Bring the Kids Home Regional Summit
Summary Report
Anchorage, Alaska
May 12-13, 2008

The goal of the State of Alaska Bring the Kids Home (BTKH) initiative is to enhance or establish an array of services statewide to ensure that Alaskan youth have appropriate treatment options within their communities or close to their families, and to minimize out-of-state placement in residential psychiatric treatment facilities. In the spring of 2008, the State of Alaska, Behavioral Health, convened the ninth in a series of twelve regional meetings with local service providers to collect their input on the system currently serving youth in the state.

The ninth summit was held in Anchorage on May 12 and May 13, 2008. Approximately thirty (30) participants were in attendance. This included family representation, the Alaska Youth and Family Network, the State of Alaska, Office of Children's Services, Division of Juvenile Justice, and Behavioral Health, the Alaska Mental Health Board, the Anchorage School District, the Alaska Mental Health Trust Authority, and local service providers employed in a variety of programs. A complete list of meeting participants can be found in Appendix A.

Meeting Format

The May 12th meeting began at 9:00 AM and concluded at 4:30 PM. The May 13th meeting began at 9:00 AM and concluded 12:00 PM. The program began with a panel presentation titled: *Why Are We Bringing the Kids Home and How Can We Work Together for Success?* Presenters included Carol Comeau, Superintendent of Schools, Anchorage School District; Joe Federici, Behavioral Health with Southcentral Foundation; Master William Hitchcock, Alaska Children's Court; and Margaret Lowe, Trustee, AMHTA. Each panelist discussed their experiences in providing and/or accessing services to youth in the region. The panel was moderated by Melissa Stone, Director of the Division of Behavioral Health.

Following, Maureen McGlone, Utilization Review Specialist, State of Alaska, Division of Behavioral Health, presented a basic overview of the current statewide Bring the Kids Home Efforts – including the Individualized Service Agreement (ISA) funds and the Medicaid Waiver Pilot Project to increase community-based services for youth with Severe Emotional Disturbance and FASD.

Following the panel, meeting participants broke into small groups and engaged in focused discussion about regional characteristics in the following areas:

- "What's Working" + "What's Not Working"
- Solutions
- Resources + Leads

Groups recorded detailed notes of their discussions. As the small group segment of the Summit was completed, attendees reported their results to the larger group. Major themes and three priority solutions were identified by each small group which were then compiled into a master list of priority solutions.

During May 13th, the list of priority solutions was revised by the group and voted on by all participants to determine the top four priority solutions. Participants then broke into small groups once again, developing action plans for each priority solution. A complete list of solutions can be seen in Appendix B. The top four priority solutions and related action plans are discussed in the Solutions and Action Plans section of this report.

Following is a summary of group responses recorded during the small group break out sessions. A detailed listing of group responses is included as Appendix C.

"What's working?"

Groups were asked to identify community strengths that assist in supporting and serving youth close to their home communities. The responses can be grouped into four general categories: agency collaboration, in-state placements, improved funding and programs, and improved training and program sustainability models.

Agency Collaboration

Small groups noted as strengths: collaboration with the State, collaboration between agencies, agency collaboration with families and the educational system, and agencies collaborating with grass-roots organizations. Specific examples mentioned were the State committing to support the necessary number of Level V beds, agencies collaborating with other agencies for discharge planning, and grassroots BTKH meetings where real kids are discussed and solutions for them are sought.

In-state placements

Participants mentioned that in-state as opposed to out-of-state placements have increased and efforts towards keeping kids in state for treatment are gaining success. Specific examples pointed to were Anchorage Community Mental Health Services "Trauma Program" which does "whatever it takes" to prevent out of state placement, such as sponsoring the BTKH program and a home-based treatment program. Additionally, the Department of Behavioral Health's care coordination and gate-keeping efforts are helping.

Improved funding and programs

Participants noted that the mandatory 90-day case review for custody youth improves programs by increasing communication among stakeholders. Program improvements also result from the Office of Children's Services (OCS) TDM process (team decision making), which increases family/provider communication and relationships with OCS. Additional specific examples were community crisis intervention, the goal of which is to avoid acute hospitalization; and the Prime for Life Under-21 program, which is a prevention program

that focuses on three measurable behavioral prevention goals: increase abstinence for a lifetime; delaying the age of first use of alcohol; and reducing high-risk choices.

Participants recognized that funding has become more available through recent increases and diversification of funds. Specific examples cited were TEFRA; DBH assistance; ISA funding, which can be used to send outpatient staff to Residential Treatment Centers to aid in treatment plans; and the SED/FASD Medicaid waiver pilot project.

Improved training and program sustainability models

Participants stated that adding to positive coordination and sustainability of efforts is the fact that organizations are collecting and analyzing more data to determine which systems/process work and which do not. A group participant suggested a specific example of a program sustainability model: the national Fetal Alcohol Spectrum Disorder training program and the program's sharing of processes and data about treatment for children with FASD abroad. This allows providers to apply knowledge gained from this work to the work they do– promoting flexibility in service delivery and adoption of models which work.

"What's not working?"

Participants were asked to identify community weaknesses or barriers that make supporting and serving youth locally difficult or challenging. The ten general areas of concern noted by participants were: education; lack of services for under-12 children; lack of fidelity to treatment models/plans; need for better transition planning; funding issues; negative implications of diagnosis and behavioral issues; workforce issues; lack of early intervention and family support programs; lack of family participation; and treatment and program issues.

Following is a brief overview of each category.

Education

Participants stated that the continuity of education is disrupted when kids are moved to and from out-of-state placement, and that there is a lack of advocacy for kids when they return to a school setting from residential treatment.

Lack of Services for Under-12 Children

Participants specifically noted that there are no crisis programs in place for this age group in particular, and very few treatment slots for this age group available locally. This means that many children under-12 are being sent out of state, away from their families and communities. Participants pointed to the lack of crisis respite and family skill building.

Lack of Fidelity to Treatment Models/Plans

Participants mentioned the lack of a comprehensive State vision and long-term planning (including the need for program, treatment and discharge evaluation) as well as a lack of fidelity to systems/models.

Need for Better Transition Planning

According to participants, lack of transition planning begins with a lack of early recognition of a youth's resources (family, community, etc.) and continues through the child's treatment. There is a lack of transition planning between agencies, in and out of state, to/from school, home, and the treatment facility; and to adult life (specifically when the child "ages out" of the system).

Multiple participants noted the lack of a system for less restrictive treatment and transitional programs/options.

Funding issues

Funding restrictions get in the way of providing services. For example, Medicaid funding service definitions are narrow restricting the treatment options which are reimbursable. ISA funds, though flexible, are still not available for all needs and currently only behavioral health providers can initiate requests for funds. [Some discussion on this topic resulted in the conclusion that more education is needed among providers regarding what ISA funds can and cannot cover.] Also noted was that insufficient reimbursement rates for skilled case managers leads to inadequate case management.

Negative implications of diagnosis and behavioral history

Participants noted that often past behaviors (for example aggressive, sexual), medical diagnosis and behavioral history is held against children and their families for many years, which leads to local service providers denying services without fully examining the individual case. This results in many of these children being sent out of state.

Workforce

This category includes a lack of applicants for available positions, high case loads for those providing services, and training for providers. Specific examples included the lack of specialized training (eating disorders, non-adjudicated sexual and/or aggressive behaviors) and specialized therapeutic foster homes. Participants also noted the need for an increase in the number of Native and multi-cultural homes, and for an increase in village services.

Lack of early intervention and family support programs

Participants stated that early intervention and family support is needed, as is funding to support services for them. Additionally, participants noted there needs to be more family

and child centered treatment and children/youth need a voice in their care/lives as opposed to viewing the agency as the expert on what is best for them.

Lack of family participation

Strategies need to be developed which will engage families and encourage follow through by parents.

Treatment and program issues

Treatment plan issues include the need to involve families more in developing treatment plans, that there is a lack of planning for discharge and on-going therapy, there is a need for better assessment of disabilities, that treatment plans should be, but are not always, written by a 3rd party, and that there is a disconnect between educational and treatment plans.

Participants noted other problems including the fact that there is a waiting list for treatment, the lack of therapeutic foster homes, group homes, short-term stabilization options (especially for boys), alternatives to traditional clinical settings and lack of secure residential treatment in the State.

Solutions & Action Plans

Major themes and three priority solutions were identified by each small group and compiled into a master list of priority solutions. The list of priority solutions was then revised by the larger group and voted on by all participants to determine the top four priority solutions.

Participants divided into small groups once again, and developed action plans for each priority solution. The top four priority solutions were as follows:

- Before any child is sent out of state, use the existing grassroots BTKH meetings to work with an inter-disciplinary team and develop resources/brainstorm in-state options
- Attach ISA funds to the client and family rather than to the provider agency, similar to the Developmental Disabilities waiver model
- Coordinate care and empower parents and youth; provide peer advocacy for every child and family
- Reduce funding barriers for providers

Action Plans

Priority Solution #1: Before any child is sent out of state, use the existing grassroots BTKH meetings to work with an inter-disciplinary team and develop resources/brainstorm in-state options.

Priority Solution	Tasks	Community Lead	Resources Needed	Timeframe	
				Next 6 months	Longer term
Use existing grassroots BTKH meetings to work with an inter-disciplinary team and develop resources/brainstorm in-state options before any child is sent out of state	Expand decision making group to include family, youth, providers, Medicaid/Qualis, Stone Soup, UR specialists, AYFN, cultural groups, OCS, DJJ, Education.	BH UR	Larger meeting place, email list for meeting notice	X	
	Clarify the process of out-of-state/in-state placement for families and youth. Create an online information triage process for individuals to investigate treatment options	AYFN, BH UR, Stone Soup	Publication funds, Public awareness campaign	X	
	Create a shared management information system to track care, treatment and discharge plans; focus on what works.	Qualis, provider groups, BH, OCS, DJJ	BH?		X
	Create a resource guide of youth behavioral health agency services, trainings, resources	BH UR, Agency/Provider groups	BH? Providers	X	
	Create a crisis respite system in Anchorage	MHTA, BH providers, AYFN, Stone Soup	AMHTA funding for pilot project	X planning	
	Create a crisis respite system in rural Alaska.	MHTA, BH providers, AYFN, Rural Families, Stone Soup	AMHTA funding for pilot project	X planning	X

Priority Solution #2: Attach ISA funds to client and family

Priority Solution	Tasks	Community Lead	Resources Needed	Timeframe	
				Next 6 months	Longer term
Attach funds to client and family	Identify a state lead and regional directors to oversee the funds.				
	Determine how to identify a child and their needs				
	Identify funding—needs process with key players				
	Provide a living wage for new and existing employees –assists with workforce development (recruitment, training, retention).				
	Education funds attached to child upon school enrollment—Goes with the child no matter where they go, even RPTC.	Commissioners from other Departments go to Legislature			

Additional suggestions were to model the program after the waiver program which has the structure of funding being attached to the child/family instead of the service provider agencies and for providers to utilize ISA funds.

Priority Solution #3: Coordinate care and empower parents and youth

Priority Solution	Tasks	Community Lead	Resources Needed	Timeframe	
				Next 6 months	Longer term
Coordinate care and empower parents and youth	Identify a point person who will be the lead for the family and for the system.	State (BH UR, AMHTA), community	Funding for stipends		
	Identify protocols within and across agencies which describe how the treatment system works and how it should work (the educational system, behavioral health).	State: UR, Qualis, OCS, DJJ, Providers Community			
	Determine the mechanism/incentive to get protocols written and talked about— Changing how people think and what they do.	State: Grants and Contracts Community			
	Evaluate where there is duplication, gaps in service.	State Community			
	Continue to refine clear system protocols, point person for each child family.	State Community			

Additional suggestions were:

1. The State should work to identify the protocols for how State agencies work together, and the community should do the same.
2. Protocol should include a decision tree—guidance on how system should function, determine leads.

Priority Solution #4: Reduce funding barriers for providers

Priority Solution	Tasks	Community Lead	Resources Needed	Timeframe	
				Next 6 months	Longer term
Reduce funding barriers for providers	Develop a committee comprised of providers, decision makers and funders to identify barriers to funding services adequately.				
	Find solutions for each barrier.				
	The State needs to provide solid Medicaid technical assistance, and designate one individual responsible for providing it; use websites to post process requirements.				

Additional suggestions were:

1. The State should clarify the Medicaid process, and simplify the process for Medicaid billing as well as clearly define the intent of ISA dollars.

2. The State should separate ISA funding requirements from Medicaid requirements. Though the requirements are similar, it is too cumbersome for smaller providers and those who are not Medicaid billers to get reimbursement for ISA dollars alone.

3. Develop a web-based application for ISA funds: the secondary benefit of this is information and data gathering.

4. Create an on-going dialog between the service providers and those who make funding decisions.

Existing Resources

Participants described existing resources as productive GAAP meetings, which are sponsored by the Office of Children's Services, as well as improved technology, such as the availability of web and pod-cast for education and training delivery. Examples of organizations that currently have this technology are the Department of Corrections, the school system, the Special Education Service Agency, the University of Alaska System, Native Corporations, and the Governor's office.

Follow up/ Wrap up

During the wrap up, participants reiterated that they would like to see the State develop training about how to access alternative funds such as ISA dollars and that they would like to establish a planning group which continues to work together.