

ALASKA LEGISLATURE COMMITTEE FILES

2007-2008

SHES

12



# Factoids



- 1.4 million TBI's occur in US every year
- 22% of OIF vets report mTBI-inducing event
  - 7% report mTBI sx
- In-theater, 60-83% of TBI's are via blast/explosions
  - Blast TBI → more cognitive problems than blunt force trauma
- Army Post ~ 17k screened
  - 18% had TBI over 12 mo deployment
  - ½ of those had residual symptoms @ PDHA
- Major Theater Hospital ~ 7.5k screened
  - 23% positive for TBI
  - 75% of those complained of symptoms when screened



*One Team—One Fight!!*





# More Factoids



- Majority of neuro-imaging studies in acute phase are negative (6-15% positive)
- Those with ruptured eardrums had 3x risk of TBI
- 85% of mTBI victims recover w/o sequelae in 3-6 mo's
  - 70% of TBI victims recover in 3-6 mo's
  - 85% of TBI victims recover in 12 mo's
- 23% of those TBI'd developed personality d/o\* within 30 years



*One Team—One Fight!!*



# Troop brain injuries

The Army has begun brain-function tests on soldiers before war to give doctors critical data for treatment if a soldier returns with a traumatic brain injury.

## Symptoms of soldier brain injuries ...

... right

after injury

... after

returning home

### Headache



### Dizziness



### Memory problems



### Balance problems



### Irritability



Staff Sgt. Justin Duncan takes the **Automated Neuropsychological Assessment Metric 4 (ANAM)** to establish a baseline for cognitive functioning should he sustain injuries affecting mental performance. The 386th Expeditionary Medical Group is administering the assessment to members of Det. 3, 732nd Expeditionary Security Forces Squadron, who are augmenting the Army in "in-lieu-of" taskings. (10/15/2007 AF News

Article//U.S. Air Force photo/Master Sgt. John Nimmo, Sr.)

SOURCE: Walter Reed Army Medical Center

AP





- **Recent DVBIC facility study (50 participants)**
  - 55% had cognitive disorder
  - 50% mild deficits
  - 5% moderate-severe deficits
  - 71% PTSD
  - 52% Major Depressive Disorder
  - 90+% Medical disorders (especially pain, equilibrium)
  - 90+% chronic hyperarousal



***One Team—One Fight!!***





# Treatment



- Research evidence support remains weak for cognitive rehabilitation of brain injured
- Some research supports education
- Palo Alto is Defense & Veteran Brain Injury Center (DVBIC) servicing Alaska
- Vestibular Rehabilitation




*One Team—One Fight!!*





# Treatment



- Headaches
  - Irritability
  - Memory probs
  - Sleep probs
- 
- Los Angeles Times / Luis Sinco via AP
- Treat the H-I-S first as they confound the memory symptoms



*One Team—One Fight!!*





# 3 key elements to recovery



- Education & reassurance @ outcomes
- R & R & gradual return to activity
- Instruction in general cognitive/memory coping strategies
- Barriers to recovery
  - >60 days post injury w/ on-going high stress duty
  - Repeated injury
  - Comorbid conditions (PTSD, MDD, pain, SA, etc.)



*One Team—One Fight!!*





- **Psycho-education**

- **Redefine problem**

- Post-concussive disorganization of brain
- Not severe structural brain injury

- **Redefine treatment**

- Functional re-organization of brain
  - Rebuilding and reconnecting connections/neural pathways



*One Team—One Fight!!*





- **Physiological relaxation training**
  - mantra meditation and mindful breathing
- **Cognitive Rehabilitation**
  - Assertiveness & Anger management training
  - Self-instruction & role-plays for common stressors
  - Re-estab systematic life goals, direction, sense of purpose
  - Use of lists, reminders, habits, and PDA as cognitive aids



***One Team—One Fight!!***





**TBI**

**vs**

**PTSD**



- Altered consciousness
  - Post-traumatic amnesia
  - Fatigue
  - Impulsive, poor judgment.
- Numbing, reduced awareness
  - Dissociative amnesia
  - Avoidance
  - Hypervigilance, hyperarousal



***One Team—One Fight!!***





# TBI/Concussion vs Post Combat Stress



## TBI/ Concussion

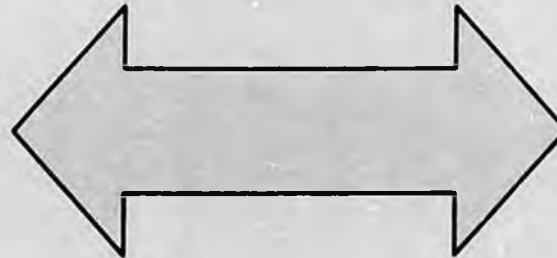
## Common Symptoms

## Post Combat Stress

Physical injury

Immediate symptom presentation

Generally improve quickly with time



Emotional reaction to traumatic event(s)

Delayed symptom presentation

May require long term assistance



*One Team—One Fight!!*



**2/15/08**

**PRESENT.:**

**BRING THE**

**CHILDREN**

**HOME**

**UPDATE**

# Bringing (Keeping) the Kids Home

*A collaboration of Department of Health and Social Services, Alaska Mental Health Trust Authority & partner boards, Denali Commission, Rasmuson Foundation, Alaska Native health providers & other service providers, parents, advocacy groups, AHFC*

**February, 2008**

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*BTKH seeks to develop a comprehensive system of care with enhanced in-state capacity to serve children in the*

- *least restrictive settings,*
- *as close to home as possible, and*
- *with full family participation.*



# **The Bring (Keep) the Kids Home Initiative**

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## **Problem:**

- ❖ **Over use of out-of-state Residential Psychiatric Treatment Centers**

## **Causes:**

- ❖ **Funding Gaps**
- ❖ **Lack of Resource Coordination**
- ❖ **Regulations/Policies**

## **Results:**

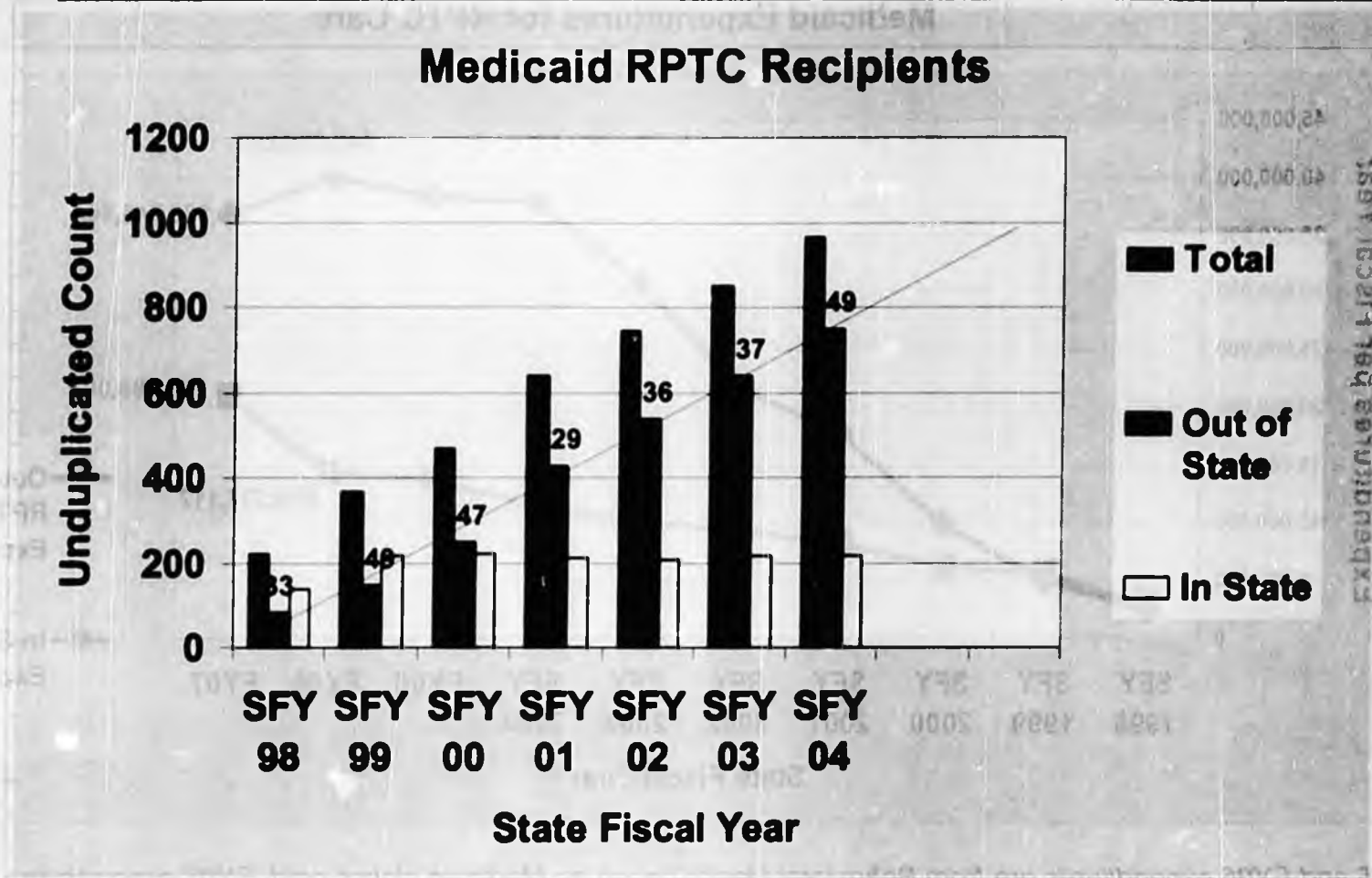
- ❖ **Disconnection**
- ❖ **Transition Problems**
- ❖ **Weaker Outcomes**
- ❖ **Expense**

## **Goals:**

- ❖ **Serve children with their families and closer to home**
- ❖ **Serve children with severe disturbances effectively**
- ❖ **Prevent children from becoming severely disturbed**
- ❖ **Invest resources in-state**



## History: Exponential Growth In Use Of Out-of State Residential Psychiatric Treatment Centers (RPTC)



*Data are from Behavioral Health, Policy and Planning based on Medicaid claims paid for unduplicated RPTC recipients. Recipients include all children served per fiscal year – including those admitted in a previous year but served during the current year.*

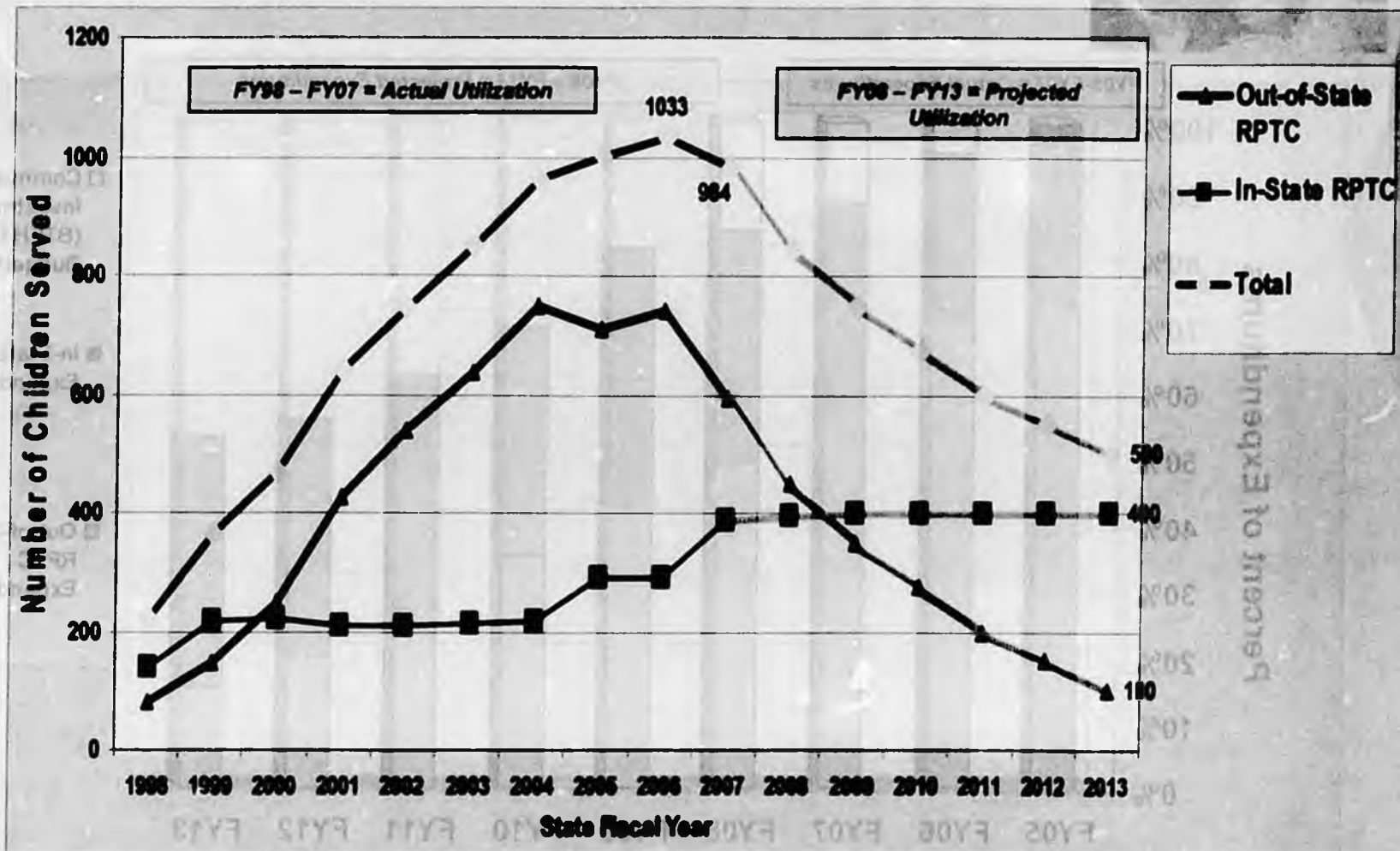
# Shift to In-State Expenditures

**Medicaid Expenditures for RPTC Care**



*FY05 and FY06 expenditures are from Behavioral Health based on Medicaid claims paid. FY07 expenditures are from DHSS Finance Management and include claims incurred and paid in FY07 as well as claims incurred in FY07 and paid in the first quarter of FY08. Every attempt was made to replicate the parameters used between Behavioral Health and Finance Management Services.*

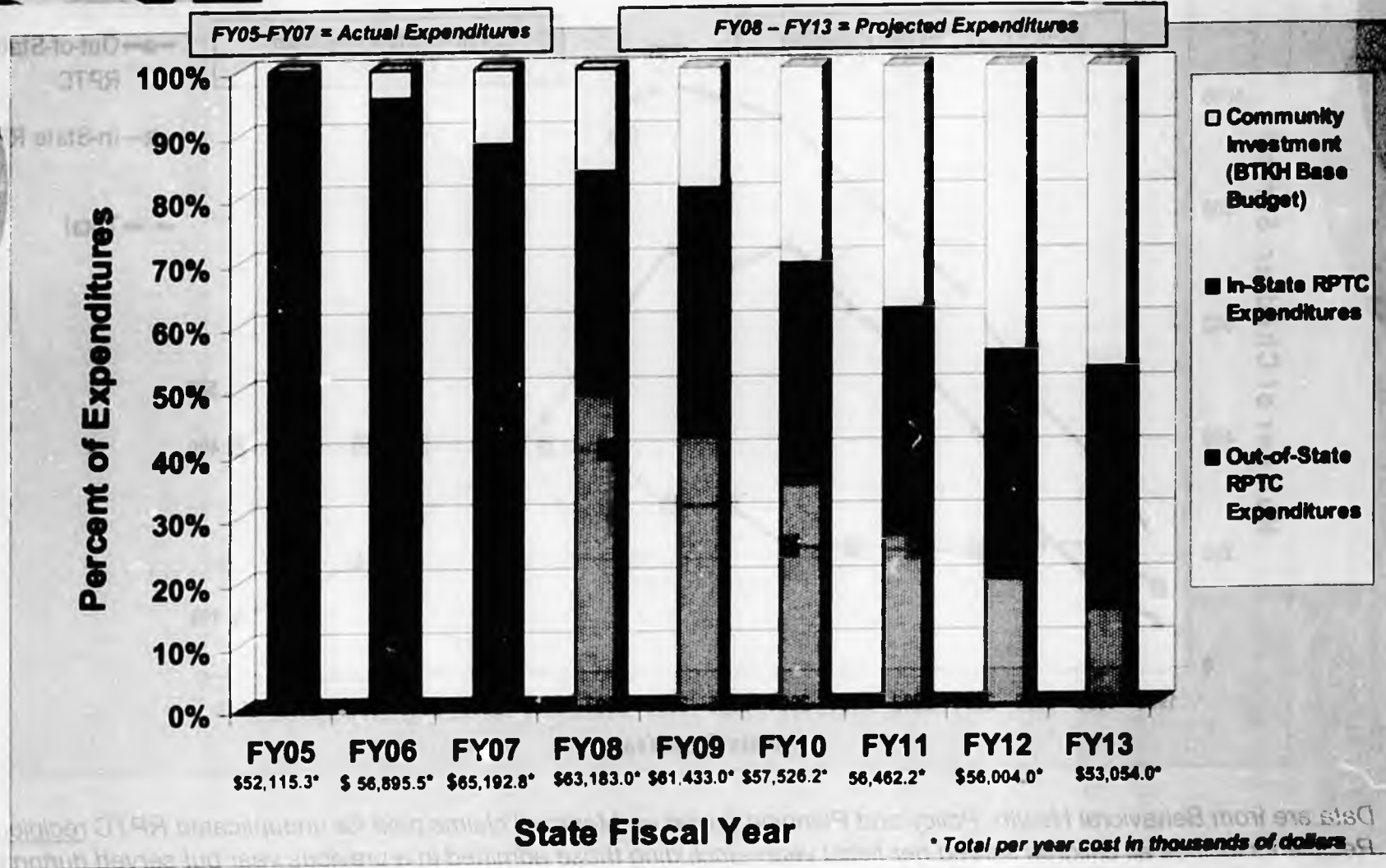
# Change in RPTC Use Over Time



Data are from Behavioral Health, Policy and Planning based on Medicaid claims paid for unduplicated RPTC recipients. Recipients include all children served per fiscal year – including those admitted in a previous year but served during the current year. FY05-07 are based on the actual children served in RPTC care. FY08-13 are based on BTKH goals for RPTC utilization.



# Projected BTKH Reinvestment



Data for FY05-06 are from Behavioral Health based on paid claims for Medicaid data. Expenditure data for FY07 are from Finance Management Services and includes all claims incurred and paid in FY07 and claims incurred in FY07 and paid in the first quarter of FY08.

## BTKH Indicators\*

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### Indicator 1 - Client Shift. Progress between FY06-FY07:

Decrease in 36.3 % for admissions to out-of-state RPTC care (children admitted to RPTC in the fiscal year).

Decrease of 19.8% for recipients served in out-of-state RPTC care (children admitted in current or a previous FY but served in the current year).

Increase of 33.8% for recipients served in in-state RPTC care.

### Indicator 2 - Funding Shift. Progress between FY06-FY07:

Decrease of 8.16% in out-of-state RPTC Medicaid expenditures.

Increase of 46.1% in in-state RPTC Medicaid expenditures.

### Indicator 3 - Length of Stay (LOS) in RPTC. Progress between FY06-FY07:

Decrease of 31.9% in average LOS for in-state non-custody placements.

Increase of 12.8% for average LOS for out-of-state non-custody placements.

Decrease of 3% for average LOS for all placements.

### Indicator 4 - Service Capacity. Progress between FY06-FY07:

Increase in bed capacity below RPTC (level V) from 535 beds to 638 beds.

Increase in RPTC bed capacity from 123 to 166

### Indicator 5 - Recidivism. Progress between FY06-FY07:

Decrease of 48% in the over-all recidivism rate to RPTC w/in 365 days of discharge.

\*Data are from DBH Policy and Planning and DHSS Finance Management Services.

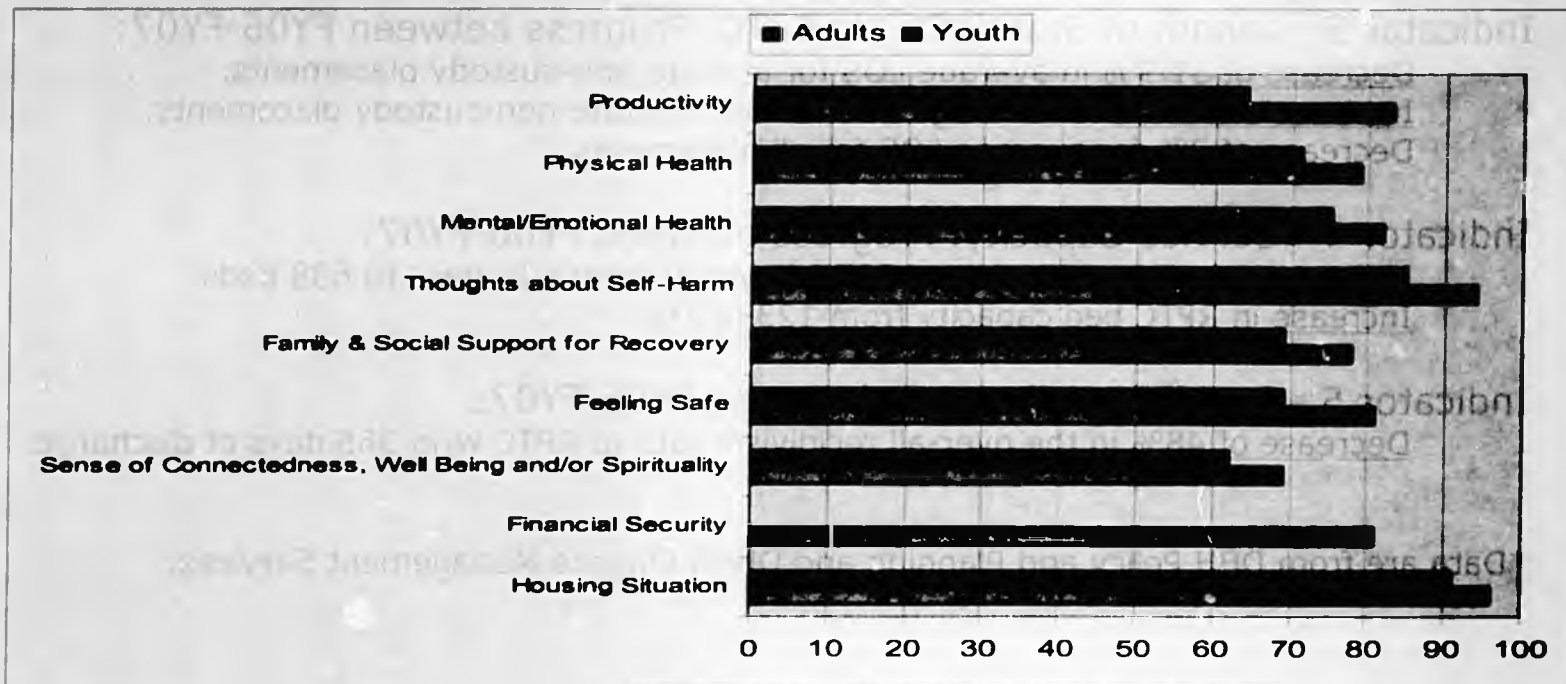
## BTKH Indicators, continued

### Indicator 6 - Client Satisfaction. FY07 (grantees, community based services only):

#### Youth Behavioral Health Consumer Survey (all youth respondents):

Access to services	55%
Satisfaction with services	69%
Participation with treatment	65%
Cultural sensitivity	74%
Positive outcomes of services	70%

### Indicator 7 - Functional Improvement. Client Status Review, FY07 (grantees, community-based services only)



# FY09 Projects/Funding

## Transition into BTKH Base Budget:

	<u>MHTAAR</u>	<u>GF/MH</u>	<u>Authority Grant</u>	<u>Total</u>
○ Peer navigation services	\$ 0	\$ 0		\$ 0
<i>Requested Amendments:</i>	\$ 50.0	\$ 100.0		\$ 150.0

## Build capacity within BTKH Base Funding:

○ Community BH capacity development	\$ 500.0			\$ 500.0
<i>Requested Amendments:</i>	\$ 250.0	\$1,250.0		\$1,500.0
○ Crisis stabilization services (Anch)	\$ 100.0	\$ 200.0		\$ 300.0
○ Early childhood mental health	\$ 225.0	\$ 150.0		\$ 375.0
○ Foster parent/parent services	\$ 75.0	\$ 75.0		\$ 150.0
○ RPTC training site	\$ 50.0	\$ 50.0		\$ 100.0
○ Independent evaluation of BTKH grants			\$100.0	\$ 100.0

## Maintenance of Effort:

○ BTKH strong family voice	\$ 25.0			\$ 25.0
○ Individualized services	\$ 250.0	\$ 250.0		\$ 500.0
○ School based capacity & coordination	\$ 200.0			\$ 200.0
○ School based services: tool kit – best practices	\$ 100.0			\$ 100.0

## BTKH Capital Funding:

- Continue planning for projects in development for FY10. No FY09 capital budget requested.

***Funding in thousands of dollars***

## 5-Year Plan: Strategies

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### Primary strategies:

1. **Build capacity for lower levels of non-residential care.**
2. **Expand care coordination to ensure that children access lower levels of in-state care whenever appropriate.**
3. **Address funding gaps & invest in system development.**
4. **Monitor system access, service utilization & outcomes.**
5. **Develop community partnerships to serve children experiencing severe disturbances and their families.**
6. **Implement strategies to develop and maintain a skilled behavioral health work force.**



# 5-Year Plan: Activities and Estimated Budget



## Capacity Infrastructure Development

<b>GF/MH</b>	<b>federal</b>	<b>other</b>	<b>total</b>
\$17,480.0	\$1,250.0	\$135.0	\$18,865.0

- Expanding grant services
- Implementing system for access to individualized funding
- Developing crisis stabilization services statewide
- Obtaining a foster care rate increase

## Community Diversion, Care Coordination and Gate Keeping

<b>GF/MH</b>	<b>federal</b>	<b>total</b>
\$2,361.1	\$544.5	\$2,905.6

- Linking families with supports
- Managing access to residential care resources
- Developing partnerships to support children and families in lower levels of care
- Developing peer to peer supports

## System Management, Outcomes Tracking & Continuous Quality Improvement

<b>GF/MH</b>	<b>federal</b>	<b>total</b>
\$2,203.4	\$105.0	\$2,308.4

- Evaluating individual clinical, family, provider and system outcomes
- Developing and implementing regulations and policy changes
- Supporting provider & tribal health infrastructure development

**Funding in thousands of dollars**

## 5-Year Plan: Activities and Estimated Budget

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### Work force Development

**GF/MH**

**\$975.0**

**total**

**\$975.0**

- Advanced training and mentoring for BH workers at all levels
- Providing scholarships for BH providers to obtain training and certification
- Developing a tribal training site for rural BH workers.

### ***Funding in thousands of dollars***

### Capital Development:

- Completing current BTKH infrastructure development projects
- Developing 3 - 5 group homes
- Developing crisis stabilization beds

**general funding**

**authorization through Denali Commission**

**total**

**\$7.1 million**

**\$6.3 million**





# Volunteers of America Alaska

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- **Assertive Continuing Care**
- **ARCH Residential Facility Expansion Project (from 16 beds to 24 beds)**

## Assertive Continuing Care (ACC)

- Home & Community based
- Serves youth transitioning from residential & outpatient care.
- To date: 121 youth served.
- In FY 07:
  - 37% increase in retention
  - 90% (48 out of 52) of the youth served were diverted from secure residential

# Current ARCH Facility

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# Funding

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## Capital:

- HRSA Funding \$3,444,325
- Denali Commission \$1,059,234
- State GF Match \$1,059,234
- Rasmuson Foundation \$1,280,760

Land: \$200,000. State of Alaska  
\$17,767. Donor contributions  
\$82,030. Volunteers of America

# Anchorage Mental Health Services – Outpatient Services to Youth

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**30 MONTHS BTKH FUNDING:  
7/1/05-12/31/07**

**RESULTS (107 treated):**

- **24 returned from Out of State residential**
- **24 received from In State residential**
- **59 prevented from admit to residential treatment**
- **65 % successfully completed treatment**

# Juneau Youth Services

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- Montana Creek Residential Program
- Black Bear Transitional Living Apartments

# Community vs. Residential

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## Community

## Out of State Residential

Day: \$ 68

Month: \$ 1322

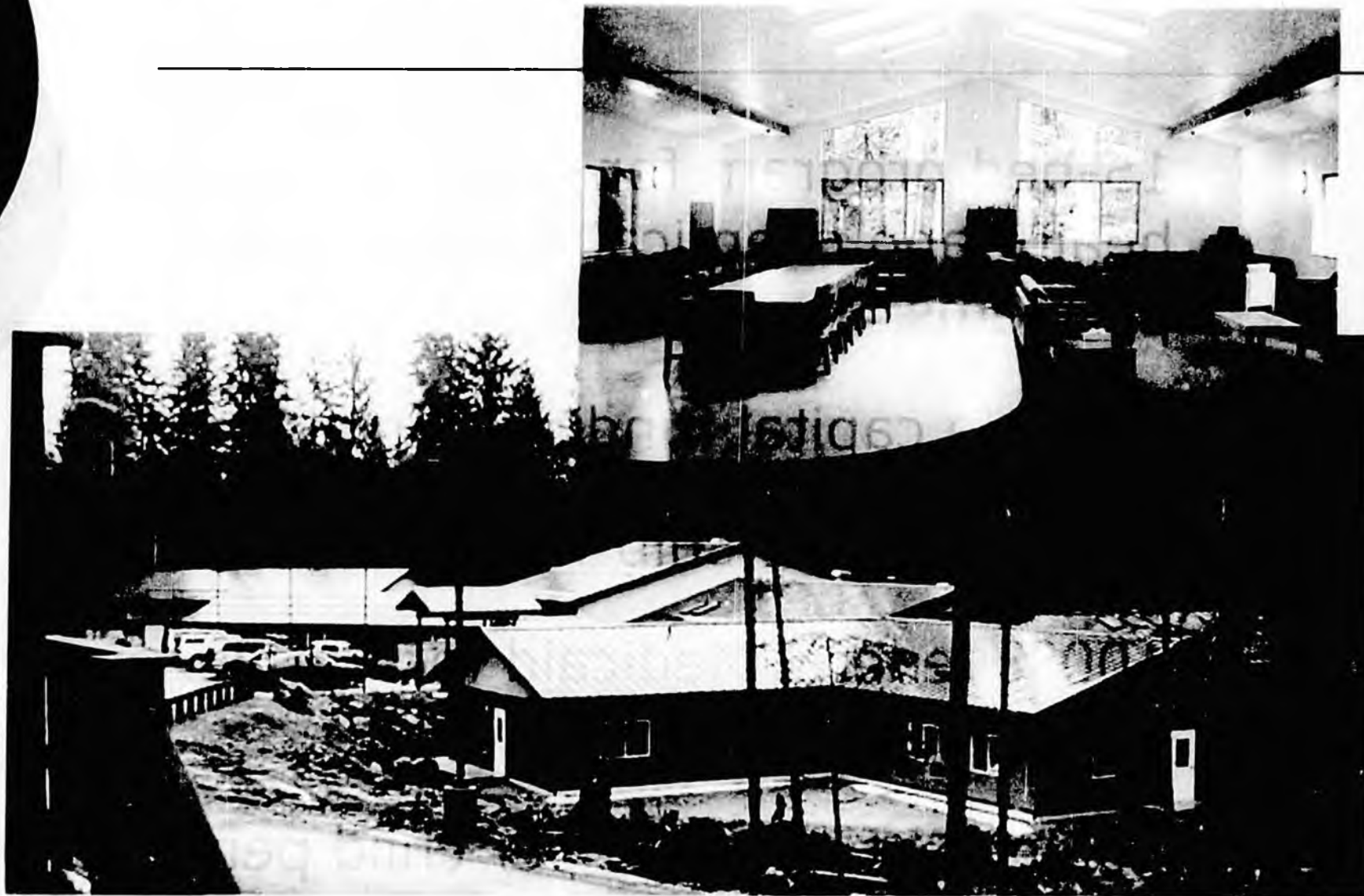
Year: \$ 24,504

Day: \$ 300

Month: \$ 9,000

Year: \$ 108,000

# Montana Creek Residential Program



# Montana Creek Residential Program

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- 15-bed program for youth with mental health and chemical dependency problems
- Multiple capital funding partners
- Unique partnership with SEARHC
- 100% federal Medicaid for Native clients
- Savings of \$64,000 per child per year

# Black Bear TLP Apartments



# Black Bear TLP Apartments

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- 13-bed facility for youth ages 18 to 21
- Includes Resident Case Manager
- Capital funding partnership
  - Denali Commission
  - Alaska Housing Finance Corporation
  - Juneau Youth Services

**Reports and detailed information on BTKH are available at:**

<http://www.hss.state.ak.us/commissioner/btkh/>

<http://146.63.9.166/sites/SSA/default.aspx>

<http://trustgroups.infoinsights.com/docbtkh.html>

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Bring the Kids Home



3 Year Update

State of Alaska • Department of Health & Social Services • Fiscal Years 2005-07

More information can be found on our Web site: <http://www.hss.state.ak.us/commissioner/btkh/>



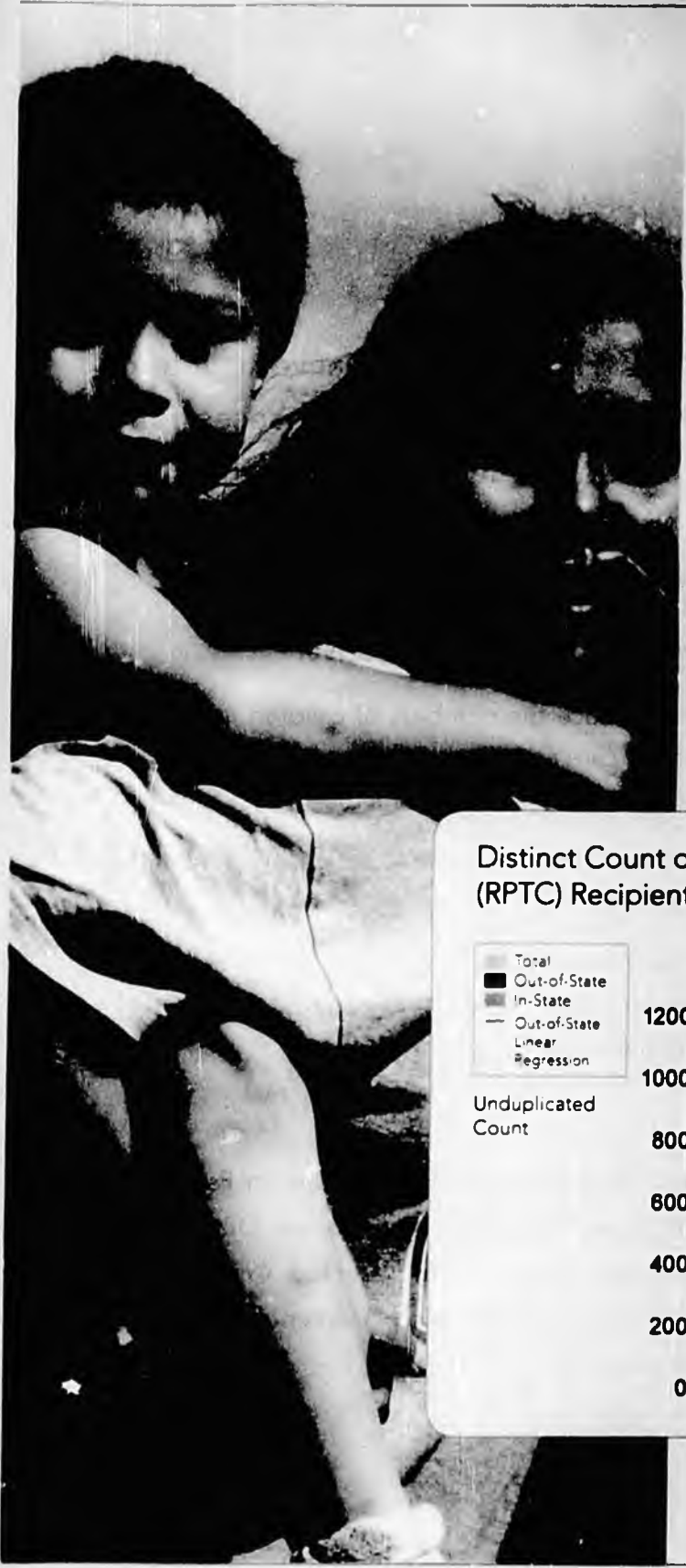
**Bring the Kids Home** is an initiative to return children with severe emotional disturbances from out-of-state residential facilities to treatment in Alaska and to keep new children from moving into out-of-state care.

**Three primary goals guide the initiative:**

- Significantly reduce the numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.
- Build the capacity within Alaska to serve children with all intensities of need.
- Develop an integrated, seamless system that will serve children in the most culturally competent, least restrictive setting, and as close to home as possible.

**History:**

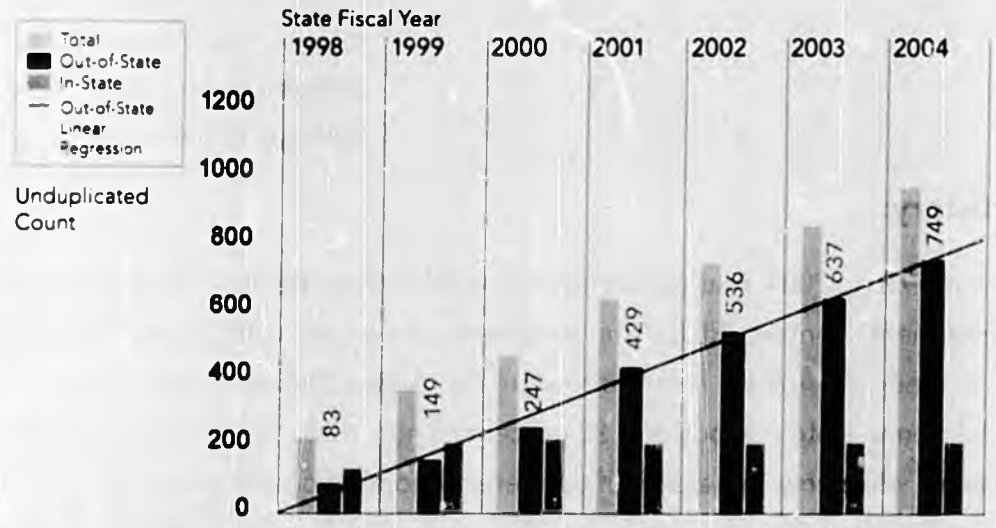
From 1998 to 2004, Alaska's behavioral health system became increasingly reliant on Residential Psychiatric Treatment Centers (RPTC) for treatment of youth with severe emotional disturbance. Out-of-state placements grew by nearly 800 percent. Alaska Native children were over-represented: 49 percent of children in state custody and 22 percent of non-custody children in out-of-state placements were Alaska Native while only 16 percent of the general population is Alaska Native.



## Out-of-State Residential Psychiatric Treatment Centers

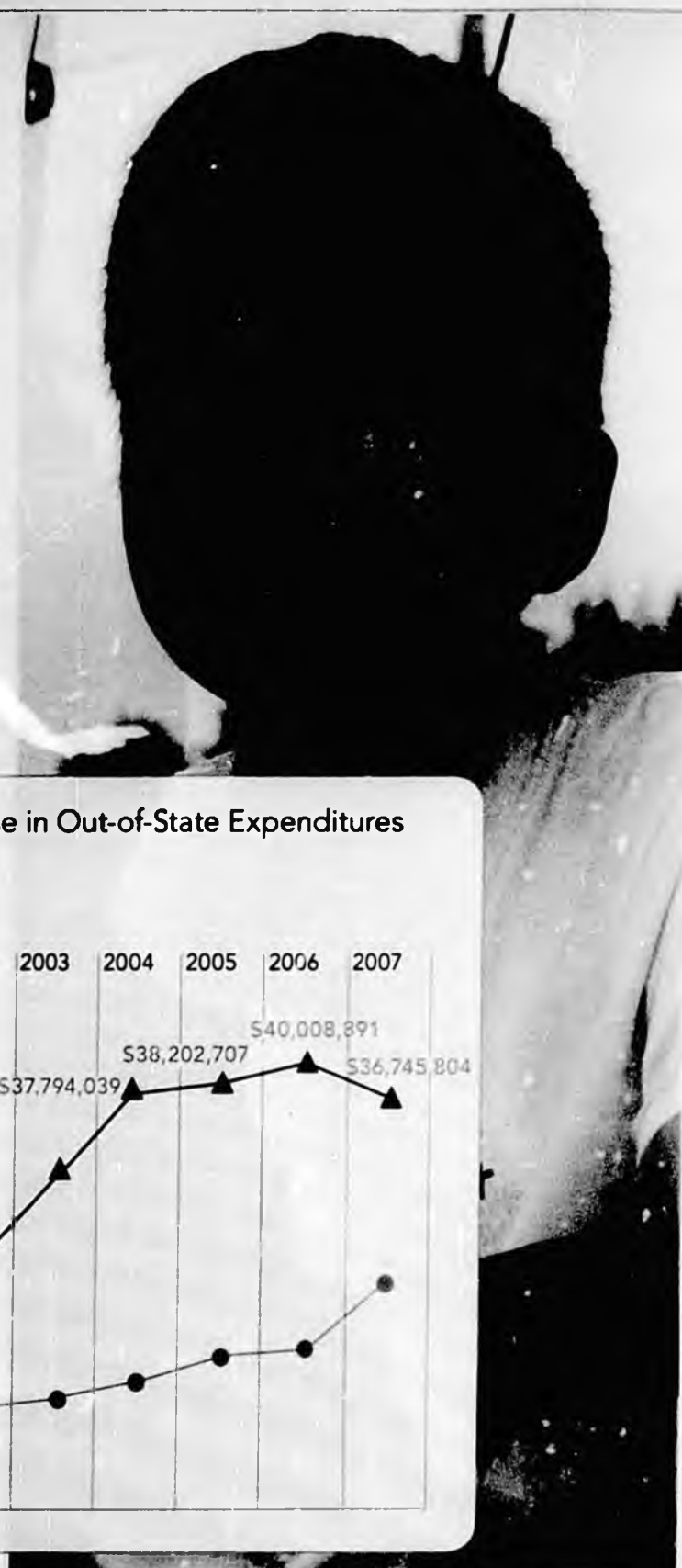
Between fiscal year 1998 and fiscal year 2004, out-of-state Residential Psychiatric Treatment Centers (RPTC) Medicaid expenditures experienced an overall increase of over 1,300 percent. By fiscal year 2006, Medicaid expenditures were over \$40 million for a relatively small number of children with severe emotional disturbances in out-of-state Residential Psychiatric Treatment Centers.<sup>1</sup>

**Distinct Count of Medicaid Residential Psychiatric Treatment Centers (RPTC) Recipients**

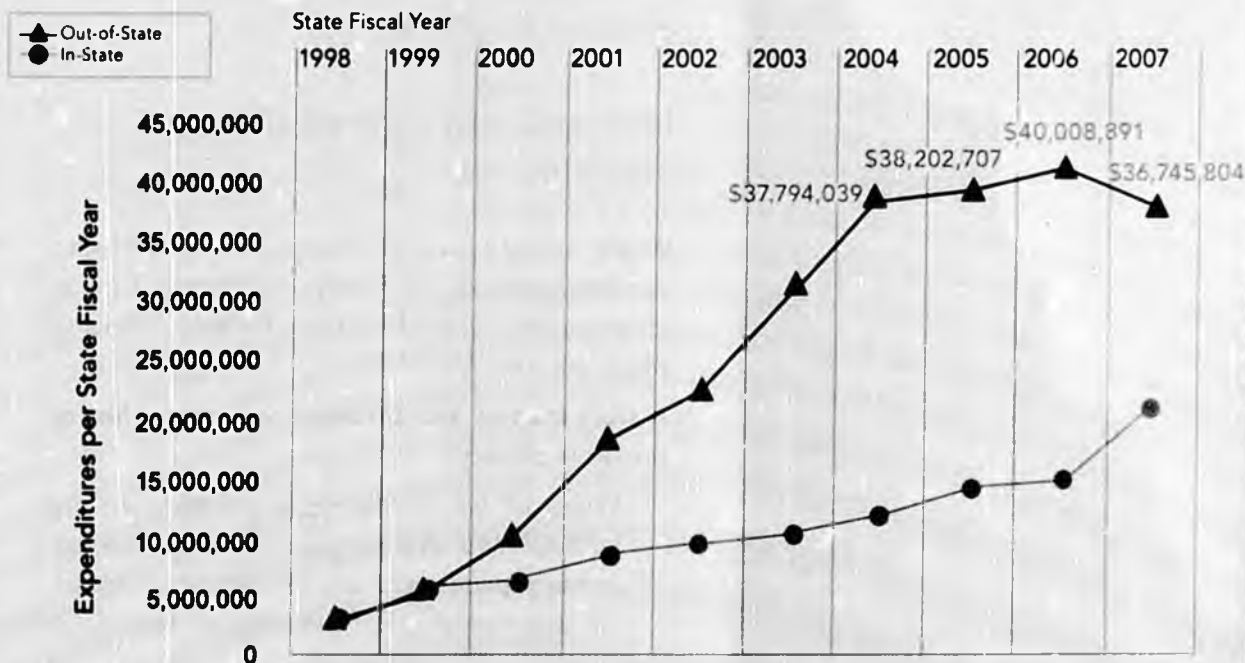


<sup>1</sup>Data found in this update are from Behavioral Health Policy and Planning — more detail can be found in Bring the Kids Home yearly reports for FY05, FY06 and FY07 at: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html).

By fiscal year 2006, Medicaid expenditures were over \$40 million for a relatively small number of children with severe emotional disturbances in out-of-state Residential Psychiatric Treatment Centers.



### Residential Psychiatric Treatment Centers: Decrease in Out-of-State Expenditures and Shift to In-State Care



State Fiscal Year (SFY) 07 calculations completed by the Department of Health & Social Services (DHSS), Finance and Management Services (FMS) and include all claims incurred and paid in FY07 as well those incurred in FY07 and paid in the first quarter of FY08. SFY 98-SFY06 calculations were provided by Behavioral Health (DBH). Every attempt was made to replicate the parameters used between DBH and DHSS FMS. Parameters have now been standardized and future years will replicate the parameters used for FY07.



## System impact of these trends:

The foregoing cited trends limit the development of in-state mental health care because Alaska Medicaid resources are already invested in the out-of-state services. These trends create difficulty coordinating a child's return home, resulting in problems with medication management, school records and involving families in clinical supports in the community. Families and children are separated and cultural differences can be significant. If children need residential care, it is better delivered close to home.

As noted, these trends represent a financial investment in residential services. However, waiting until children move into residential care increases the problems experienced by the child, the family and the community. Alaska needs proactive, community-based services to keep children from becoming severely disturbed and needing residential treatment, as well as in-state residential services for children with severe emotional disturbances.

## Human impact of these trends:

When a child needs intensive mental health services in Alaska, the family often faces a serious dilemma: what is the best thing for their child and what can they afford?

***A story (names and situation are composites to preserve privacy):***

*When Jill was 13, she became withdrawn and suicidal. Her mother (Lisa) tried counseling, consequences and bribes. Nothing helped. Jill attempted suicide when she was 14. By*

then, their insurance benefits were used up. The family went to a Community Mental Health Center (CMHC), but services were limited by funding, workforce, training and geography. Both Lisa and the CMHC were afraid that Jill would hurt herself again. Lisa took increasing time off from work and her boss began to complain. The younger children started to act out. Local residential treatment facilities did not want to admit a child who had attempted suicide when there were other children with less severe problems being referred.

A friend told Lisa about an out-of-state facility that boasted a strong school program and welcomed suicidal and depressed children. The state would pay for Jill's treatment after 30 days. Out-of-state residential care seemed the only option.

#### **How can families manage in these very difficult circumstances?**

Problems exist with a system that cannot provide care before a child becomes severely disturbed. Problems can include:

- The family's insurance, financial and emotional resources are exhausted.
- Family relationships are disrupted and the other children begin to have difficulties.
- The child becomes more disturbed.
- School performance suffers and school resources are stretched thin.
- The juvenile justice or children's protective services systems become involved.

A frequent result is that a child enters acute care and is referred for long-term residential placement. **After 30 days, the state begins to pay for most residential care through Medicaid.**



# Bring the Kids Home Accomplishments:

The following is a summary of Bring the Kids Home accomplishments. Detailed reports and budget information are available on the Bring the Kids Home Web site at: [hss.state.ak.us/commissioner/btkh/](http://hss.state.ak.us/commissioner/btkh/).

## Capacity Development

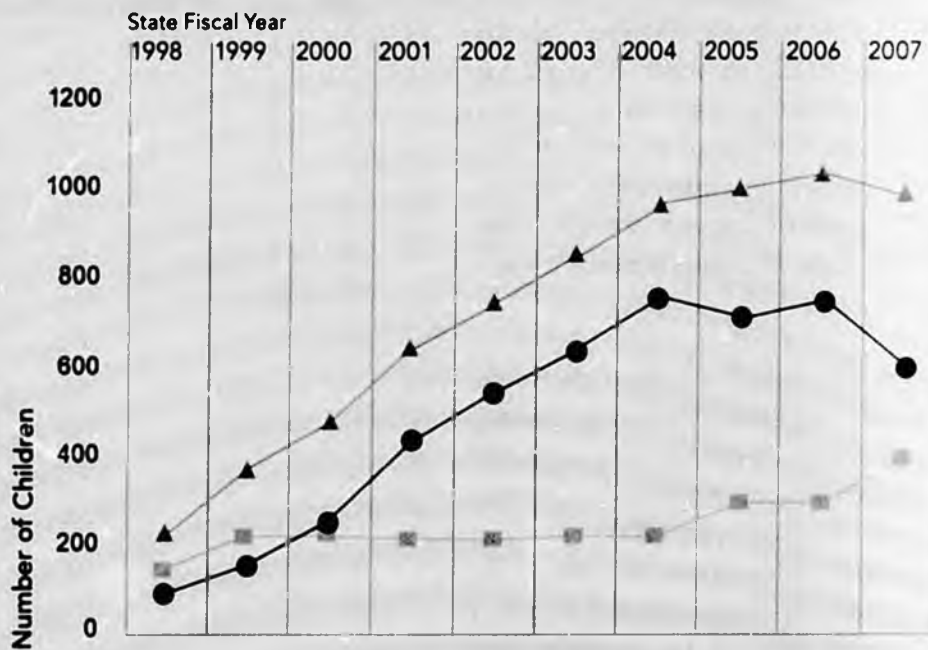
- 28 new Bring the Kids Home operating grants are developing services in 12 communities. During fiscal year 2006 and 2007, 56 new in-state beds were developed, 236 children were stepped down from more restrictive in-state or out-of-state care and approximately 500 children were served.
- Individualized Service Agreements (ISA) were created to fund services to prevent children from moving into residential care. During the first full year, ISA supported 61 children in community-based settings.
- A Department of Health & Social Services rate review mandated an 18 percent increase for behavioral rehabilitation services and new regulations expanded access to 54 in-state beds for non-custody children. During fiscal year 2007, the length of stay for non-custody children in in-state Residential Psychiatric Treatment Centers was 141 days, whereas the out-of-state average was 335 days.
- Funding was identified to develop a facility in Anchorage to stabilize children in acute crisis and help return them to community settings. This will proceed in fiscal year 2008.
- Regulations were developed for school Medicaid mental health service delivery as part of a child's individualized education plan. During fiscal year 2008, a "tool kit" will be created to assist with expanding school mental health capacity. Two schools enrolled in fiscal year 2007.
- New capital funding is developing residential treatment/group homes in Anchorage, Fairbanks, Juneau, Ketchikan, Kenai, Kotzebue, Dillingham and Eklutna.
- New funding is supporting expanded tribal mental health services that are culturally competent, closer to home, and that access the 100 percent federal reimbursement rate. One new tribal facility estimates full year savings of state general funds of \$500,000.
- Workforce issues are being addressed with new grants: through training and mentoring, and through the Bring the Kids Home workforce subcommittee. During fiscal year 2007 the "Residential Services Certificate Program" enrolled 58 students; the Fetal Alcohol Spectrum Disorder demonstration waiver trained its first cohort of over 25 participants; and a statewide early childhood mental health learning collaborative trained providers and began follow-up mentoring.

For more information: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)

How do outcomes reflect this capacity development?

Out-of-state care is declining and in-state care is increasing. (Table shows the distinct count of children served in Residential Psychiatric Treatment Centers during a fiscal year.)

Change in In-State and Out-of-State Residential Psychiatric Treatment Centers Placements Over Time



## Community Diversion, Care Coordination and Gate Keeping:

- A new care coordination team within the Department of Health and Social Services is monitoring referrals to out-of-state Residential Psychiatric Treatment Centers (RPTC) care, ensuring use of in-state resources prior to out-of-state RPTC care and engaging in system development. The team's activities will expand during fiscal year 2008. A pilot project by this team diverted 37 children in acute care from out-of-state Residential Psychiatric Treatment Centers care during fiscal year 2007.
- Parent/Peer Navigation grants are diverting youth from residential care by helping parents and youth navigate the system and access in-state resources. Between March and September 2007, 55 youth referred for Residential Psychiatric Treatment Centers care were served. Of these, 45 percent (25) were able to remain in community settings. Another 34 percent moved into in-state residential settings. In total, 79 percent were maintained in-state.
- Behavioral Health held Bring the Kids Home summits in 2007 in Bethel, Fairbanks, Juneau, Kenai and Kodiak to identify service gaps and to build collaboration. Additional summits will be held in fiscal year 2008, starting with Kotzebue. Information is used for planning, system development and ongoing coordination of services for children and families.
- In 2007, the Department of Health and Social Services began a pilot project to return/divert children from the Mat-Su region from out-of-state care. The contractor will coordinate comprehensive service plans for the children and their families. If effective, this model may be expanded.
- A new fiscal year 2008 project will coordinate educational transitions, establish protocols and monitor success for children returning from care in Residential Psychiatric Treatment Centers.
- A Level of Care Assessment was implemented at three acute care sites to standardize decision-making. During 2008, it will become part of out-of-state placement reviews.

For more information: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)