DRAFT **Logic Model for building behavioral health service delivery systems in rural areas to improve outcomes for Ak Native youth.** DRAFT

RESOURCES/ INPUTS

Partners

- Tribes
- ANTHC
- DHSS
- Trust
- Stakeholders
- Providers
- Planning Board
- Parent/Youth org

Funding

- The Trust
- BTKH - GF
- Medicaid
- Tribal
- ?

Planning

- CPT
- JMT
- RHB 61 planning
- ANTHC planning
- Tribal BH Directors

Research/Best Practices

- ANTHC BH Aide Standards

ACTIVITIES

Planning Activities

- Engage Tribal BH Directors for coordinated planning/system development.
- Link with tribal planning on SB 61.
- DHSS planning group gathers input from stakeholders

- Develop PD and rationale for New PD.
- Engage with the Trust around staff positions and need for LBNA

Implementation Activities

- DBH on-going BH Medicaid TA & Trng
- Tribal Health Programs on-going Medicaid TA & Trng
- ANTHC on-going Medicaid TA & Trng
- BTKH funding to increase staff for increased TA & support to tribes
- DHSS Planning Group develops funding solicitation or contracts for training "modules"
- Existing and future BTKH H & CB grants to expand capacity (Medicaid component)
- DBH and OCS competitive grant solicitations for rural/tribal areas

Social Marketing

- Discuss reinvestment strategies with tribes as well as the long-term health benefits of a delivering a continuum of BH health care.
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OUTPUTS

Identify service modalities, gaps, strengths, needs: meaningful to tribes.

Provide training and staff development to tribal providers based on the strengths and needs of each tribe/community.

Identify mechanisms for providers to train each other in best billing practices.

Implement necessary steps to create new service types, (if needed).

- Medicaid training modules are developed.
- Website is developed to allow on-line access
- On-going CQI process established to maintain accuracy and usefulness
- Exploring enhanced methods for training.
- Link training efforts for maximum efficiency.

- New staff are hired
- Staff are trained to use modules.

OUTCOMES - IMPACT

Short Term:

- Tribes develop internal capacity for Medicaid service delivery: staff availability, competency, training,
- Tribes have established organizational business processes that support full utilization of Medicaid.
- Tribes develop Medicaid billing competency
- Tribes increase capacity and quality of BH service delivery.
- Tribes overall increase in Medicaid reimbursement
- Improve ability to bill clean claims: lower % of denials.
- Increased tribal/state collaboration on tribal system development.
- Tribes will reinvest increased Medicaid revenues to increase BH services.

Medium Term:

- More developed rural continuum of care
- Increase in strategies/practices appropriate to rural areas in particular
- Fewer children with SED moving out of rural areas to access services
- Lower recidivism rate
- Less Medicaid cost for DHSS

Long Term

- Healthier rural communities

Assumptions

1. Increasing Tribal Access to Medicaid could increase funding available for behavioral health services IF the tribal organization is committed to expanding BH care.

2. Expect overlap between tribal/rural projects and urban projects – can leverage funding/activities.

External Factors

1 Federal policy RE RPTC Waivers, Tribal Case Mgt, etc.
2. Funding available in DHSS
3.