House Finance Subcommittee Health and Social Services
Division of Behavioral Health
October 21, 2013
Pre-Meeting Questions

- **What is the expenditure plan for the $3 million of one-time funding that was appropriated FY13-FY15 to Behavioral Health Grants?**

In fiscal year 2013, the Division of Behavioral Health began to implement the expenditure plan for the appropriation by working within the Department and with stakeholders to identify appropriate and needed substance abuse prevention, early intervention and treatment projects that could potentially be funded with the original $9 million in alcohol tax funds that were awarded to DBH over three years. During the initial process of identifying and developing critical-need projects, eight project proposals were completed. They covered a broad range including prevention, collaboration with primary care, provider training, new use of technology, home visitation, medication assisted treatment, and abstinence compliance testing.

During the 2013 legislative session and with the potential cuts to DHSS, as well as the Division of Behavioral Health, the original planning was temporarily suspended, while the legislative budget process moved forward.

In the last two months, we began to identify projects most critical and ready for implementation and have restarted a revised expenditure plan. At this time there are six projects under consideration for funding for FY14 and FY15. Two have been funded, two have been submitted for approval, and two are in development.

  - **When that funding is no longer available after FY15, do you anticipate requesting ongoing funding?**

The Division has been clear with stakeholders that available funding is limited to the three year period. Knowing that ongoing funding is not assured, projects with one time funding have been most favored.

- **What is the anticipated impact of the Affordable Care Act on behavioral health services?**

The anticipated impacts of the Affordable Care Act include increased access to services and a higher number of people served in the behavioral health system. There is the potential for greater coordination between primary care and behavioral health services. Characteristics of the Act that effect access, volume and coordination include:

- Coverage cannot be denied due to a pre-existing condition.
- Health plans must include mental health and substance use services.
- Insurers cannot discriminate based on a person's disability.
- Health plans cannot have a lifetime or annual limit on some benefits.
- Young adults may stay on their parent's health insurance until age 26.
- Premiums may vary only on the basis of a few factors including tobacco use, age, geographic area and family size and not on an individual's health status.
- Supports coordinated primary care and mental health care.
- Promotes preventive services.

The budgetary impacts are unknown at this time. DBH is engaged with the Alaska Mental Health Trust Authority in a statewide study looking at issues of provider capacity.

- **Given that API only has 80 total beds (with only 50 acute adult beds), and that the population is rising, does the department have plans to address the shortage of beds?**

While there are no specific plans to add beds to API, issues of utilization and occupancy have been central areas of review and planning in the last several years. In 2010 API had a prolonged period of high bed occupancy that caused wait times for admission. In the last several years, API has experienced a marked increase in admissions (FY 2011 - 1325; FY2012 - 1630; FY2013: - 1698). These census increases have resulted in an internal reorganization process to develop an admissions office and a utilization management plan. Better utilization management now will provide us data for future decision making. It is important to note that the building API has occupied since 2005 was designed with expansion in mind and the ability to construct a 10 bed addition.

The UAA Center for Behavioral Health Research & Services (CBHRS) report completed in 2012 estimated bed need at API based on population projections. The projections were based on information from the Alaska Department of Labor and looked at the impact on API based on Labor's low, medium, and high population projections. Moderate population growth would generate moderate increases in admission rates, ranging from about 1,750 to 1,900 admissions per year through 2034, an increase of about 4%, depending on the level of growth beyond population changes. This projected increase does not consider other factors that impact admission such as community resources, changes in forensic referrals, etc.

Discussion has been occurring within the Division, Department, and with community stakeholders, to resolve gaps in service with populations that otherwise may be admitted unnecessarily to API due to lack of more appropriate alternatives. These include seniors with Alzheimer's disease and related dementias; mentally ill forensic patients, including sexual predators found non restorable or who have exceeded Department of Correction's treatment capacities; and adolescents with diagnoses of intellectual and developmental disorders. The Complex Behaviors Collaborative project is aimed at addressing these populations by building capacity and expertise within the state to serve individuals with complex behavior management needs and keeping participants at a community level of care, thereby preventing and/or reducing hospitalization and institutional care.

Since introducing the "acute care" model of care in 2010 API has been able to manage the flow of patients and for the most part avoid waiting lists. This has been possible only with the continued help and support of the provider community. Internal to API, one of the issues relative to census management and its uncontrollable fluctuations is workforce shortages. At times, the ability to staff has been challenged by key vacancies in psychiatry, nursing and social work.

Developing psychiatric hospital units in communities that have high, active admission rates to API, such as the Kenai Peninsula, MatSu and Anchorage would significantly reduce the immediate need for additional beds at API. Recently two private community hospitals have expressed interest in developing acute psychiatric capacity.

Future options to explore will include expansion of the State's designated evaluation and

treatment (DET) program, using community hospitals and federal Medicaid Disproportionate Share Hospital (DSH) dollars which are matched 1 for 1 by the State. However, the federal methodology for state DSH allotments is in a state of change and the Office of Rate Review is monitoring it closely.

- **What has been the impact of the "Bring the Kids Home" initiative (and increments)?**

Bring the Kids Home impacts:

- An **81% decrease in admissions** for out-of-state Residential Psychiatric Treatment Centers from 752 in 2004 to 143 in 2012. **This was the primary goal for BTKH.**
  - BTKH decreased the overall number of admissions to RPTC.
- A **64% decrease in Medicaid expenditures** for out-of-state RPTC between FY06 and FY12.
  - BTKH decreased overall expenditures for RPTC by 37% between FY07 and FY12.
- A shift in funding to in-state RPTC and for community-based mental health services,
- A **decrease in the RPTC recidivism rate from 20% in FY04 to 5% in FY12**. *(Recidivism = number of youth who return to RPTC or acute care w/in 1 year after discharge*).

BTKH achieved these outcomes by:

- making changes to regulations, policies and practices within DHSS,
- partnering with stakeholders to address system issues,
- and through a new grant program which is funding best practices at DBH and at OCS.

1. **DBH BTKH grants: FY13 congregated statewide data for projects such as; Peer Navigation, Parenting with Love and Limits, Transition to Independence Process, and Crisis Stabilization. These projects:**
   - Accepted 64 children returning from out-of-state RPTC
   - Diverted 481 children from out-of-state RPTC
   - Accepted 302 children from more restrictive in-state residential care.
   - Achieved a 91% satisfaction rate.
   - Resulted in functional improvement for 85% based on the global assessment of functioning score
   - Resulted in progress/completed treatment goals for 89% of youth served.
2. **Transition to Independence Process (TIP): The FY13 pilot project at Denali Family Services serving youth with severe emotional and behavioral disorders found that for youth served a full year:**
   - 400 youth served
   - 68 % of TIP youth had a housing plan,
   - 93 % of TIP youth made progress on treatment,
   - 94 % of TIP youth avoided hospitalization,
   - 0% of TIP youth attempted to run away from treatment,
   - 96 % of TIP youth had no incidents of arrest or incarceration,
   - 68 % of TIP youth were in an educational process.

- Of those not in an education process 65 % had graduated and all, but six, were employed.

3. **Parenting with Love and Limits: FY13 statewide data for PLL found that it improves family functioning, keeps children at home, and shortens length of stay in residential:**
    - 189 youth served
    - 334 family members served
    - BRS Level 3 average length of stay for PLL youth average length of stay 47 days less than non-PLL youth in same BRS facility. (PLL seeks to decrease length of stay and return youth to home community)
    - Statistically significant changes in the attitudes/behaviors of diversion and probation youth in aggression, rule breaking, conduct disorder and in externalizing, oppositional, and internalizing behaviors.
    - Statistically significant changes for the SED youth in decreasing aggressive, oppositional and internalizing behaviors.
    - Statistically significant improvements in family cohesion; significant decrease of family problems.
    - 79% successful completion rate. (National Average is 70%)

4. **Matsu Care Management: Expedites the return of children from out-of-state RPTC and keeps children in the community.**
    - Of the 219 youth served, 81 were in an out-of-state RPTC.
    - 68 of the 81 youth were returned to Alaska
    - 131 youth were diverted from level IV or V residential care.
    - 52 youth were reunified with their families and 29 went into level II or III (foster or group home)
    - None of the youth placed in level IV, V, or inpatient treatment.

    As of 7/1/2013, of the 81 youth who returned from out-of-state:
    - 41 were at home
    - 16 in a foster/group home,
    - 1 was in assisted living
    - 18 were closed cases/aged out/unknown
    - 2 was in DJJ custody at McLaughlin
    - 3 were in acute care.

5. **Tribal Rural System Development (statewide data)**: FY12 outcomes showed that:
    - + 60 tribal professionals received training to address Medicaid gaps (clinical, behavioral health aides, and support/QA staff).
    - 70% of the rural tribal providers received direct assistance from the contractor.
    - 100% found the assistance "useful" or "very useful".
    - 6 agencies are working towards accreditation.
    - 14 of 15 tribal agencies participating are now billing BH Medicaid (up from 8 of 15 in 12/2011).

6. **Peer Navigation (statewide data): Uses trained peers to provide BH support, skills training, and education. FY13 outcomes:**
    - 506 youth served
    - 2144 individual family members served statewide.
    - 59 (12%) admissions of youth whose families were discharged from other agencies.
    - 389 (49%) of families have OCS/DJJ Involvement
    - 209 (41.3%) of youth served were in an RPTC setting in prior 12 months
    - 794 families served
    - 86% of parents/youth who used peer navigation reported satisfaction with these services.
    - 92% of the families demonstrated progress in engagement, skills and/or competence.
    - 56% of families admitted for Navigation services (1467 families referred; 794 admitted for services)
    - Only 5.7% (29 total) of youth admitted to RPTC while receiving Navigation services

7. **Outpatient Substance Use Grants: Volunteers of America (VOA) FY13 outcomes show reduced MH symptoms and less substance abuse for youth served in both the ARCH Residential Program along with the VOA/Covenant House Project to serve homeless/runaway youth with substance use disorders:**
    - 256 youth served
    - 313 families served
    - 108 (55%) families served actively engaged in Family Therapy
    - 90% of clients experienced a reduction in MH symptoms.
    - 77% of youth served with both SED and SUD experienced a reduction in substance abuse.
    - 72% of youth with co-occurring disorders experienced a reduction in mental health symptoms.
    - 73% of youth with SUD and SED experienced a reduction in their substance abuse.
    - 84% increase in parent involvement /contacts
    - 88% of the youth served reported increase in supportive people in their lives

8. **Sub-Acute Crisis Stabilization: The program provided short-term sub-acute stabilization to prevent children from moving into acute care or from acute care into RPTC and to allow time for development of community services. FY13 outcomes included:**
    - 117 youth served.
    - 74 families served
    - 51 (69%) of families served actively engaged in Family Therapy
    - 3-month post discharge outcomes showed that 87 children (74.4%) remained in a lower level of care
    - 30 children (25.6%) moved into a higher level of long-term treatment.
    - Parent satisfaction ranged from 84% to 93% with a yearly average of 89%.

- Child progress on treatment goals each quarter ranged from 70% to 77% with a yearly average of 74%.

9. **Early Intervention for Young Children:** Early Childhood MH Learning Network: FY12 outcomes included:
    - 40 children in early care and learning programs and 70 children in other settings received Individual MH Consultation
    - 6 early care and learning programs received Intensive Consultation
    - 42 early care and learning programs received Program Consultation (not intensive)
    - 81% of children receiving individual consultation maintained their placement
    - Individual and Intensive Consultation impacted 736 children
    - 15 early care and learning programs implemented the Social Emotional Pyramid Model (TACSEI) serving 737 children
    - 528 professionals participated in Reflective Facilitation and/or Learning Network training, impacting approximately 7,900 children

10. **School-Based Programs to Prevent Residential Placement and to assist Youth Returning from Placement to Succeed**: FY13 projects developed school behavioral health systems to support children at high risk for residential placement or returning from residential care. Two projects were funded: the Special Education Services Agency coordinated between residential psychiatric treatment centers and rural schools and behavioral health centers; and the Mat Su School District and Alaska Family Services utilized PBIS to support children in school. In addition, the project provided technical assistance to implement PBIS for high risk youth in Haines and Petersburg. These projects resulted in the following outcomes:
    - 94 youth served, 97% of whom were maintained in the community;

    For the PBIS Project,
    - Unexcused absences decreased by 39%
    - Problem behaviors decreased by 59%
    - Adaptive replacement behavior increased by 71%
    - 100% of youth involved in the project advanced to the next grade level at the end of the school year.

11. **Foster Parent & Parent Services:** Train foster parents, parents and youth to support youth with SED in community-based settings. For FY13:
    - Seven (7) training events held statewide.
    - Travel or financial assistance to 53 resource families
    - Training to 220 participants (121 resource families.)
    - Positive feedback received from families.

Intensive Family Preservation: Intervene with children and families to reduce number of children placed outside the home for treatment/care. Target: families with a child with an SED

- 18 families served (27 parents and 36 children)

- Major concerns: parental developmental disability and mental illness compounded by substance abuse.
- Of the 36 children served 7 (18%) were removed (five children in one family (mother with FAS & substance abuse issues), the other two have a disabled father and a mother with substance abuse issues.
- The children who were removed are currently in therapeutic and regular foster placements parental developmental disability and mental illness compounded by substance abuse.
- Provided 976 hours of direct service and family group conferencing.

- **In regards to grants:**
  - **What is the definition of "administrative fees"?**

For clarification purposes, we are assuming that the question is asking for administrative costs rather than administrative fees.

For a not-for-profit agency, administrative costs include the expenses for overall function and management of the organization rather than for direct services. These costs usually include the salaries and expenses of the director or chief officer of the organization, that officer's staff (except the time they spend supervising or performing direct service), utilities, and back-office functions (accounting including patient accounting and billing), human resources, general liability insurance, audit, etc). Many of these are treated as "overhead" or "indirect costs" because they are not directly connected with a particular program the organization operates but rather support all of its programs.

  - **How does the State monitor the usage of the monies that are awarded?**

- The State of Alaska requires that grantees receiving financial assistance with a cumulative total of $500,000 or more during the entity's fiscal year (which may be different from the state fiscal year) shall submit an audit report for the audit period**. (2 AAC 45.010. Audit requirements)**
- The State Single Audits must be submitted by the earlier of (A) 30 days after the entity receives its audit report for the audit period; or (B) nine months after the end of the audit period. (**2 AAC 45.010. Audit requirements**)
- The submitted audits are rigorously reviewed by the State Single Audit Coordinator, Division of Finance/DOA. If any elements are missing, or the audit does not meet strict criteria, it is sent back to the grantee for revisions.
- If there are audit findings, the State Single Audit Coordinator determines which State department should address the finding. For DHSS, audit findings are forwarded to the Audit Section. The Audit Section then sends out a management decision letter documenting the corrective actions taken, or to be taken by the grantee. The management decision letter must be issued within 180 days of the date the audited financial statements were received by the State Single Audit Coordinator.
- DHSS Audit Section follows up on implementation of corrective action.

- At least once every two years, grantees not meeting the above mentioned $500,000 threshold, are required to ensure that a fiscal audit of the grantee's operations under the grant program is performed by an independent certified public accountant.
- Reporting requirements – grantees are required to submit financial and progress reports in accordance with the requirements of the grant agreement. (**7 AAC 78.200. Reports**)
- Regular contact – regular contacts with grantees and inquiries concerning program activities are performed by program staff.
- Site visits

    - **What is the State's authority on how grant dollars are spent?**

Duties of the Department of Health and Social Services include

- To receive and distribute state appropriations and funds (AS 47.30.530)
- To administer a community grant-in-aid program for alcoholism and drug abuse (AS.47.30.470)
- To help communities plan, organize and finance community mental health services (AS 47.30.520)
- To provide a means of allocating money available for state mental health services according to community need (AS 47.30.520)

We grant money under 7 AAC 78 and grant dollars are awarded in response to the providers application and its merits relative to meeting the criteria of the proposal that outlines the Division's intentions. We also utilize 7 AAC 81(Services to Individuals) both of which give us the authority to require reporting on the financial and program requirements of the grant agreement.

- **How does the State measure the value/effectiveness of the service provided by the grantee?**

Treatment

Division of Behavioral Health Comprehensive Treatment and Recovery grants are awarded to provide a particular set of program and Medicaid services. The value and effectiveness of services is measured in terms of **client outcomes** as well as **program efficiency** and **effectiveness**. Both are necessary for maximum value. For instance a program could be producing very good client outcomes (people getting better), but serving a very small number of people (program inefficiency). Or a program could be serving a large number of people, getting them rapidly into treatment (access) but producing poor client outcomes.

Client Outcomes DBH uses the Client Status Review of Life Domains (CSR), a survey completed by the client at the time of intake and at subsequent 4-month intervals during treatment and at discharge from services, to assess client outcomes. Questions in the CSR measure people's benefit from treatment looking at 1) reduction in symptoms and 2) improvement in health, safety, productive activity, and living with dignity (life functions). DBH is working the with Alaska Mental Health Trust Authority to compare client

outcomes at 6 and 12 months post discharge, to their status at the time of intake.

Medicaid chart reviews identify quality of care issues.

Program Efficiency and Effectiveness Accumulation of client outcomes data can produce an average outcome rate for an agency, demonstrating that agency's effectiveness relative to people improving from treatment. Accumulation of all client outcome data statewide can produce an average outcome rate for the entire state. Thus an agency's effectiveness can be measured compared to the statewide average and to its previous year's outcomes as a baseline for improvement.

In addition to client effectiveness, DBH measures each program's effectiveness relative to access (average number of days from screening to first treatment service), engagement (percent of clients serviced within 30 days of enrollment), and retention (percent of enrolled clients not served within 135 days) for every comprehensive treatment and recovery grantee.

In addition to general client outcomes and program efficiency and effectiveness, special grants have additional measures specific to the particular set of services provided. Some examples include:

Program	Efficiency Measure	Effectiveness Measure
Assisted Living Home Training	Cost per participant	Pre/post test improvement Reduced # critical incidents
Bridge Home	Cost per participant	Reduced days incarcerated Reduced days in API
Complex Behavior Collaborative	Comparison of pre and post program costs by participants	Reduced days in higher levels of care
DOC Incentive	Cost per client per grantee	# of inpatient days at API # of arrests since admitted to program
IMPACT		Decrease in depression scores (PHQ-9)
Transition to Independence Program	Cost per participant	# Enrolled in school # Employed # With housing plans
Tribal Rural System Development	Increase in Medicaid billings Percent denied claims	

The number of people served is also collected for every program/grantee.

DBH conducts chart audits to assess compliance with Medicaid regulations. Chart reviews identify risks for Medicaid overpayments.

Prevention

DBH prevention grantees have various focus areas depending on the funding category and community need, but in general address substance use/abuse prevention, underage alcohol use, prevention and services related to fetal alcohol spectrum disorders, early mental health promotion, suicide prevention, criminal recidivism, domestic violence, and sexual assault. Every prevention grantee is accountable for program measures. Successful prevention grantee performance at the program level impacts population level change. Statewide, population level indicators include:

- 30 day youth and adults alcohol, marijuana & prescription drug use
- First use of alcohol and other drugs before age 13
- Youth and adults binge drinking
- Women who drank alcohol in last 3 months of pregnancy
- Youth perception of harm related to alcohol, marijuana and prescription drugs
- Days of poor mental health in past month
- Youth experiencing depression in past year
- Youth who have contemplated suicide
- Non-fatal suicide attempts
- Youth who feel they matter to people in their community
- Youth who have 2+ adults in their lives they can talk to and seek help from

- **Has the actual number of Alaskans receiving behavioral health services changed since your response to this question in March of 2013? If so please update those numbers.**

The numbers reported in March (41,719) were preliminary – and at the close of the fiscal year we are able to report that the number of Alaskan's who received Behavioral Health Services in FY2012 = 42,946

This number has changed because it reflects the implementation of a new methodology that addresses integrated regulations and includes the Illness Self-Management counts not previously reported

- **Has the number of Alaskan's using Medicaid changed since your response to this question in March of 2013? If so please update those numbers.**

There is no change to the 138,755 unduplicated Alaskan beneficiaries receiving Medicaid services in FY2012. (source: DHSS Medicaid Budget Group)

  - **What is the number of Medicaid beneficiaries that are receiving Behavioral Health Medicaid Services.**

There is no change to the previously reported 13,127 Behavioral Health Medicaid beneficiaries during FY2012. (source: DHSS Medicaid Budget Group)