

Bring the Kids Home Initiative

Master Planning Document¹

The Division of Behavioral Health (DBH) and the Alaska Mental Health Trust Authority (AMHTA) are coordinating planning efforts to address issues relative to the Bring the Kids Home (BTKH) initiative. Therefore, in an effort to minimize any duplication of effort, this document will be used as a master planning document to coordinate all planning efforts with the BTKH initiative. In this respect, this is a working document, and will be updated regularly to reflect the progression of the project. It is noted that the document may identify goals and strategies that may or may not be completely endorsed by all planning bodies.

Population of Concern

The Bring the Kids Home initiative focuses on children and youth with severe behavioral health disturbances at risk of institutional placement outside of home, community or state.

Introduction

Alaska's system of care has become increasingly reliant on institutional care for children and youth with severe emotional disturbance: in the past 6 years, acute care admissions increased by one-third and total days of inpatient care increased by 90%. Out-of-state placements in RPTC care grew by nearly 700% and in-state RPTC care grew by 145% from FY'98-FY'03.² At any given time, approximately 400-500 (ranging as high as 600 in recent months) children are being served in out of state placements, ranging in age from six to seventeen, (average age between 14 and 15). Alaska Native children are over represented in the population of children in custody and represent 49% of the custody children sent to out of state placements and 22% of the non-custody children sent to out of state placements.³

Based on data provided by First Health Services Corp., the managed care contractor for Medicaid in Alaska, seventy-two Alaska children were approved for residential psychiatric treatment in the month of June 2004. Of these thirty-two were approved for out-of-state treatment. The DBH estimates the average number of admissions to outside programs per month is thirty. As the total number of children in out-of-state programs has not increased significantly in recent months, it is assumed there is a similar number of discharges per month. The following observations have been made:

The Alaska System of Care

- Reliance on institutional care in general and specifically out-of-state RPTC's has shaped a system of care that reinforces referrals toward a higher level of care.
- Referrals for out-of-state placements are not guided by consistently applied clinical guidelines, or administrative procedures and oversight.

¹ This report is a joint effort between DBH "Policy and Planning" and MHTA

² AMHTA: FY06-07 Budget Recommendation Planning Process (Focus Area Issue Summary).

³ Child and Youth Needs Assessment (CAYNA, 2002)

- Institutionally based services (in and out-of-state) frequently occur without accessing a lower level of care i.e. community based services.
- Families and their children, who are ineligible for Medicaid-funded community based services, can only become eligible after a 30 day institutional placement.
- The current system of care doesn't have capacity to provide specialized services (ex. sex offenders treatment, lower function, FAS, runaway-at-risk, eating disorders), requiring further reliance on out-of-state institutions.

Financial Resources:

- Financial resources for children's mental health, primarily Medicaid expenditures, have proportionately shifted even more dramatically toward institutional care.
- Medicaid expenditures for in-state RPTC care increased 400% from \$3 to \$12 million from FY'98-FY'03.
- Medicaid expenditures for out-of-state RPTC care increased more than ten-fold (from \$3 to \$31 million) during that same period.

Out-Of-State Treatment

- Out-of-state treatment may not be as therapeutically helpful to the children and their families as services delivered close to home might be.
- Out-of-state treatment may result in extended lengths of stay, at greater cost, and at a higher risk of re-admissions.
- Out-of-state treatment sets in motion a therapeutic milieu that expects successful transition of a child back in a family and community environment that may not have been impacted by the episode of care/treatment.
- Out-of-state treatment presents challenges in effective discharge planning, with impacts on successful reentry back into community services and supports.

DBH: A Conceptual Model

The Division of Behavioral Health recognizes that the BTKH project highlights multiple challenges facing the current system of care. The DBH conceptual model reflects an understanding that effective solutions must address these challenges at each different level of the system. In an effort to establish a common vocabulary and understanding of the overall scope of the BTKH project, a flowchart has been developed (attachment). The scope of this project is defined with an understanding that there are 4 levels of the system of care that must be addressed concurrently: community, regional, in-state, and out-of-state care. Further, there are additional issues that are applicable to the underlying foundation of the overall system of care i.e. "utilization oversight", enhanced care coordination, workforce development, funding, facilities, clinical and practice, and continuum of services.

Goals

1. Build the behavioral health service system capacity to address needs of children.

2. Enhance the children's behavioral health system to provide a complete and balanced continuum of care needed to reduce institutionalization.
3. Re-focus State resources from out-of-state institutional care (inpatient hospital care and RPTC care) toward home and community-based services and additional institutional treatment capacity within Alaska.
4. Develop reimbursement mechanisms required to sustain an integrated behavioral health continuum of care and increase the capacity of Native tribal health organizations to serve Native children - maximizing federal support for children's mental health care.
5. Develop a single system of care that promotes the resiliency and recovery of families and youth.
6. Services are matched with: the level of the clients need with the appropriate level of care, the capacity of service delivery in the community of origin, and delivered in the least restrictive environment.
7. Identify DHSS vision for the system of care for children/youth services including home and community-based, foster care, residential care, secure care and secure institutions.

Assumptions

1. Long-term expenditures will be reduced as a state infrastructure is built, children and youth are moved to appropriate levels of care and/or stepped down; and/or their length of stay in the most restrictive settings is decreased.
2. Families and schools will be able to remain actively involved in their child's/students' treatment plan leading to better aftercare.
3. Recruitment of direct service staff and specialized training and plans for retention will be needed on an on-going basis.
4. Planning for infrastructure development needs to maximize existing systems, structures, and resources when they make sense.

Outcome Indicators

1. Increase in the number of children and youth receiving home and community based services in communities or regions of meaningful ties by 60% by FY 12.
2. Decrease in recidivism to residential care by 75 percent by FY 12. Recidivism is a return to the same or higher level of residential care within one year.
3. Reduction in the total number of children and youth being sent out of state by 90 percent by FY12.
4. Annual reporting will indicate that 85 percent of consumers (kids and families) report satisfaction with services received.
5. Reduction in the length of stay in out-of-state and in-state institutions by 50 percent by FY 12.
6. Eighty-five percent of children and youth will show functional improvement in one or more life domain areas at discharge.

General Strategies

1. Articulate and communicate a formal theory of change to *Bring the Kids Home* to various stakeholders statewide and continue ongoing communication. (See Addendum # III)
 2. Develop a strong family and youth voice in policy development, advocacy, family education and support, and quality control/assurance and evaluation. (See Addendum # IV)
 3. Examine financing and policy issues. (See Addendum # V)
 4. Ensure that strong performance measurement/continuous quality improvement procedures are in place. (See Addendum # VI)
 5. 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. (See Addendum # VII)
 6. Build the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders. (See Addendum # VIII)
- Page 1. Develop gate keeping policies and practices and implement regional networks to divert kids from psychiatric residential care. (See Addendum # IX)

Targeted Work Areas

The Division of Behavioral Health and the Mental Health Trust Authority recognize that the BTKH project highlights multiple challenges facing the current system of care. Effective solutions must address these challenges at each different level of the system. The scope of this project is defined with an understanding that there are 4 levels of the system of care that must be addressed concurrently: community, regional, in-state, and out-of-state care. Targeted work areas will be articulated through each general strategy, which will in turn have a logic model (See Addendum, Section III-IX)

Parallel Planning Processes

The scope of the Bring the Kids Home Initiative is broad, and requires the collaboration of multiple planning groups throughout the State. Therefore, when parallel planning processes intersect with the overall Bring the Kids Home Initiative, they will be integrated into the related “targeted work areas”.

DHSS has requested support and assistance from the AMHTA and the AMHB to design, develop, and implement various elements of a comprehensive system of care through time-limited demonstration projects. These projects will help develop the service delivery system and ensure that as soon as possible the majority of Alaskan children will receive the services they need, at the appropriate levels, in Alaska. The AMHTA has developed the following long term goals:

- 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, closest to home as determined to be safe and appropriate.
- Significantly reduce the existing numbers of children and youth in out of state care and gate- keep ensuring that the future use of out of state facilities is kept to a minimum.

Other parallel planning projects that are closer to the service delivery system includes the Alaska Mental Health Providers Association, as well as the Anchorage Providers Group, which has resulted in the return of over thirty children.

Addendum

Section I Utilization Oversight Surveyor

Community- Behavioral Health Centers are encouraged to work together to utilize local resources. This may require implementing incentives to ensure that community agencies are cooperating to provide youth with all available resources prior to referring on to regional teams. It is not anticipated that **gate keeping** or ECC mechanisms will be utilized at this level. Additional resources will be required at the community level to cover evaluation, care coordination, and service coverage gaps to divert and maintain children in community-based care.

Regional- When community resources have been exhausted and youth cannot be served as clinically necessary within their locality, they will be referred on to the regional placement teams. The Trust is funding efforts to utilize regional teams and **gate keeping** efforts to serve children at this level and/or to refer children back to the level of community based services, when additional resources to support such a placement are available, and when community-based placement is clinically preferable. In order to formalize a **gatekeeper** position within the division, it is anticipated that this position may be involved in these committees to monitor youth that may be eventually referred on to more intensive levels of care. When the youth can be served in the region, the **gate keeper** will coordinate efforts with community core teams, when indicated.

Statewide- The regional team including the **gatekeeper** would authorize the child to be served outside of their region, but within the state when clinically indicated. The **gatekeeper** would coordinate with the regional teams and the ECC to identify instate resources, coordinate and monitor services. If placement includes acute care or RPTC levels of care, the **gatekeeper** will begin work with ECCs to identify instate bed availability. When the child is ready to receive lesser restrictive services, the **gatekeeper** would also coordinate and monitor with the appropriate regional or community team to ensure services are effective.

Out of State- The **gatekeeper** would participate on the existing Out of State Placement Committee to discuss those youth who are not experiencing success with instate services. This committee prior authorizes and monitors out of state placement in RPTC's.

Section II Enhanced Care Coordinator (ECC)

The utilization of ECC services through First Health will serve youth who have been placed in RPTC/Acute care (in and out of state). ECCs will participate on treatment teams (be required to for continued authorization?) of these facilities. They will ensure that appropriate state, regional or community BH agencies participate on treatment team meetings. ECCs will monitor discharge criteria, ensure treatment team staffings and

continued care authorizations are clinically appropriate. ECCs will train RPTC and acute care facilities in regards to designing achievable treatment objectives, discharge criteria, Alaskan laws, policies, cultural issues and other special concerns. ECCs will continue to identify youth in the process of being discharged and work with local agencies to set services up for the child and family upon return. ECCs will also monitor aftercare.

Overlapping Duties

It is anticipated that there will be some areas that overlap between The **Gate keeper**, and the ECC, the RPTC coordinator role (to some extent) and the children's specialist role (when referring to lesser restrictive settings than RPTC). These roles will work together as a team, communicate with one another and will assist each other out as needed. Some of these areas of overlap may include:

- Utilization reviews
 - Site visits/reviews
 - Database accessibility/analyses
 - Grievance tracking
 - Tracking policy issues
 - Maintaining knowledge of in and out of state resources
 - Level of care assessments
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Addendum

Section III

Strategy #1: Articulate and communicate a formal theory of change and continue ongoing communication.				
ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<p><i>In order to address our problem or asset we will accomplish the following activities:</i></p> <p>1. Define terms and clarify core values and guiding principles.</p> <p><u>Core Values:</u></p> <ul style="list-style-type: none"> ▪ Child and family centered ▪ Community based ▪ Culturally competent <p><u>Guiding Principles:</u></p> <ul style="list-style-type: none"> ▪ Access to comprehensive array of services ▪ Individualized services ▪ Least restrictive environment and most clinically appropriate ▪ Full family participation ▪ Integrated services ▪ Care coordination ▪ Early identification and intervention ▪ Smooth transitions ▪ Rights of child/family protected ▪ Non-discrimination and cultural appropriateness ▪ Implementation of CQI approach to better managing all aspects of BH care ▪ Resiliency (strength-based) and Recovery Management Model rather 	<p><i>In order to accomplish our set of activities we will need the following:</i></p> <ul style="list-style-type: none"> ▪ Agreement among stakeholders as to the core values and guiding principles for bringing/keeping the kids home ▪ Outreach to private providers ▪ Opportunities for family members and youth to have access to training on understanding and navigating system of care 	<p><i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i></p> <ul style="list-style-type: none"> ▪ Consensus reached ▪ Guiding principles and core values are published and disseminated to stakeholders (on website, included in written materials) 	<p><i>We expect that if accomplished these activities will lead to the following changes:</i></p> <ul style="list-style-type: none"> ▪ Annual increase in the availability of community-based services 	<p><i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i></p> <ul style="list-style-type: none"> ▪ Indicator 1: Increase in the number of children and youth receiving home and community based services in communities or regions of meaningful ties by 60% by FY12

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

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
than medical/problem based model)				
<p>2. Identify population of concern: Children and youth with severe behavioral disorders (includes substance abuse, DD, FASD) at risk of (or in) residential placement outside of home, community and/or state</p>	<ul style="list-style-type: none"> ▪ Agreement among stakeholders as to the population of concern 	<ul style="list-style-type: none"> ▪ Consensus reached ▪ Service providers plan for including and serving children with diverse needs 	<ul style="list-style-type: none"> ▪ System of care is developed to meet diverse needs and children and youth are directed toward treatment, services and supports appropriate to their individual needs 	<ul style="list-style-type: none"> ▪ Indicator 2: Decrease in recidivism to residential care by 75% by FY12. Recidivism is defined as returning within one year to the same (or higher) level of residential care
<p>3. Clarify general strategies</p> <ul style="list-style-type: none"> ▪ Develop uniform system of care coordination and gate keeping for children and youth regardless of custody status ▪ Implement a standardized functional assessment to assist in identifying the level of care a child need that is least restrictive, closest to home and will meet their clinical treatment needs ▪ Integrate BH delivery systems, including SA, MH, DD and FASD ▪ Participate in workforce development activities ▪ Support implementation and development of evidence based practices (<i>outcomes contracting rather than managing process issues</i>) ▪ Remove policy, procedural and regulatory barriers to home and community-based care 	<ul style="list-style-type: none"> ▪ Agreement among stakeholders as to what the general strategies are 	<ul style="list-style-type: none"> ▪ Uniform standards of care coordination are articulated for all children. ▪ Standardized functional assessment system in place ▪ Integrated BH system in place ▪ Annual increase in number of children’s behavioral health professionals. ▪ Use of evidence-based practices in service delivery ▪ Policies, procedures and regulations are analyzed for barriers 	<ul style="list-style-type: none"> ▪ See Activity 2 above 	<ul style="list-style-type: none"> ▪ Indicator 3: Reduction in the total number of youth being sent out of state by 90% by FY12

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

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
<ul style="list-style-type: none"> ▪ Encourage collaborative partnerships between formal and informal supports to enhance and develop the regional systems of care serving children and youth ▪ Understand dual/parallel systems will need to be in place while the current in-state System is enhanced. This requires bridging resources to develop additional in-state capacity and remedy gaps in the continuum of care to leverage re-investment of resources currently used for out-of-state residential psychiatric care 		<ul style="list-style-type: none"> ▪ New service options are developed in state that are billable to third party payers 	<ul style="list-style-type: none"> ▪ Policies, procedures and regulations reflect guiding principles and core values ▪ As services are increased in-state, funds previously used for out-of-state care are being used to support the in-state system 	
<p>4. Develop mechanisms to communicate widely and on an ongoing basis with stakeholders around <i>Bring/Keep the Kids Home</i> and system of care initiatives</p>	<ul style="list-style-type: none"> ▪ Communications plan (use external stakeholder group to develop and internal resources to implement) ▪ Communications mechanisms ▪ Presentation to boards ▪ Legislative platforms ▪ Cascading of the plan outward ▪ Use of website in more proactive, interactive way ▪ Identification of other resources 	<ul style="list-style-type: none"> ▪ Implementation of communications plan ▪ Increased public awareness ▪ Active list serve or phone trees to regularly inform stakeholders of planning or evaluation efforts 	<ul style="list-style-type: none"> ▪ Community-based services are increased annually 	<ul style="list-style-type: none"> ▪ Indicator 4: Via annual reporting, 85% of kids and families report satisfaction with services received

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Section IV

Strategy #2: Develop a strong family and youth voice in policy development, advocacy, family education and support, and quality control/assurance and evaluation.				
ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
1. Integrate family and youth voice into planning and policy development.	<ul style="list-style-type: none"> ▪ Identification of ways to most effectively use the family and youth representation in the AMHB, GCDSE and ABADA and Suicide Prevention Council ▪ Outreach plan with opportunities for families to learn system navigation and policy issues related to system of care planning ▪ Continued partnerships with family and youth groups and faith-based organizations ▪ Outreach to schools and youth organizations ▪ Coordination with youth initiatives ▪ Stipends (\$25.0) 	<ul style="list-style-type: none"> ▪ Participation records (i.e. meeting minutes, public testimony records) ▪ Participation on committees reflects the regional and cultural diversity of the state 	<ul style="list-style-type: none"> ▪ Increased family involvement ▪ Increased youth involvement 	<ul style="list-style-type: none"> ▪ Indicator 4: Via annual reporting, 85% of kids and families report satisfaction with services received
2. Explore Medicaid funding strategies to support parent-to-parent services (i.e. parent navigation systems) and youth-to-youth peer services.	<ul style="list-style-type: none"> ▪ CMS guidance on what services are reimbursable and what services are not reimbursable 	<ul style="list-style-type: none"> ▪ Addition of parent-to-parent and youth-to-youth services to the Medicaid State Plan 	<ul style="list-style-type: none"> ▪ Parent-to-parent and youth to youth services are Medicaid billable 	<ul style="list-style-type: none"> ▪ Indicator 4

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

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
	<ul style="list-style-type: none"> ▪ Information of approaches used by other states ▪ Medicaid State Plan amendments 			
<p>3. Ensure active family and youth involvement in the development and implementation of regional networks/teams.</p> <ul style="list-style-type: none"> ▪ Assist parents and youth to be active members of regional networks/teams ▪ Implement staged development process to train and support family members/youth through individual system navigation through policy planning and development 	<ul style="list-style-type: none"> ▪ Development of outreach plan to systemically disseminate information related to the system of care for youth and families 	<ul style="list-style-type: none"> ▪ Implementation and evaluation of outreach plan 	<ul style="list-style-type: none"> ▪ Families and youth are active members on regional networks/teams 	<ul style="list-style-type: none"> ▪ Indicator 4

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Section V

Strategy #3: Examine financing and policy issues.				
ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
<p>1. Ensure planning processes are coordinated to comprehensively address financing issues and determine solutions.</p> <ul style="list-style-type: none"> ▪ Collaborative work on the Integrated Behavioral Health Plan (AMHB/ABADA/SPC) ▪ Collaborative work on the Comprehensive Integrated Mental Health Plan ▪ DHSS children’s policy group ▪ DBH COSIG steering committee and work groups ▪ AMHTA B/KTKH focus work group ▪ Comprehensive rural infrastructure planning and development (ANTHC Rural BH Needs Assessment) ▪ DSDS Medicaid Study ▪ AMHB children’s subcommittee ▪ Children’s Justice Act (CJA) task force ▪ State participation with federal tribal system of care grantees ▪ Youth Transition and Mentoring Grant 	<ul style="list-style-type: none"> ▪ Mechanism to communicate widely and on an ongoing basis with stakeholders around financing policy deliberations ▪ Broad stakeholder input ▪ MOA on integrated planning ▪ Designation of a communications point person (attach functions, not dollars) ▪ Coordination of planning ▪ Note: Consider re-establishing monthly teleconferences for stakeholders related to children’s 	<ul style="list-style-type: none"> ▪ Stakeholder input secured and incorporated into financing policy deliberations ▪ Consistent financing policies across the department 	<ul style="list-style-type: none"> ▪ Plan documents reflect common goals, and activities are coordinated among all stakeholder groups 	<ul style="list-style-type: none"> ▪ Indicator 1: Increase in the number of children and youth receiving home and community based services in communities or regions of meaningful ties by 60% by FY12
<p>2. Explore a number of financing possibilities, including but not limited to:</p> <ul style="list-style-type: none"> ▪ Regionalizing funding strategies 	<ul style="list-style-type: none"> ▪ Research and grantwriting assistance (may be covered with existing staff) 	<ul style="list-style-type: none"> ▪ Financing plan, which includes the cost of implementation 	<ul style="list-style-type: none"> ▪ All potential funding sources are identified and utilized leading to stable 	<ul style="list-style-type: none"> ▪ Indicators 1-4 ▪ Indicator 5: Reduction in the

Strategy #3: Examine financing and policy issues.

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<ul style="list-style-type: none"> ▪ Medicaid expansions to support home and community-based care ▪ Accountability; incentives for performance measure outcomes and positive family and youth satisfaction reports ▪ Opportunities for blended/braided funding ▪ Opportunities to maximize funding for Native beneficiaries ▪ Application for federal system of care grant 	<ul style="list-style-type: none"> ▪ Financing work group 		financing of services	length of stay in in-state and out-of-state institutions by 50% by FY12 <ul style="list-style-type: none"> ▪ Indicator 6: 85% of children and youth show functional improvement in one or more life domain areas at discharge and one year after discharge

Addendum

Section VI

Strategy #4: Ensure that strong performance measurement/continuous quality improvement procedures are in place.				
ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
1. Develop process to collectively determine what should be measured, data sources, how to collect it and how to best report it.	<ul style="list-style-type: none"> ▪ Broad stakeholder group ▪ Articulation of performance measures 	<ul style="list-style-type: none"> ▪ Performance measures and data sources are defined ▪ Methods of data collection and reporting standards are developed 	<ul style="list-style-type: none"> ▪ Standardized data collection leads to monitoring and continuous quality improvement 	<ul style="list-style-type: none"> ▪ Indicator 4: Via annual reporting, 85% of kids and families report satisfaction with services received. ▪ Indicator 6: 85% of children and youth show functional improvement in one or more life domain areas at discharge and one year after discharge

Strategy #4: Ensure that strong performance measurement/continuous quality improvement procedures are in place.

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
<p>2. Integrate performance measurement/CQI into the business of DHSS/DBH through MIS, data collection and reporting:</p> <ul style="list-style-type: none"> ▪ DBH web infrastructure treatment system (WITS) project – Alaska Automated Information Management System (AKAIMS) ▪ DBH mental health & substance abuse block grants and data infrastructure grant (DIG) data collection ▪ Medicaid MIS ▪ OCS: online resources for the children of Alaska (ORCA) data management system ▪ DJJ juvenile offender management information system (JOMIS) ▪ Other reporting structures 	<ul style="list-style-type: none"> ▪ Evaluation/Information technology assistance (may be covered with existing resources) ▪ Performance/CQI work group ▪ Centralized IT – Ted Israelson ▪ Extraction of data across systems and participant agencies ▪ Compilation and analysis of data 	<ul style="list-style-type: none"> ▪ Performance measures and data sources are defined ▪ Methods of data collection and reporting standards are developed 	<ul style="list-style-type: none"> ▪ Data is available to assess extent to which outcome indicators are achieved 	<ul style="list-style-type: none"> ▪ Indicators 1-6
<p>3. Develop collaborative data exchange mechanisms with State partners outside of DHSS to collect aggregate level data</p> <ul style="list-style-type: none"> ▪ Meet with Department of Education & Early Development to identify potential data sets and mechanisms for data exchange ▪ Consider possibilities of utilizing data from the Adult Correction System and the Department of Labor & Workforce Development 	<ul style="list-style-type: none"> ▪ Clear understanding of what we want these other state agencies to collect and report ▪ MOAs ▪ Exemplars from other states 	<ul style="list-style-type: none"> ▪ Memorandums of Agreement are signed by collaborative partners 	<ul style="list-style-type: none"> ▪ Data are analyzed across state agencies and outcomes are reported jointly 	<ul style="list-style-type: none"> ▪ Indicators 1-6

Addendum

Section VII

Strategy #5: 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.

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
<p>1. Develop and/or enhance family group homes, group homes with 24/7 staff, OSLC multi-dimensional homes and crisis/nursery homes.</p> <ul style="list-style-type: none"> ▪ Develop additional beds and/or enhance existing foster care beds – using SAMHSA evidence based model, maintaining an evaluation component for the model or using programs with an empirical basis ▪ Develop additional beds and/or enhance existing residential (group home beds) – required at all levels of care to provide step down and diversion. Use individual child indicators for outcome measures as there is not an EBP model available. Need for a range of group home placements, not all of which will provide the same intensity of MH services ▪ Develop crisis nursery/TX preschool/stabilization home (under development) – services for children younger than 6 at risk of placement 	<ul style="list-style-type: none"> ▪ Start-up costs for family group homes (\$45.0 each), group homes with 24/7 staff (\$100.0 each), OSLC multi-dimensional homes (\$34.0 each) and crisis nursery homes (\$125.0 each) ▪ Step up/step down foster care (something other than group homes) ▪ Review of regulation changes needed to facilitate group home and foster home development and sustainability 	<ul style="list-style-type: none"> ▪ Number of new foster and residential care beds created and location of new beds ▪ Number of beds utilized for custody or non-custody children ▪ Number of secure beds created ▪ Use of outcome data from pilot project providers to inform/advance evidence-based treatment principles for Alaska ▪ Increase in the number of stabilization beds and day treatment slots for children ages 4-8 	<ul style="list-style-type: none"> ▪ Children served at appropriate levels of care and closer to home ▪ Families and youth more fully involved in treatment ▪ Placement stability increased (decrease in children returning to residential care) ▪ Decrease in the number of children waitlisted for in-state RPTC care ▪ Decrease in time kids await discharge from in-state and out of state RPTCs ▪ Provider application of treatment principles to clinical care ▪ Increased family and youth satisfaction with services ▪ More children ages 4-8 stabilized in their homes environments ▪ Residential/out of state funding available for reinvestment into 	<ul style="list-style-type: none"> ▪ Indicators 1-6

Strategy #5: 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.

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
			developing a system of care emphasizing community-based care, early intervention and prevention	
2. Provide technical assistance and training for existing foster care providers.	<ul style="list-style-type: none"> ▪ Funding for training and technical assistance toward existing foster care providers (\$60.0) 	<ul style="list-style-type: none"> ▪ Number of new foster care beds created and location of beds ▪ Number of beds utilized for custody and non-custody ▪ Increased retention of foster care providers 	<ul style="list-style-type: none"> ▪ Children served at appropriate levels of care and closer to home ▪ Families and youth more involved in treatment ▪ Placement stability increased (decrease in children returning to residential care) 	<ul style="list-style-type: none"> ▪ Indicators 1-6
3. Enhance existing in-home resources for prevention of crisis situations.	<ul style="list-style-type: none"> ▪ Funding for the enhancement of existing in-home resources for prevention of crisis situations (\$300.0) ▪ Review of regulation changes needed to facilitate in-home service development and sustainability 	<ul style="list-style-type: none"> ▪ Use of outcome data from pilot project providers to inform/advance evidence-based treatment principles for Alaska ▪ Availability of flexible funds for the provision of in-home services 	<ul style="list-style-type: none"> ▪ Children served at appropriate levels of care and closer to home ▪ Families and youth more involved in treatment ▪ Residential/out of state funding available for reinvestment into developing a system of care emphasizing community-based care, early intervention and prevention 	<ul style="list-style-type: none"> ▪ Indicators 1-6
4. Establish in-state Residential Psychiatric Treatment Centers.	<ul style="list-style-type: none"> ▪ \$9 – 10 million dollars requested (<i>Capital Costs</i>) from Congressional delegation ▪ Determination of level of security needed within the 	<ul style="list-style-type: none"> ▪ Number of new RPTC beds created and location of new beds ▪ Number of beds utilized for custody and non-custody kids 	<ul style="list-style-type: none"> ▪ More children will remain in-state for residential care (fewer out of state placements) ▪ Families will be more fully involved in treatment 	<ul style="list-style-type: none"> ▪ Indicators 1-6

Strategy #5: 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.

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
	<p>state</p> <ul style="list-style-type: none"> ▪ Review of regulations to determine barriers to a lock-down facility (i.e. staffing, liability, revenue and expenditures and use of API – (youth wing has struggled to stay full -coordination and gate keeping, stigma and short-term facility status may be issues) 	<ul style="list-style-type: none"> ▪ Number of secure beds created ▪ Use of outcome data to inform/advance evidence-based treatment practices for Alaska 	<ul style="list-style-type: none"> ▪ Placement stability increased (decrease in children returning to residential care) ▪ Providers application of treatment principles to clinical care 	
<p>5. Promote development of day treatment programs.</p> <ul style="list-style-type: none"> ▪ Promote both school-based and non-school-based program development, to serve children and youth in need of intensive supports and services after discharge from residential care or to prevent movement into residential care. ▪ Explore opportunities to promote partnerships between agencies willing to provide day treatment and agencies eligible to bill Medicaid for behavioral health services ▪ Explore opportunities to promote partnerships between schools and community mental health centers to provide school-based supports ▪ Explore impact of school districts billing Medicaid 	<ul style="list-style-type: none"> ▪ Work group ▪ Review of regulations and policies to identify ways to increase the number of day treatment “slots” both in school settings and in non-school settings and make needed changes 	<ul style="list-style-type: none"> ▪ Increase in day treatment and school based services ▪ Better coordination of treatment between school and home settings 	<ul style="list-style-type: none"> ▪ Increase in days of school attendance for children with SED (Mental Health diagnosis) served in schools ▪ Increase in percent of children with SED (MH Diagnosis) performing at grade level equivalent. ▪ Increased number of children served in their home school district 	<ul style="list-style-type: none"> ▪ Indicators 1, 4 and 6

Addendum

Section VIII

Strategy #6: Build the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders.				
ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
1. Utilize Federal Grant awards to implement systems improvements. <ul style="list-style-type: none"> ▪ COSIG Grant (10/03 – 9/08) ▪ TBI Grant (4/03 – 3/06) ▪ FASD Grant (through FY05) ▪ State Improvement Grant (Department of Education & Early Development) 	<ul style="list-style-type: none"> ▪ Plan for stakeholder involvement ▪ Mark Haines-Simeon (COSIG Coordinator) ▪ Diane Casto (FASD Coordinator) ▪ Coordination and collaboration with the Department of Education & Early Development 	<ul style="list-style-type: none"> ▪ Increase in integrated treatment plans with MH & SA goals ▪ No wrong door entry into service system available ▪ Development of integrated RFPs for behavioral health providers ▪ FASD pilot project funded and on-line ▪ Delivery of prevention, outreach, education and diagnostic services related to FASD 	<ul style="list-style-type: none"> ▪ Placement stability increased (decrease in children returning to residential care). ▪ Improved client satisfaction on surveys. ▪ Improved treatment outcomes (CANS or other outcome mgt tools) ▪ Less GF allocated to administrative costs. ▪ More in-state options for treatment of children with SED and FASD. ▪ FASD Assessments provided. ▪ Behavioral health care providers given FASD training 	<ul style="list-style-type: none"> ▪ Indicators 1, 4 and 6
2. Use federal grants to leverage resources to build capacity. Consider applying for additional grants. Obtain additional Federal funding to leverage and guide system development and capacity building activities <ul style="list-style-type: none"> ▪ SAMHSA Federal System of Care 	<ul style="list-style-type: none"> ▪ Grantwriting teams to develop concept and plan ▪ Assistance from contractor (depends upon availability of existing staff) ▪ Grant tracker 	<ul style="list-style-type: none"> ▪ Number of applications submitted ▪ Amount of funds leveraged for workforce development, capacity development and system development 	<ul style="list-style-type: none"> ▪ Successful completion and receipt of grants ▪ Commencement of workforce development, capacity building and systems development activities 	<ul style="list-style-type: none"> ▪ Indicator 3

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

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
Grant (RFP probably out in 1/05) <ul style="list-style-type: none"> ▪ SAMHSA Strategic Prevention Framework grant (application completed) ▪ CMS Mental Health Transformation Grant (application completed) 			<ul style="list-style-type: none"> ▪ Increased capacity to meet the needs of children and youth 	
3. Increase workforce capacity development at a certificate, associates, bachelors, masters and/or doctoral level of education. Partnership strategies: <ul style="list-style-type: none"> ▪ Work with University of Alaska curriculum development and departmental entities ▪ Work with DBH to develop core competencies ▪ Identify appropriate activities related to licensure and certifications for staffing credentials ▪ Partner with the Alaska Workforce Investment Board to pursue joint workforce development goals ▪ Partner with OCS to promote workforce training and development using IV E and other existing funding to enhance workforce development strategies ▪ Ensure cross-training across agencies 	<ul style="list-style-type: none"> ▪ Trust funding (\$250.0) ▪ Funding from the University of Alaska (\$100.0) ▪ Coordination and collaboration with a variety of organizations and state agencies 	<ul style="list-style-type: none"> ▪ Increased number of trained personnel providing children’s behavioral health services ▪ Implementation of core competencies ▪ Establishment of licensing and certification standards 	<ul style="list-style-type: none"> ▪ Children served at appropriate levels of care and closer to home ▪ Families and youth more fully involved in treatment ▪ Provider application of treatment principles to clinical care ▪ Increased in-state capacity to meet the needs of families and kids 	<ul style="list-style-type: none"> ▪ Indicators 1 and 4
4. Implement recruitment and retention strategies to bring behavioral health workers into the field and keep them within the field.	<ul style="list-style-type: none"> ▪ Note: The Trust is currently funding a \$150.0 project through FY05 to recruit/retain direct service 	<ul style="list-style-type: none"> ▪ Use of recruitment and retention tool kits by providers ▪ Number of people 	<ul style="list-style-type: none"> ▪ Increased number of behavioral health workers providing services to children and youth 	<ul style="list-style-type: none"> ▪ Indicator 1

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

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
<ul style="list-style-type: none"> ▪ Media campaign ▪ Outreach to targeted groups ▪ Participation in career fairs ▪ Recruitment tool kits for providers ▪ Leadership Institute for front-line supervisors (coaching and mentoring skills) ▪ Retention tool kit for providers ▪ On-site technical assistance ▪ Develop strategies to enhance supervision available to behavioral health workers 	<p>staff – there is a request in to extend this project)</p> <ul style="list-style-type: none"> ▪ Separate pot of money (\$100.0) for hands-on, itinerant technical assistance ▪ Identification of ways to increase on-site clinical supervision (i.e. in Iowa, Medicaid reimburses clinical supervisors for providing an hour of supervision to direct service staff; in Alaska, supervisors must provide direct services in order for the agency to get reimbursed) 	<p>participating in Leadership Institutes</p> <ul style="list-style-type: none"> ▪ Extent to which on-site technical assistance and supervision is available to front-line staff 	<ul style="list-style-type: none"> ▪ Increased capacity to meet the needs of families and kids ▪ Increased retention rate of behavioral health workers providing services to children and youth 	

Addendum

Section IX

Strategy #7: Develop gate keeping policies and practices and implement regional networks to divert kids from psychiatric residential care.				
ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<p><i>In order to address our problem or asset we will accomplish the following activities:</i></p> <ol style="list-style-type: none"> 1. Establish regional/CMHC teams with individualized funding pools and implement care coordination and gate keeping policies and practices. <ul style="list-style-type: none"> ▪ Provide bridge funding to design, start up, implement and refine teams <i>and</i> start up regional individualized services funding pools for un-funded children at risk of movement into residential care and/or needing supports to move back into community-based care (sliding fee scale for families with resources). ▪ Activities include a) identifying work group membership; b) evaluating viability of different models of collaboration and coordination utilizing diverse team structures; c) redesigning MOA for regional and out of state placement (state staff); d) identifying collaboration and coordination mechanisms; e) identifying mechanisms to manage, maintain accountability and provide reinvestment for the individualized 	<p><i>In order to accomplish our set of activities we will need the following:</i></p> <ul style="list-style-type: none"> ▪ Trust funding (\$1,000.0) ▪ Reinvestment of GF money being spent out of state ▪ Medicaid/Denali Kids Care 	<p><i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i></p> <ul style="list-style-type: none"> ▪ Regional teams functioning with mechanisms for family and CMHC involvement clarified ▪ Funding pool established, management mechanisms in place and criteria, tracking and outcome measurement tools identified. ▪ Number of children reviewed by team and placement outcomes ▪ Number of families receiving individualized funding ▪ New MOA developed ▪ System flow chart/decision tree available to guide parents, providers and state staff through system. ▪ Number of children served by new care coordination and gate keeping team. ▪ Number of CANS completed 	<p><i>We expect that if accomplished these activities will lead to the following changes:</i></p> <ul style="list-style-type: none"> ▪ Children from the region served at appropriate levels of care and closer to home ▪ Placement stability increased (decrease in children returning to residential care). ▪ Implemented discharge plans are timely, comprehensive & integrate clinical expertise from both receiving and sending programs ▪ Families and youth more actively involved in treatment services ▪ Greater consumer satisfaction ▪ Improved coordination between state entities around service delivery. ▪ Residential/out of state funding reinvested into developing community based care, prevention and 	<p><i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i></p> <ul style="list-style-type: none"> ▪ Indicators 1-5

Strategy #7: Develop gate keeping policies and practices and implement regional networks to divert kids from psychiatric residential care.

ACTIVITIES	RESOURCES	PROCESS PERFORMANCE MEASURES	OUTCOME PERFORMANCE MEASURES	OUTCOME INDICATORS
<i>In order to address our problem or asset we will accomplish the following activities:</i>	<i>In order to accomplish our set of activities we will need the following:</i>	<i>We expect that once accomplished these activities will produce the following evidence or service delivery:</i>	<i>We expect that if accomplished these activities will lead to the following changes:</i>	<i>We expect that if accomplished these activities will lead to the following changes in 7-10 years:</i>
<p>funding pools, which will support services necessary to allow diversion from a RPTC and reinvestment of that funding into community-based care; and f) developing and piloting team & funding pool in 1 or several regions.</p> <ul style="list-style-type: none"> ▪ May include implementation of a standardized functional assessment and use of a level of care determination guide at the regional level. ▪ Provide enhances care coordination, diversion, step down and provision of CANS assessment for children and youth. 			<p>early intervention services</p> <ul style="list-style-type: none"> ▪ Decrease in number served out of state ▪ Decrease in length of stay in RPTC & acute care 	
<p>2. Establish standardized <i>Level of Care</i> guide.</p> <ul style="list-style-type: none"> ▪ Identify implementation plans for a standardized level of care assessment tool for use to guide and support gate keeping and care coordination decisions and planning for FY06 and beyond. 	<ul style="list-style-type: none"> ▪ Trust funding (\$15.0) ▪ Analysis of CANS data ▪ Evaluation of <i>Level of Care</i> guide 	<ul style="list-style-type: none"> ▪ Level of care determination guide that differentiates profiles of children most likely to benefit from various levels of care (Acute, out of state, in-state, various levels). ▪ Implementation of LOC guide to inform placement decisions 	<ul style="list-style-type: none"> ▪ Children served at appropriate levels of care and closer to home 	<ul style="list-style-type: none"> ▪ Indicators 3 and 5