12 expand peer/parent navigation and support to additional communities. $100 MHTAAR + $100 GF increment required
For FY13 provide statewide technical assistance to CBHC to implement internal peer navigation. $100 MHTAAR + $100 GF increment required

Proposal 4 - Foster Parent and Parent Recruitment, Training and Support: Children in the custody of the Children's Services or Juvenile Justice made up about 26% of the population in residential psychiatric treatment centers during FY09. Custody youth have a consistently higher recidivism rate for out-of-state RPTC. 64% of the youth in out-of-state RPTC have experienced physical abuse and 76% have experienced multiple traumas. Foster parents and parents for these youth have requested services to assist them to support children to remain in their homes/foster homes.

This funding will support training, technical assistance, and targeted recruitment activities for parents and foster parents. In addition, it will develop intensive family preservation and support for families with behavioral health needs. It will target families for whom a report of harm may not be substantiated and provide support to prevent a child being removed from parental custody.

The State Division of Children's Services frequently interfaces with families for whom a report of harm has been received: even when there is no finding of abuse or neglect, families experience parenting difficulties and challenges that can result in more severe problems in the future. Research on Intensive Family Preservation (IFSP) estimated savings of about $2.54 on placement services for every dollar spent providing IFSP[5]. However, for FY08, only about 1/5 of the children in OCS out-of-home care during FY08 could access prevention or stabilization services. Family Preservation grants were able to serve only 19% of the total child welfare population (425 out of 2,150 children) and Family Preservation funding decreased for FY09 & FY10.

For FY11 expand intensive family preservation services and continue training and TA.
For FY12 maintain services at the current level and move MHTAAR to general fund. $138 MHTAAR + $138 GF increment required
For FY13 maintain at current level, add one-year training effort, and move MHTAAR to general fund. $138 MHTAAR + $138 GF increment required

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[3] See "RPTC Admissions Summary Draft" & "RPTC Discharged Recipient Summary Draft" at http://www.hss.state.ak.us/commissioner/btkh/reports.htm
[4] See "AYFN BTKH Reports"at: http://www.hss.state.ak.us/commissioner/btkh/reports.htm
[5] See National Family Preservation Network at: http://www.nfpn.org/

Proposal 5 - DJJ Parenting with Love and Limits Clinician: Youth in out-of-state RPTC have complex treatment needs and presentations: aggression is the primary referral reason for 56%. 26% of the youth in out-of-state RPTC and 31.4% of the youth in in-state RPTC have "legal problems" as a risk factor. 62% of the youth in out-of-state RPTC and 69% of the youth in in-state RPTC have "treatment compliance" as a risk factor.

When youth with severe behavioral health disturbances come through the justice system there is an opportunity for DJJ to provide intensive family therapy when the family dynamics and the child's behavioral health problems suggest that this is required to reduce recidivism and improve outcomes. However, many youth in detention do not have access to Medicaid and many families do not have private insurance to cover the cost of intensive family therapy.

This project will implement Parenting with Love and Limits (PLL) at DJJ facilities in Anchorage and Fairbanks. PLL is an evidence-based family therapy intervention for children with mental health and substance use problems and for children with juvenile justice involvement. PLL is ideal for a relatively quick start-up of a high quality intervention that works with youth with highly problematic behaviors and challenging family situations. During FY10, a clinician position was created at the Anchorage DJJ detention facility to implement PLL.

For FY11 continue PLL at the Anchorage facility.

For FY12 or FY13 establish one new position at the Fairbanks facility $120 GF increment required

Consequences of no funding: The Adverse Childhood Experiences study[6] showed that children exposed to abuse or neglect (or other adverse events) developed risk taking behaviors in adolescence and adulthood including alcoholism and drug abuse, suicide attempts, and multiple sexual partners. They had higher risks for heart disease, stroke, diabetes, mental illness and other chronic health problems. There are also additional costs related to having children come into custody of OCS or DJJ or moving in/returning to a behavioral health residential placement.

Most children return from RPTC, or from a DJJ detention placement, to their families or relatives. Many families experience challenges of their own. Often, insurance does not cover the cost of intensive family therapy. In order to stabilize children and improve outcomes, we need to address family functioning. Without services these children are at high risk for involvement in expensive high-end services. Despite increases to the Medicaid rate for community-based services, there continues to be a lack of family therapy statewide. This is particularly true for families who have multiple needs. However, these are (often) the type of families to which children return after an out-of-home placement. In addition to their need for clinical services, these families often need additional support and training to provide a stable placement for their children. Children with challenging presentations such as aggression still have difficulty accessing services in Alaska. This makes it even harder for a family to get comprehensive services.

Without a targeted response, the desired increase in the in-state capacity to effectively serve these youth and their families will not occur and our system will continue to rely on high end residential services.

[6] See Adverse Childhood Experiences Study website: http://www.acestudy.org/

BEHAVIORAL HEALTH TECHNICAL ASSISTANCE

FY12				FY13			
MHTAAR Increment	General Fund Increment	Fed Increment	Total	MHTAAR Increment	General Fund Increment	Federal Increment	Total
$300	$200	$0	$450	$225	$160	$60	$445

Proposal 1 - Clinical Performance Improvement (BH TA): DHSS is engaged in statewide performance improvement through BTKH and seeks to increase implementation of best practices. These practices are required in the community behavioral health service system as well as in State run facilities. These system improvement efforts are occurring in an Alaskan environment of workforce, staffing and sustainability challenges.

This project supports on-going training and technical assistance to support implementation of best practices in clinical programming. Two contracts will be funded by this project:

Parenting with Love and Limits (PLL): Dr. Scott Sells, the originator of PLL, will provide training technical assistance and clinical supervision in PLL implementation in Alaska. During FY10, Dr. Sells provided these services for community-mental health pilot projects that served Kenai, Homer and Seward and trained one Anchorage DJJ clinician.

For FY11 continue TA and expand this contract to one additional CMHC PLL pilot project.
For FY12 continue TA and expand this contract to one additional CMHC PLL pilot project. $125 GF increment required
For FY13 continue TA, expand to an additional OCS and DBH clinician and an additional CMHC PLL pilot project. $125 MHTAAR increment required

Transition to Independence Process (TIP): Dr. Rusty Clark from the University of South Florida National Network on Youth Transition, and a team, will provide technical assistance and training in the Transition to Independence Model. This training will be available to the grant funded sites as well as to other providers serving youth of transition age with behavioral health challenges. Technical assistance will be available to DHSS to support development of policies and procedures.

For FY11 expand contract to cover additional system development and training activities for DHSS grantees.
For FY12 expand contract to cover an additional TIP site. $200 MHTAAR increment required
For FY13 expand contract to cover an additional TIP site. $100 GF increment required

Proposal 2 – BRS Medicaid Training and TA (BH TA): DHSS is engaged in major system restructuring to align OCS behavioral health rehabilitation services (BRS) with DBH behavioral health residential services. These system improvement efforts are occurring in an environment where behavioral health providers in Alaska experience workforce, staffing and sustainability challenges. This funding will support a contractor to work with DHSS and BRS providers to implement Medicaid service delivery and billing for BRS providers.

For FY12 establish one contract for statewide TA & Training. $ 100 MHTAAR increment required
For FY13 continue contract if needed. $ 100 MHTAAR increment required

Proposal 3 – School Based Services Tool Kit: This project has established a Medicaid billing tool kit to assist schools in developing access to Medicaid funded services to support children's individualized education plan. This project allows schools to expand school-based behavioral health services.

For FY12 move required on-going funding to GF. $25 GF increment required

Proposal 4 – Child Psychiatrist: This project funds a contract with a Board Certified child psych to provide and/all of the following: doc to doc consultation to residential treatment facilities, acute care and primary care, around issues of case planning and treatment recommendations; second opinion for state staff working to divert children from RPTC or step down from acute care and consult to primary care docs for children at risk of moving into acute or residential care. The focus of this consultation service will be to determine appropriate levels of care/placement; reduce overuse of psychiatric medications; promulgate the use of alternative, non-medical evidence based treatment practices for children and families.

For FY12 move required on-going funding to GF. $50 GF increment required

Proposal 5 - DBH Family Specialist: Despite increases to the Medicaid rates for community-based services, there continues to be a lack of family therapy statewide. This is particularly true for families who have significant challenges. These are (often) the type of families to whom children return after RPTC placement: in a FY09 sample of out-of-state RPTC admissions/discharges there was a family history of substance abuse for 70% of the families and of mental illness for 64%. 64% of the children had experienced physical abuse. However, 66% of children leaving RPTC in the sample returned to their parents or another relative. This project provides training, consultation and technical assistance to behavioral health providers to increase implementation of evidence based family interventions. The position will have a statewide system development and consultation role.

For FY13, DBH is requesting one position for a "clinical family specialist". $60 GF + $60 Federal match increment required

Consequences of no funding: BTKH efforts have required a substantial investment of staff time and resources from DHSS. This allocation of time and resources has been highly effective in creating system change. However, DHSS resource cannot take on the additional technical assistance, training, and strategic planning activities required as "next steps" for system development. Without these resources DHSS will have difficulty institutionalizing and continuing the BTKH efforts over the long-term.

SCHOOL-BASED SERVICES

FY12				FY13			
MHTAAR Increment	***General Fund Increment***	***Fed Increment***	***Total***	***MHTAAR Increment***	***General Fund Increment***	***Federal Increment***	***Total***
$75	$75	$0	$150	$75	$75	$0	$150

Proposal 1 – Grants to Improve School Based Services: Most youth admitted to out-of-state RPTC have education issues: for a FY09 sample; 84% of these youth had "education" as a psycho-social factor, 56% had "school suspension" as a risk factor, and 41% had an individualized education plan. The Department of Education and school districts have identified a number of problems in serving children with severe emotional disorders: difficulties with transitions of children between behavioral health residential care and schools as well as access to the behavioral health services that children need access to in the school setting. Parents and community mental health centers have identified school-based services as an essential component to maintain and return children with behavioral health services to their homes and communities. Alaska does not have consistent access to school-based behavioral health services and school transitions continue to be challenging in many circumstances. This funding supports three projects to improve school-based behavioral health services:

Educational Coordination: Provides educational coordination for youth returning from RPTC outside of Alaska to ensure that when youth return from residential settings to their home schools they have access to school behavioral health services to support this transition. This requires coordination between the family, the residential system, the schools and the community-mental health centers. During FY11 and FY12 we will evaluate the educational coordination pilot project and institutionalize necessary long-term components and make regulation and policy changes to address system issues. We do not anticipate fully funding this project long-term.

For FY11 continue project at its current level of funding. No new funding.
For FY12 evaluate and continue necessary components. No new funding.
For FY13 provide long-term grant/contract for any necessary long-term components. No new funding.

Positive Behavioral Supports: Supports four community pilots to prepare for implementing Positive Behavioral Support Services (PBS). PBS is a school-based mental health best practice that impacts youth at the primary and secondary prevention and early intervention level as well as at the tertiary (intervention) level for children with severe disturbances. In pilot project schools there has been improvement in the frequency of disciplinary referrals.

For FY11 continue projects and expand to two additional communities.
For FY12 fund two additional three-year Early Childhood PBS grants $75 MHTAAR + $75 GF increment required
For FY13 fund one additional three-year grants $75 MHTAAR + $75 GF increment required

Consequences of no funding: The gaps in the Alaska system of care will continue to present barriers to treating children in their homes and communities. This will continue to contribute to children failing into higher levels of care (or back into such care). Strong school-based services are an essential component of the community-based service system required to treat children with severe disturbances in their homes.

ADDRESS FUNDING/SERVICE GAPS

FY12				*FY13*			
MHTAAR Increment	***General Fund Increment***	***Fed Increment***	***Total***	***MHTAAR Increment***	***General Fund Increment***	***Federal Increment***	***Total***
$300	$2,825	$2, 000	$5,125	$300	$550	$0	$850

Proposal 1 – Individualized Service Agreements (ISA): Funding gaps result in children moving into mental health residential care and/or which represent a barrier in transitioning children back into their homes and communities can be addressed through ISA. Gaps include "individualized" needs when the child is not eligible for Medicaid, the family's insurance can not cover the service and the family does not have the resources to cover the service. The service must be essential to the child's treatment plan and stabilization in the community. Examples are: clinical and rehabilitation services; transportation costs; treatment incentives; equipment or supplies; recreational activities, etc. FY09 data showed that less than 1% of youth who received an ISA moved into an RPTC placement. This suggests that ISA are an effective diversion/step down strategy to keep children out of high-end Medicaid funded residential services.

This project will increase ISA access to children with a primary diagnosis of Substance Use Disorder in order to reach children before they demonstrate behavioral health disturbances that result in mental health residential treatment. It will also support on-going efforts to enroll the remaining children's behavioral health service grantees with DBH as ISA providers.

For FY11 expand ISA to cover additional populations and communities/providers.
For FY12 expand ISA to cover additional communities/providers. $300 GF increment required
For FY13 expand ISA to cover additional communities/providers. Narrow ISA access based on high-priority usage. $200 GF increment required

Consequences of no funding: The current funding serves a population that is fairly narrow and excludes children with primary diagnoses of substance use disorders. Current funding is sufficient to cover the cost of current providers; however, more than 10 providers have not yet enrolled. If the funding pool is not expanded, there will be a shortfall in funding as ISA use expands. This may have an impact on the ability to divert these youth from residential care.

Proposal 2 - Implement Transition to Independence Process (TIP) (Transition Aged Youth): A FY09 sample found that most youth in out-of-state RPTC were admitted and discharged between ages 14 – 22 (64% and 88.1%). 25% of the RPTC discharges were for young adults aged 18 – 21. This sample also found that 66% of the youth returned (initially) to live with a parent or family member. However, these family members had substantial challenges including histories of substance abuse problems (70%) and mental illness (64%).

National research shows that despite continuing mental health disorders, mental health service use drops off as youth with behavioral disorders move into adulthood. The BTKH youth who are discharging from RPTC and returning home to families who experience their own challenges are at extreme risk for poor long-term outcomes. Covenant House Alaska found that almost 40% of the youth served had a history of residential mental health treatment and approximately 80% were Alaska Mental Health Trust beneficiaries. The disconnection from positive supports can result in many poor outcomes in addition to homelessness:

interference of mental health and substance abuse problems in daily functioning, involvement with criminal justice, unplanned pregnancy, unemployment, poverty, and high utilization of public services.

This project will implement the "Transition To Independence Model" a cross disciplinary engagement and strengths-based model to work with youth and young adults so that when youth reach transition age their plan includes a full range of appropriate (and desired) vocational, educational and support activities. This project will improve outcomes for these youth by linking them effectively with existing resources, teaching life skills, and providing support to create the safety network that many of their families are unable to provide. The project will also begin to use the TIP to develop housing alternatives for transition age youth. Housing remains a barrier to stabilizing TAY in the community. By first developing the coordination and system collaboration required by TIP implementation we anticipate that identifying strategies for start-up and maintenance of housing for these youth will be sustainable.

For FY11 expand to one additional community.
For FY12 expand to one additional community and add one or more housing pilot projects. $200 MHTAAR + $100 GF increment required
For FY13 expand to one additional community and add one or more housing pilot projects. $200 MHTAAR + $100 GF increment required

Consequences of not funding: Although Alaska has a range of services and supports for transition age youth and young adults who experience disabilities, many youth do not take advantage of these services. With appropriate engagement, skills training and coordination youth can become productive adults with stable housing, employment and a safety net and reduce reliance on expensive high-end social services, health and criminal justice interventions.

Proposal 3 - Early Childhood Mental Health Services: Most of the children who end up in out-of-state RPTC have long-standing and complex problems that began at an early age. In a FY09 sample, 64% of the youth in out-of-state RPTC had experienced physical abuse and 76% had experienced multiple traumas. Most had families who had experienced significant problems: 70% of the families had a history of substance abuse and 64% of the families had a history of mental health problems. However, Alaska is plagued by a lack of mental health practitioners experienced in early childhood mental health issues and interventions. Currently very few (3 or 4) community mental health centers have programs for young children. Mental health services for young children in most of Alaska are inconsistent or unavailable. Mental health clinicians, Early Intervention/Infant Learning, child care, Head Start staff, and others need basic professional early childhood mental health training and consultation to identify mental health problems and to serve children with these issues in their natural environments in order to interrupt the development of severe problems and movement into high-end residential mental health services.

This project has two parts designed through the Early Childhood Comprehensive Systems Grant to improve mental health outcomes for young children in Alaska. These will support development of a statewide, integrated service system to keep young children from developing more severe problems.

Early Childhood Grants: This project will develop Early Childhood Mental Health Consultation for programs serving children (birth – 6) at risk/or experiencing social emotional disturbances. ECMHC is an evidence based practice. Currently this funding supports a pilot project in Anchorage that is working with young children who have been traumatized and their parents.

For FY11 continue pilot project.
For FY12 maintain services at the current level and move the MHTAAR to general fund. $75 GF increment required

Clinician for Day Care and HeadStart Programs (Early Mental Health Learning Network): Fund a contract for a statewide training coordinator and/or consultation, technical assistance, and professional development to mental health clinicians, family support workers, and early interventionists.

For FY11 continue pilot projects in Anchorage.
For FY12 maintain services at the current level and move MHTAAR to general fund. $100 GF increment required

Consequences of no funding: The Adverse Childhood Experiences study[7] showed that children exposed to abuse or neglect (or other adverse events) developed risk taking behaviors in adolescence and adulthood including alcoholism and drug abuse, suicide attempts, and multiple sexual partners. They had higher risks for heart disease, stroke, diabetes, mental illness and other chronic health problems. Discontinuing the funding will end current pilot projects to reach children earlier in order to prevent their entry into high-end Medicaid funded behavioral health residential services and/or other negative systems (juvenile justice, children's services).

Proposal 4 - Tribal/Rural System Development: 34% of the children in out-of-state residential psychiatric treatment centers are Alaska Native. However, between Federal FY 2007 - FY 2008 tribal Medicaid payments for mental health and substance abuse services decreased by 10.27%. This decreases access to services designed for AK Native youth and families as well as decreasing access to services in rural areas of the State. Also, health and mental health services delivered by eligible tribal organizations can access a 100% Federal Medicaid payment rate for tribal beneficiaries. There are good programmatic, access and fiscal reasons for supporting tribal organizations to develop Medicaid billing capacity.

This project will provide a gaps analysis for tribal volunteer sites, development of Medicaid training modules, adaptation of training modules to become culturally competent, development of portions of the tribal behavioral health aide manual, and other grant or contract funded activities to support tribal behavioral health service delivery. These projects were developed with assistance from an oversight group which includes tribal behavioral health directors, the Alaska Native Tribal Health Consortium, The Alaska Mental Health Trust Authority, the State Planning Boards and DHSS staff.

For FY11 continue pilot projects and develop DBH staff position.
For FY12 continue pilot projects, develop new projects as needed. $100 MHTAAR + $100 GF increment required
For FY13 maintain pilot projects, develop new projects, and reinvest in new tribal efforts. $100 MHTAAR + $100 GF increment required

Consequences of no funding: Disproportionately high numbers of Alaska Native children and families are involved with the behavioral health, juvenile justice and children's services systems. FY07 data[8] shows that for Alaska Native youth aged 10 – 19 suicide is the leading cause of death. 32% of Alaska Native high school students reported marijuana use during past 30 days as compared to only 17% of Alaska non-Native students. The proportion of Alaska Native children under age 18 living below the poverty line exceeded 22%: more than double that of the Alaska White population. Lastly, Alaska Native youth under 20 are projected to increase by almost 13,000 between 2000 and 2030. Given that tribal Medicaid payments for mental health and substance abuse services are dropping, it is a priority to develop the capacity of tribal providers to expand behavioral health services via Medicaid.

Proposal 5 – Sub-Acute Stabilization Services: Acute Care continues to be the single highest source of referrals to residential psychiatric treatment centers. This project provides short-term stabilization services to keep children from moving into acute and RPTC care and as a temporary placement while developing long-term plans to move a child from a residential to community setting.

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[7] See Adverse Childhood Experiences Study website: http://www.acestudy.org/
[8] Alaska Native Health Status Report, Alaska Native Epidemiology Center, Alaska Native Tribal Health Consortium, August, 2009

For FY11 continue pilot projects and solicit one additional project in Fairbanks.
For FY12 continue pilot projects, evaluate need for additional services in Matsu. $150 GF increment required
For FY13 maintain pilot projects, evaluate long-term need, move MHTAAR to GF if necessary. $150 GF increment required

Consequences of no funding: Currently most children go straight into an acute care placement rather than utilizing a sub-acute stabilization placement. This is appropriate in many cases when the child's behavior is severe and can not be contained in a less restrictive setting. However, there are also many situations where a child may no longer meet medical necessity criteria for acute care but a safe alternative community placement has not been developed yet. In these cases, a move into long-term residential care can sometimes be avoided through short term stabilization services.

Proposal 6 - BRS Rate Increase: This increment will address the gap between the cost of providing residential services inside Alaska and the current payment rates. During FY ___ DHSS completed a residential rate study recommended a ___% rate increase. A rate increase of ____% was approved and awarded to residential providers. That left an un-funded rate differential of ____%. Adjusted by cost of living that increase the rate increase would be ____%.

For FY12 implement residential rate increase. $ 2,000 GF increment required + $ 2,000 Federal match. (These figures are placeholders and need to be calculated based on actual estimated costs and actual requested rate increase).

Consequences of no funding: During FY10 two level II facilities went out of business and another level II facility is having trouble. One RPTC estimates that operation can continue for one additional year at the current rate, after which they may start to covert beds for other purposes so that they do not lose money operating. Residential providers have participated in BTKH and system improvement efforts but it is increasingly difficult to provide high quality services with competent staff under the current rate structure. While the goal of BTKH is to keep children in their homes, there are also many children who require a residential placement in order to stabilize. BTKH expectations are that residential providers expand their current service profile to become more flexible, more individualized and to better engage families. This will not happen unless they receive adequate funding to run high quality programs.

OVERSIGHT, REGULATION, POLICY AND PROCEDURAL WORK:

Proposal 1 - Joint Management Team: The DHSS Joint Management team is responsible for on-going system development and oversight. As BTKH ends as a free standing initiative, mechanisms need be in place to ensure that cross system collaboration and cooperation continues. This will require agreements about mechanisms for on-going system development and system monitoring. This will be put in place by FY2013. *No cost*

Proposal 2 – Transition Age Youth:

- Efforts at system development for youth and young adults of transition age are hampered by regulation and policy issues which interfere with developing housing and supports for youth of transition age. DHSS will continue this work in FY2012. *No cost*
- Apply for Federal grant or Policy Academy opportunities to support system development for transition age youth and youth adults. As available. *No cost.*

Proposal 3 – Education:

- In order to maintain on-going collaboration between DHSS and DEED post BTKH, we will develop an interagency agreement with the Department of Education to facilitate information sharing, planning and system development for children with severe emotional disturbances. *No cost*
- In order to expand access to behavioral health services we will target Positive Behavioral Support pilot sites to become Medicaid billing agencies. *No cost*

Proposal 4 – Continuum of Care Development:

- DHSS intends to define and describe the behavioral health service system in order to guide system development and access to services. *No cost*
- DHSS intends to implement the CASII as a level of care tool over the next three years. *No cost for policy development.*

Proposal 5 - Person Centered Planning/Wraparound:

- Develop scope, policy and procedure for Person Centered Planning billing by those trained/certified by the UAA Center for Human Development. *No cost*
- Evaluate independent billing for PCP as a mechanism to access Medicaid for cross system care management. *No cost*