System of Care Report to the Montana Legislature

Report and Recommendations as Required by House Bill 243

Prepared For

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I. Executive Summary

OPEN MINDS is pleased to present the Montana Department of Public Health and Human Services (DPHHS) and the Children's Mental Health Bureau (CMHB) with this report on the Department's progress towards the development of a statewide children's system of care. This information was requested in House Bill 243 which directs the Children's System of Care Planning Committee to study the system of care, with a focus on high-risk children with multi-agency service needs.

OPEN MINDS methodology for this engagement included the review of system of care literature, documents submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) to meet grant requirements; site visits to existing Kids Management Authorities (KMAs) and partners at these sites; interviews with CMHB staff; interviews with youth and family members, providers, state agencies, including the Children's Mental Health Bureau (CMHB), as well as System of Care Planning Committee members. This report provides an overall description of Montana's system of care, an assessment of system strengths, weaknesses, and recommendations for sustainability of Montana's system of care.

Following are:

- Strengths of the Montana system of care overall and the KMA model in particular
- Weaknesses of the of the Montana system of care overall and the KMA model in particular
- Assessment of progress toward the overall Montana system of care as established in legislation (52-2-301)
- Recommendations

More detail can be found in the body of the report.

<u>Strengths of the Montana System of Care Overall and the KMA Model in Particular</u>

The Montana system of care overall has significant strengths, and the KMA model was successful in a number of key areas.

1. The Montana legislature has an established history of commitment to a system of care for children.

2. The State Agencies are committed to system of care concepts and ideals. Along with the KMA model described in this document, there have been other initiatives by state agencies that reflect this commitment to wraparound process and values and community-based care.

a. Juvenile Probation is taking initiative in developing out-of-home alternatives for youth in the probation system. This has included using unspent dollars in the Juvenile Delinquency Intervention Program (JDIP) to fund prevention programs and other community based programs. JDIP funds are appropriated to the Department of Corrections and are allocated to district courts for delinquency intervention.

b. The Child and Family Services Division is utilizing the Family Group Conferencing model, and using wraparound principles in its work with families and youth. This includes efforts to identify and utilize natural supports and community-based alternatives whenever possible as alternatives to out of home placements.

c. The Children's Mental Health Bureau's PRTF Waiver program uses high fidelity wraparound to provide intensive services and supports in a community setting. Thus far the average cost per youth is far less than the average cost of a PRTF admission.

3. The leaders of the State Agencies have an established history of working together.

4. The KMAs worked diligently to involve a wide range of community stakeholders to address the needs of children and families, both from a system planning and case planning perspective. This culture of local community and stakeholder involvement is critical to effectively address the needs of children and families.

5. KMA staffs were strong supporters of community-based alternatives to out-of-home placements, and this was clearly reflected in their approach to case planning.

6. There have been a number of examples of KMAs effectively facilitating multi-agency problem solving, both at the system and individual case levels.

7. A number of stakeholders identified the effectiveness of the KMAs in working with "kids falling through the cracks" in the system. These were often youth and families who were not funded by one of other systems.

8. There are many examples of KMAs working to actively empower both parents and youth in the treatment process. These efforts reflect the "voice and choice" philosophy of empowering families and youth that is central to the system of care.

9. Both families and youth viewed the KMAs as advocates.

10. Youth spoke highly of the Youth Support Groups, and the general supportive atmosphere of the KMAs.

11. Parents report that case management provided by the KMA Parent Coordinator was instrumental in making the transition back home from acute hospitalization and residential treatment easier for both the child and the family.

12. Youth and family report that working with the KMA was as a simple and easy process. KMA staff provided as much assistance as is needed with each family to help that family navigate the system.

13. Families that utilize transportation assistance (i.e. gas cards) are more consistently attending required treatment, planning and support groups.

14. There has been a reduction in the use of out-of-state placements for youth, and in the length of stay for youth in residential facilities. (See August 24, 2010 "Out of State Placement and Monitoring Report to the Legislature" in Appendix A; and "Average Length of Stay Report, August 24, 2010 in Appendix B)

<u>Barriers to the Successful Implementation of the Montana System of Care Overall and the KMA Model in Particular</u>

1. The financial model of the KMA was not self-sustaining. As grant funding decreased the KMAs were unable to generate adequate revenues to continue to function.

2. The State's approach to relying on each community to replicate the KMA model did not allow for economies of scale.

3. While the local community focus of the KMAs allowed the KMAs to be very responsive to the needs of their specific communities, at the same time it is unclear whether lessons learned and best practices developed in individual KMAs were fully leveraged to other communities.

4. There does not appear to have been a consistent interpretation of the wrap-around model across all of the KMAs. This led to variations in approach which may or may not have reflected best practices.

5. Interviewees identified children with multiple needs who are involved in multiple systems as the most challenging in terms of developing a unified individual treatment plan. Contributing factors identified included:

    a. The challenges of coordinating multiple funding streams. The KMAs had limited funds to pay for services delivered, and so would be in a facilitator/negotiator role with other entities when attempting to determine payment for needed services.

    b. Lack of, or inconsistent attendance of key decision-makers at the local interdisciplinary team the meetings, which made it difficult to make decisions and implement planning in a timely fashion.

    c. Those attending the interdisciplinary team meetings did not have the authority to make funding or policy decisions, again slowing down the decision-making needed for planning.

6. The willingness to develop cross-departmental solutions to serve the needs of children and families involved with multiple systems often appeared to have been

the result of strong leaders committed to teamwork and willing to try innovative solutions to problems. While this leadership is necessary and commendable, the sustainability of this approach appears to be reliant on the commitment and effectiveness of individuals rather than anchored in the system. It was reported that a change in leadership could often result in a significant change in commitment to a true cross-departmental problem solving model.

7. Funding rules remain a challenge for implementing a true system of care. Many of the supports and services utilized in a wraparound model may not qualify for payment as defined by funding rules. Also, Medicaid rules often have specific prohibitions against the blending of Federal funds with other dollars, making a "braided" model for funding streams required.

Assessment of Progress Toward the Goals for the Montana System of Care Established in Legislation (52-2-301)

As noted earlier, following are the goals for the overall Montana system of care are established in legislation (52-2-301):

1. To provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available

   Montana has demonstrated a strong commitment to a stable system of care, and has been quite successful in a number of areas, as noted above. At the same time, there are still barriers which will need to be addressed.

2. To serve high-risk children with multiagency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development

   There have been significant examples of initiatives in Montana to serve children in the least restrictive and appropriate settings, including the KMA model, the work of the Youth Courts, and the family group conferencing model used by the Child and Family Services Division.

3. To serve high-risk children with multiagency service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort

   There has been a reduction in the number of children in out-of-state placements, from 127 in FY 2009, to 100 FY 2010. (See Appendix A)

4. To provide integrated services to high-risk children with multiagency service needs

   While progress has been made towards this goal, families can still give examples of their experience with uncoordinated and unintegrated services.

5. To contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements

   Along with the reduction in out of state placements , length of stay in residential placements has been decreasing over the last four years. (See Appendix B)

6. To increase the capacity of communities to serve high-risk children with multiagency service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children

   Collaboration and cooperation between agencies exists at the leadership level, and was implemented to varying degrees in selected local communities.

7. To prioritize available resources for meeting the essential needs of high-risk children with multiagency service needs

   Much of the work of the KMAs was focused on developing available resources at the local level. While there were significant examples of this being done very well, barriers still remain.

8. To reduce out-of-home and out-of-community placements through a children's system of care account to fund in-state and community-based services that meet the needs of high-risk children with multiagency service needs in the least restrictive and most appropriate setting possible

   While the Legislature created the system of care account, it does not receive a specific appropriation. The KMAs had limited resources to fund direct service provision.

<u>Recommendations</u>

1. Ensure that the principles of parent and youth involvement and empowerment remain central tenets of the Montana system of care for families and youth.

2. Continue to convene the System of Care Community Planning Committee and the System of Care Statutory Planning Committee. These committees should be clearly tasked with:

   a. Oversight of the Montana system of care for children and families

   b. Maintaining the balance between the development of programming that meets the unique needs of local communities and the need for consistency in key areas:

      i. Overall system quality assurance

ii. Using outcome indicators to evaluate the effectiveness of the system of care

iii. Overall system implementation of clinical and operational best practices

iv. Encourage continuation of local interagency planning, including families, advocates and providers

c. Identification of barriers to implementing solutions to address the needs of children and families

d. Developing policies and procedures to eliminate system barriers as appropriate

3. Expand the Psychiatric Residential Treatment Facility (PRTF) Waiver Program. This is a Medicaid 1915c waiver program with home and community based services with grant funding for start up and administrative costs. The program uses a high fidelity wraparound service model. Initial results have been very positive and this could be an excellent vehicle to more firmly anchor the system of care in Montana.

4. Explore methods to address the funding issues for children served by multiple agencies, such as the braiding of funding streams. This is a very high-need group of children who ultimately will be very costly to the overall state budget. This can include:

   a. Exploring waiver options that allow for flexibility in funding

   b. Carefully exploring braided funding models

II. Description of the Montana Children's System of Care

A. Development of the Montana System Children's System of Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes a system of care as a coordinated network of community-based services and supports that is organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations so services and supports are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. The system of care recognizes that children and families have needs at many levels and promotes a holistic and wrap around approach in which all life domains and needs are considered in serving children and their families, rather than addressing mental health treatment needs in isolation. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life.

During the 2003 Legislative Session, the Montana State Legislature expanded the responsibilities of the Multi-agency Children's Committee established by Senate Bill 454 in 2001, (title 52, Chapter 2, Part 3), with Senate Bill 94 which directs the Director of the Department of Public Health and Human Services to establish a Children's System of Care Planning Committee to coordinate the development of the system of care.

The purpose of the System of Care Planning Committee is to plan for an integrated, sustainable and highly responsive system of care for high risk children with multi-agency needs, using an array of perspectives to improve knowledge, effectiveness, and eliminate barriers. Specifically, the Committee is tasked with the following (52-2-303):

1. Develop policies aimed at eliminating or reducing barriers to the implementation of a system of care

2. Promote the development of an in-state quality array of core services in order to assist in returning high-risk children with multiagency service needs from out-of-state placements, limiting and preventing the placement of high-risk children with multiagency service needs out of state, and maintaining high-risk children with multiagency service needs within the least restrictive and most appropriate setting

3. Advise local agencies to ensure that the agencies comply with applicable statutes, administrative rules, and department policy in committing funds and resources for the implementation of unified plans of care for high-risk children with multiagency service needs and in making any determination that a high-risk child with multiagency service needs cannot be served by an in-state provider

4. Encourage the development of local interagency teams with participation from representatives from child serving agencies who are authorized to commit resources and make decisions on behalf of the agency represented

5. Specify outcome indicators and measures to evaluate the effectiveness of the system of care

6. Develop mechanisms to elicit meaningful participation from parents, family members, and youth who are currently being served or who have been served in the children's system of care

7. Take into consideration the policies, plans, and budget developed by any service area authority provided for in 53-21-1006

Additionally, the committee is responsible for coordinating the development of a stable system of care for high-risk children with multiagency service needs that may include:

1. Pooling funding from federal, state, and local sources to maximize the most cost-effective use of funds to provide services in the least restrictive and most appropriate setting to high-risk children with multiagency service needs

2. Applying for federal waivers and grants to improve the delivery of integrated services to high-risk children with multiagency service needs

3. Providing for multiagency data collection and for analysis relevant to the creation of an accurate profile of the state's high-risk children with multiagency service needs in order to provide for the use of services based on client needs and outcomes and use of the analysis in the decision-making process

4. Developing mechanisms for the pooling of human and fiscal resources

5. Providing training and technical assistance, as funds permit, at the local level regarding governance, development of a system of care, and delivery of integrated multiagency children's services

The committee is composed of the following members (52-2-303):

1. An appointee of the Director of the Department of Public Health and Human Services representing the mental health program

2. An appointee of the Director of the Department of Public Health and Human Services representing child protective services

3. An appointee of the Director of the Department of Public Health and Human Services representing the developmental disability program

4. An appointee of the Director of the Department of Public Health and Human Services representing the chemical dependency treatment program

5. An appointee of the Superintendent of Public Instruction representing education an appointee of the director of the department of correction

6. An appointee of the Youth Justice Council of the Board of Crime Control

7. An appointee of the Supreme Court representing the youth court

8. Other appointees considered appropriate by the Director of the Department of Public Health and Human Services who may be representatives of families of high-risk children with multiagency service needs, service providers, or other interested persons or governmental agencies

Please see Appendix C for a listing of the members of the System of Care Statutory Committee.

In October of 2003 the State of Montana, in partnership with the Crow Nation applied for federal funding to support development of Montana's system of care. (Application: Kids Integrated Service Delivery System for Montana) In December 2004 Montana and the Crow Nation received a SAMHSA grant in the amount of $9,500,000 ($5,575,000 federal participation and $3,925,000 required state match) for a six year period (FFY 2005 through FFY 2010). Now known as the Children's System of Care Planning Committee, this opportunity accelerated statewide system of care planning.

After the SAMHSA grant was awarded to Montana in 2004, the System of Care Planning Committee also served as an advisory committee to the Children's Mental Health Bureau. The Committee was involved in strategic planning and recommending budget priorities for the grant and provided leadership in the establishment of the KMAs throughout the state. In 2007, the System of Care Planning Committee became two subcommittees to improve the effectiveness of its work. The System of Care Statutory Planning Committee meets monthly and has the statutory authority to work together to improve agency collaboration to support development of the system of care. This committee receives recommendations from the Community Planning Committee which represents a diverse group of stakeholders, including 51% family members, youth and advocates. This committee also includes KMA staff, providers that serve youth, and other community members plus representation from Montana tribes. The System of Care Statutory Planning Committee members include those required by statute plus additional members appointed by the Director of DPHHS. The two committees meet together once a year.

The purpose of the two subcommittees is to work at the community and state policy level to accomplish the following:

- Develop policies aimed at eliminating or reducing barriers to the implementation of a system of care

- Promote development of a quality array of core services in-state so that SED youth can avoid out-of-state placements

- Encourage development of the infrastructure of the system of care by initiating the development of local interagency teams known as Kids Management Authorities (KMA)

- Oversee administration of the federal Children's Mental Health Initiative – Substance Abuse Mental Health Services Administration (SAMHSA) grant, received in September 2004 for the development of the infrastructure for the state's system of care for children

Both Committees, along with the Department of Public Health and Human Services and the Children's Mental Health Bureau, work collaboratively towards a coordinated service system that is community-based, centered on the needs of the individual child and family, and fiscally responsible.

Montana's Cooperative Agreement with SAMHSA states that Montana's goal was that a system of care to be implemented by communities and other American Indian tribes throughout the state. However, the strategy Montana chose to implement this goal was to begin with pilot communities in two cohorts, selected through a competitive process and chosen one year apart. After technical assistance and planning grants were offered during 2004, three implementation grants were issued to local communities in 2005 (Missoula, Billings, and the Crow Nation). Three more communities (Havre, Helena, and Butte) received grants in 2006. Each grant funded community and tribe was required to wait at least twelve months to develop infrastructure before offering services to youth and families.

In addition to the five grant funded communities and tribe, several other communities operated KMAs without grant funding. However, without the resources of the grant they were unable to collect and report data. The System of Care Planning Committee worked on a certification process that would allow the state to recognize additional KMAs who met criteria, but the process was never implemented.

A component of the grant required the KMAs participation in the National Evaluation. The National Evaluation is a comprehensive study of the children's mental health service delivery system and a community based approach to system development that addresses highly prevalent mental health problems. The Evaluation:

- Describes who is served by CMHS-funded systems of care

- Shows whether there are observable differences in child and family outcomes that can be plausibly linked to a faithful implementation of the system of care approach

- Describes how children and families experience the service system and how they use services and supports

- Supports technical assistance activities to help CMHB best meet program goals

Participation is the National Evaluation by families and children is voluntary. Evaluation results will be presented in Chapter III of this report.

Goals for the overall Montana system of care are established in legislation (52-2-301):

1. To provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available

2. To serve high-risk children with multiagency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development

3. To serve high-risk children with multiagency service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort

4. To provide integrated services to high-risk children with multiagency service needs

5. To contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements

6. To increase the capacity of communities to serve high-risk children with multiagency service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children

7. To prioritize available resources for meeting the essential needs of high-risk children with multiagency service needs

8. To reduce out-of-home and out-of-community placements through a children's system of care account to fund in-state and community-based services that meet the needs of high-risk children with multiagency service needs in the least restrictive and most appropriate setting possible

B. Values & Principles of the System of Care

The following are system of care values and principles developed by the System of Care Planning Committee and intended as part of a KMA certification process (See Appendix D):

Values

1. A system of care should be child centered and family focused with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community based with the focus of services as well as the management and decision-making responsibility resting at the community level.

3. The system of care should be culturally competent with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the population they serve.

4. The system of care has an array of services that are comprehensive, individualized for the child and family, provided in the least restrictive appropriate setting, coordinated at the system level and service delivery level, inclusive of families and youth as full partners and invested in early identification and intervention.

5. The system of care uses a strength based approach.

6. System of care efforts are directed to a community supported, family driven model that emphasizes independence rather that dependence and empowers families.

Principles

1. Full involvement of parents and families at all levels in the children's system of care.

2. In collaboration with System of Care Planning Committee, we share responsibility to ensure the coordination of state and community resources to ensure comprehensive delivery of services to youth with emotional disturbances, including youth with serious emotional disturbances.

3. We are committed to cultural competency. When the KMA is serving tribal communities, tribal representatives will have the opportunity to participate as full members of the KMA. Cultural competency is not limited to tribal populations but also includes race, religion, sexual orientation, age, gender and socioeconomic status.

4. Partnering with the state to provide information on the system needs and development and participate in policy development and educate legislators on the needs of youth with serious emotional disturbance (SED) and the impact on their families. In collaboration with the state, we will disseminate public education

materials and participate in media strategies to reduce the stigma associated with SED.

5. Being available to serve as consultants/mentors by sharing ideas, experiences and expertise with other communities.

6. The preliminary focus of this project will include youth with SED that have multi-agency needs and are at highest risk for out of home placement or are currently in an out of home placement. As the vision for KMAs unfold, all high risk, multi-agency youth including those who are abused or neglected, dependent, delinquent and in need of intervention, developmentally disabled, chemically dependent and/or emotionally disabled for special education purposes and their families will potentially be served.

C. System of Care Funding Sources

Following is an overview of the funding sources and expenditures for the SAMHSA grant from FFY 2005 through June 30, 2010. For more detail, please refer to Appendix E.

- The Substance Abuse and Mental Health Service Administration (SAMHSA) grant authorized up to $5,575,000 in federal funding for a six year period (FFY 2005 through FFY 2010).As of June 30, 2010, federal grant expenditures were $3,650,423. Access to the federal funding ends 9/29/2010.

- In order to receive the federal funding, the state was required to provide a matching amount that varied each year (see appendix for match requirements). As of June 30, 2010, the accumulated state match was projected to be $4,044,936, $878,679 more than was required. However, most of this amount was non-cash in-kind contributions generated by both the KMAs and the state. Available state general fund was limited to an annual amount of $367,000.

- In 2009 Montana House Bill 645 appropriated $333,500 in state general funds for this biennium, but it was only used in SFY 2010. This money was used to help KMAs pay for direct services, wraparound, and evaluation services, and stipends. It also supported family and youth training and leadership development along with specific cost plans for high-risk multiagency youth through the system of care account.

III. Kids Management Authority (KMA) and Psychiatric Residential Treatment Facility (PRTF) Waiver Program

A. KMA Overview

Kids Management Authorities (KMAs) will no longer receive state or federal funding as of September 29, 2010.One grant funded KMAs Helena may continue to operate with local funding using a different structure that requires fewer resources; the community planning function of the KMA in Billings will continue; and a few of the informal KMAs may continue to meet either to identify and address service gaps or to do interagency planning for individual youth and families. This section will provide a summary of KMA activity while federal and state funding was available.

The system of care was developed and implemented primarily through the infrastructure of the Kids Management Authority (KMA). Each KMA identified a fiscal intermediary who employed the KMA staff, who contracted with the state, and who was the responsible party for the management of the funds. KMA staffs were trained in wraparound process for coordinating care and assisting families' access services and supports. The KMA was intended as the model infrastructure that supported a comprehensive and statewide system of care. The KMA had two primary functions:

- The development of a continuum of care within each respective community
- Case planning and coordination for individual youth with SED and their families

The KMA system was built on the premise that the system of care would develop both "top down" and "bottom up". Some of the grant resources were allocated to statewide positions to support some activities that would benefit the whole state. Additional resources were allocated to the six KMAs with grant funding to develop and pilot the model which could then be replicated statewide.

Staffing Supported by the System of Care Funding: State Employees

Principal Investigator: Bureau Chief: There was no grant funding for this position. This position provided oversight for all components of the grant.

Community Services Supervisor and Grant Director: This position began as 1.0 FTE in December, 2006, and was reduced to .5 FTE on October 1, 2009. During the grant period, the position assumed additional responsibilities for supervision of Medicaid funded regional staff, plus provided oversight and consultation to five KMA project directors. Grant responsibilities included: developing goals and plans for implementation of a children's system of care, monitoring and reporting on the grant budget, and supervising the evaluation component of the grant. This position will continue to develop community services and work with system of care partners when the grant ends.

Program Analyst: This was a .5 FTE position from December 2006 through June 30, 2009; now filled with a temporary person whose responsibilities will end when the grant reporting is complete. This position *w*as responsible for training and overseeing the data collection from the KMA evaluation coordinators; compiling and analyzing the data and meeting grant reporting requirements. In general, this position helped to create solutions to keep Medicaid and the SAMSHA system of care grant implementation within legislative or federal grant appropriations.

Social Marketing and Communications Director: This was a 1.0 FTE position from October, 2006 through June 30, 2009. This position was responsible for developing a social marketing plan and training plan to increase the understanding of system partners about the purpose, values and benefits of a system of care and to reduce stigma for youth and families who need services. Various statewide anti-stigma efforts were initiated during this period, including a youth developed radio message.

Family Liaison: This 1.0 FTE position began in May 2008, and will be supported beyond the grant funding. This position assisted social service professionals provide client services, and support for families. The position also assisted clients in identifying and obtaining available benefits and social and community services.

Youth Coordinator: This position was funded for one year through VISTA as of 1/2010, and may be requested again. The role of the Youth Coordinator is to develop the youth voice in the system of care so that youth are able to advocate for their needs and get the services and help they need in order to recover from their illness and live successful and productive lives.

Staffing Supported by the System of Care Funding: State Employees: KMA Staff (Employed by the Contractors)

To some extent the local KMA staffing mirrored some of the state level staffing to implement the required activities locally and to support system development more rapidly. While this was the recommended staffing structure for a KMA, each KMA had some variation from this template.

KMA Project Director: The Project Director (1 FTE) was responsible for: overseeing the development of the local plan for creating and implementing the system of care, establishing the organizational structure, hiring staff and providing leadership for the project.

Technical Assistance / Evaluation Coordinator: The Technical Assistance / Evaluation Coordinator (.5 FTE) assisted with the collection of the data required for the National Evaluation and established the procedures and protocols for acquiring and collecting that data.

Parent Coordinator: The Parent Coordinator (1 FTE) worked in partnership with other staff to provide support services for families receiving services through the KMA. The Parent Coordinator also participated in the state level Systems of Care Planning

Committee, assisted with recruiting other parent members, began implementing peer-to-peer mentoring services at the local level.

A Youth Coordinator was an optional position. The Youth Coordinator (.5 FTE) assisted in the creation of activities to engage the local voice of youth with serious emotional disturbance. The Youth Coordinator worked to ensure that the youth's voice was communicated to KMA staff and others charged with programming and the implementation of the system of care.

State Contractors

- Bach Harrison, which provided evaluation services and the development of KIDS database
- In Care Network, which provided cultural training and the development of related materials
- Various contractors who provided training, including wraparound facilitation training

Unpaid Staff and Volunteers

The number of unpaid staff and volunteers in the KMA's varied from one KMA to another. The Yellowstone KMA reported not having any official unpaid staff or volunteers in their program, but did have good community and interagency participation at their local planning committee meetings. However, other KMAs reported volunteer time as "resource hours" when stakeholders, providers and parents came together at scheduled times for planning and management meetings or events.

Participating Agencies

The KMA structure included two groups that included representatives from participating agencies who met on a regular basis. The interagency team met to improve communication and collaboration and to address community planning issues while the interdisciplinary team addressed the needs of a specific youth and family. This structure has its origins in a previous model used to plan services for children called "Managing Resources Montana" (MRM). It was adapted to include more system of care values and principles and to deliver wraparound services.

Interagency Team: The purpose of the Interagency Team, as defined in Statute 52-2-211, was to facilitate the exchange and sharing of information that a team member(s) who serve children could use. Membership could include:

- Youth Court and/or County Attorney
- Juvenile Probation Chief
- Child and Family Services Regional Administrator

- Superintendent of Schools (County and/or Public)
- Youth Corrections officer
- Sheriff or Chief of Police

Others could be invited to join the team such as physicians, licensed mental health facilities, group home providers and other providers of medical and mental health care.

Interdisciplinary Team: The purpose of the Interdisciplinary Team, as defined in Statute 52-2-203, was to coordinate services for individual high-risk children with multiagency needs. Membership could include:

- The youth's individual therapist and other providers
- The youth's teacher or a representative from the youth's school
- The youth's CFS social worker or probation officer if applicable
- Representatives from local private youth service agencies
- Representatives from other child serving agencies
- Advocates or other attendees chosen by the family or youth

KMA Fiduciaries

Following are the most current organizations/contractors that assumed fiduciary responsibility for the KMAs. These agencies were responsible for the fiscal management of KMA funding, expenses, accounting and reporting.

- Rocky Mountain Development Council, Inc. for Helena KMA
- Yellowstone Boys and Girls Ranch for Yellowstone Area KMA
- Hill County Health Department for Bear Paw KMA
- The Crow Tribe for Apsaalooke Children's System of Care/ KMA
- Butte Community Health Center for Butte KMA
- University of Montana for Missoula KMA

Target Population Served

The primary population to be served by the system of care and the KMAs as defined by statute (52-2-302) is the "High-risk child with multiagency service needs", meaning, a

child under 18 years of age who is seriously emotionally disturbed, who is placed or who imminently may be placed in an out-of-home setting, and who has a need for collaboration from more than one state agency in order to address the child's needs. The KMAs all worked to address the needs of this population, but also worked with families and children who were not able to access services because they did not meet Medicaid criteria.

Services Paid for KMAs

The KMAs used grant funds to pay for the following services for children and families:

- Respite
- Clinical assessments
- Therapy
- Co-pays for therapy, medication management and the medication itself
- Recreational activities and needed equipment to support the youth's mental health and peer skills. Examples included: Tae Kwan Do classes, YMCA membership, Boys and Girls Club activities, summer pool passes, basketball camp, and Scouts
- Naming ceremonies (with clan feed and giveaway)
- Wraparound facilitation by KMA staff
- Transportation cost assistance for youth/family from rural areas to access needed mental health services

Following is a summary of the costs of services provided.

SAMHSA Service Summary			
Services Provided Through KMA Contracts			
County	**Infrastructure Contract**	**ARRA Contract**	
Crow	$7,319.83	$2,315.88	
Hill County	$13,393.55	$16,340.78	
RMDC	$28,558.83	$25,012.43	
YBGR	$27,419.44	$17,679.11	
Total	**$76,691.65**	**$61,348.20**	**$138,039.85**

Outcomes for Youth and Families

The following outcomes were obtained from the Montana Continuous Quality Improvement (CQI) Reports for the Montana System of Care as required by the SAMHSA Grant. The CQI Progress Report is a data-driven tool designed to support dialogue within communities and between communities and federal program partners.

1. The KMAs enrolled 310 youth in services and enrolled 168 youth in the longitudinal study from December 2006 through April 2010.

2. The CQI Progress Reports address key areas of performance in five domains:

    a. System of care level outcomes

    b. Child and family level outcomes

    c. Satisfaction with services

    d. Cultural and linguistic competency

    e. Family and youth involvement

The following table from the December, 2009 CQI Report indicates the performance of the Montana system of care in the five domains in comparison with other Phase IV System of Care Communities nationwide. Items that scored in the top 25th percentile and lowest 25th percentile are listed in the table. For the complete data results, please see Appendix F.

Comparison of Montana of System of Care Performance Domains with National Systems of Care		
Item	**Top 25 percentile**	**Lowest 25 percentile**
System Level	1) Agency involvement rate-service level 2) Agency involvement rate-tx planning 3) Youth satisfaction rate-outcome 4) Individualized Education Plan (IEP) development	1) Caregiver satisfaction with access to services
Family Outcome	1) Emotional and behavioral problem improvement 2) Youth arrest rate	1) Stability in living situation rate (intake to 6 mo.) 2) Suicide attempt reduction rate (intake to 6 mo)—caregiver report

Comparison of Montana of System of Care Performance Domains with National Systems of Care		
Item	**Top 25 percentile**	**Lowest 25 percentile**
	3) Average reduction in employment days lost	3) Caregiver strain improvement rate
Satisfaction with Services	None	None
Family Involvement	None	1) Youth involvement in service planning
Cultural Competence	None	None

3. Additionally, providers and state agency representatives have reported the following anecdotal outcomes:

   a. Youth are benefiting from the youth support groups, which are on-going and youth friendly for new youth entering the KMA.

   b. Families are benefiting from advocacy and support provided by project staff and through parent-to-parent support meetings.

   c. Families are reported to be fully involved in the service delivery process, resulting in enhanced and consistent participation in treatment, support activities, and follow up care.

   d. Parents are reporting that for children enrolled in the KMA, care coordination help from the Parent Coordinator is making the transition back home from acute hospitalization and residential treatment smoother for both the child and the family.

   e. Youth and family report that entering the KMA is seen as a simple and easy process. KMA staffs provide the assistance needed to explain the program, care planning, and the local community mental health system to the family.

   f. Families that utilize transportation assistance (i.e. gas cards) are more consistently attending required treatment, planning and support groups.

   g. There has been a reduction in the number of children in out-of-state placements, decreasing from 127 in FY 2009, to 100 FY 2010. (See August 24, 2010 “Out of State Placement and Monitoring Report to the Legislature” in the Appendix A)

   h. Length of stay in residential placements has been decreasing over the last four years.

B. Psychiatric Residential Treatment Facility (PRTF) Waiver Program Overview

While Montana was operationalizing the cooperative agreement with SAMHSA and developing the system of care, the state applied for and was awarded a Psychiatric Residential Treatment Facility (PRTF) Demonstration Grant through the Deficit Reduction Act of 2005 on October 1, 2007. This demonstration project is a five year grant which operates like waiver with the possibility of becoming a Home and Community Based Waiver at the end of the project. The PRTF Demonstration Grant provides home and community based services as an alternative for youth who are at risk of out-of-home residential placement or currently in a residential treatment program, using a high fidelity wraparound services delivery model. Youth participating in the PRTF program must receive waiver services and Medicaid state plan services that do not exceed the cost of services provided in a psychiatric residential treatment facility.

The population served by the PRTF grant is youth with SED who are in or at risk of being in a PRTF. This population has many similarities to and overlaps with the population to be served by the KMAs. The service model, high fidelity wraparound provided in the home and community setting, is also similar. While the KMA model placed greater emphasis on multi-agency planning than the PRTF project does, the values and principles are consistent between these two grants.

Both the KMAs and the PRTF sites have supported the development of a system of care for children to be served in the least restrictive setting. Development of the proposed structures and processes in the PRTF sites was built on lessons learned through the SAMHSA grant and the KMAs. Although the PRTF grant will only operate in the communities chosen below during the five year grant period, these communities will be chosen based on number of youth already in PRTF level of care and readiness and capacity to develop alternative intensive community based service. This model was chosen because it could become a sustainable Medicaid funded waiver after the grant ends.

Through the grant application process, the department received federal approval to waive statewide coverage in the provision of program services funded by Medicaid. (Participants in this program also have access to all state plan Medicaid services). Program services may only be delivered in the following service areas for which federal approval of coverage has been received:

1. Yellowstone County (core site) with implementation date of October 1, 2007

2. The surrounding counties of Carbon, Stillwater, Musselshell and Big Horn with implementation date of October 1, 2010

3. Missoula and Ravalli Counties (core site) with implementation date of August 1, 2009

4. Lewis and Clark County (core site) and the surrounding counties of Jefferson and Broadwater with implementation date of October 1, 2010

5. Cascade County (core site) with implementation date of October 1, 2010

6. One more site will be planned for implementation in 2011

PRTF Waiver Eligibility

Eligibility of a youth for the program is determined by the department in accordance with the following criteria. A youth is eligible to be considered for enrollment in the program if he/she:

1. Is age six through 17, up to the 18th birthday

2. Is Medicaid eligible

3. Requires the level of care, as determined through the certificate of need process, for a psychiatric residential treatment facility in accordance with Children's Mental Health Bureau Provider Manual and Clinical Guidelines for Utilization Management, Effective July 1, 2010

4. Is not residing in a hospital or a psychiatric residential treatment facility while enrolled in the program

5. Has mental health and related supportive services needs that can be met through the program

6. Meets the clinical criteria for serious emotional disturbance

7. Has a viable, consistent living environment and the youth's parent(s) or other responsible caregiver having physical custody is committed to supporting and facilitating the youth's participation in the program

8. Resides in an approved service area

9. Has services waiver services and Medicaid state plan services do not exceed the cost of services provided in a psychiatric residential treatment facility

10. Is not otherwise receiving Medicaid funded case management services

11. Is not receiving services through another Medicaid funded home and community program

Purpose

The goal of the PRTF Waiver program is to provide home and community-based services as an alternative for youth who meet criteria for psychiatric residential

treatment facility level of care, using a community-based, and high fidelity wraparound service delivery model.

The Plan Manager, an employee of the Department of Public Health and Human Services located in the regions of the state where the PRTF waiver is operational, is responsible for making the initial contact with the family; exploring their needs and goals; referring the youth for a level of care evaluation, and assisting with the choice of providers to work with. The Plan Manager works with the Wraparound Facilitator in developing the plan of care in collaboration with the youth and family, parent(s) or custodial caregiver, appropriate health care professionals, and others who treat or have knowledge of the youth's mental health and related needs.

Services will be provided through a high fidelity wraparound service model that includes the youth and family and will be structured to provide the supports needed to safely maintain youth in their home and community.

These are the waiver services available for youth enrolled in the PRTF Waiver. The plan of care is specifically designed to meet the individual needs of the youth.

Waiver Services

Caregiver Peer-To-Peer Support Specialist: Caregiver peer-to-peer support services offer and promote support to the parent/guardian of the youth with SED. The services are geared toward promoting self-empowerment of the parent, enhancing community living skills and developing natural supports. These services include:

- Supporting parents to make informed independent choices in order to develop a network for information and support from others

- Coaching parents in developing systems advocacy skills in order to take a proactive role in their youth's treatment and to obtain information and advocate with the school system

- Assisting parents in developing supports including formal and informal community supports

Consultative Clinical and Therapeutic Services: Consultative clinical and therapeutic services provide treating physicians and mid-level practitioners with access to the psychiatric expertise and consultation in the areas of diagnosis, treatment, behavior, and medication management.

- Consultative clinical and therapeutic services are provided by licensed psychiatrists.

- Consultation is provided to licensed physicians or mid-level practitioners who are treating youth enrolled in the program.

- Both the consultant psychiatrist and the treating physician or mid-level practitioner may bill for the consultative clinical and therapeutic services.

Customized Goods and Services: Customized goods and services as a program allow for the purchase of services or goods not reimbursed by Medicaid. These customized goods and services typically are used by the youth to facilitate access to supports designed to improve and maintain the youth in the community. The plan of care must:

- Document the youth's therapeutic need for this service
- Document attempts to identify alternative funding and/or resources
- Include all documentation/receipts

Customized goods and services must be prior authorized and are limited to $1,000 for each twelve month period beginning with the youth's most recent enrollment date in the PRTF waiver.

Education and Support Services: Education and support services are provided to family members, unpaid caregivers, and persons providing treatment or otherwise involved in the youth's life.

- Education and support services include instruction about the diagnostic characteristics and treatment regimens for the youth, including medication for the youth, and behavioral management.
- Education and support services are provided by appropriate community agencies with the capacity to offer periodic trainings specific to parent(s) or legal guardians of youth with serious emotional disturbance.
- All training curricula and community providers of such training must be approved by the department.

Family Support Specialist: The family support specialist services provide support and interventions to parents and youth, under the guidance of the home-based therapist. These services may include:

- Assisting the therapist in family therapy by providing feedback to the in-home therapist about observable family dynamics
- Providing education to parents regarding their child's mental illness
- Coaching, supporting, and encouraging parenting techniques learned through parenting classes and/or family therapy
- Providing, as necessary, parenting skills specific to the child
- Participating in family activities in order to assist parents in applying specific parenting methods in order to change family dynamics

- Working with youth to develop wellness recovery tools such as a wellness recovery action plan tool kit

- Serving as a member of the crisis intervention team

Home-Based Therapy: Home-based therapists are:

- Social workers licensed in accordance with ARM 37.88.205 OR

- Professional counselors licensed in accordance with ARM 37.88.305 OR

- Psychologists licensed in accordance with ARM 37.88.605

The home-based therapist and wraparound facilitator cannot be employed by the same Agency.

Non-emergency Transportation: Nonmedical transportation is the provision of transportation through common carrier or private vehicle for the youth's access to and from social or other nonmedical activities that are included in the waiver plan of care. Nonmedical transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted.

Respite Care: Respite care is the provision of supportive care to a youth so as to relieve those unpaid persons normally providing day to day care for the youth from that responsibility. Respite care services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods. Respite care services may be provided in a youth's place of residence or through placement in another private residence or other related community setting, excluding psychiatric residential treatment facilities.

Wraparound Facilitation: Wraparound facilitation services are comprehensive services comprised of a variety of specific tasks and activities designed to carry out the wraparound process. These tasks include:

- Assembling the wraparound team

- Facilitating plan of care meetings

- Working with the department in identifying providers of services and other community resources to meet family and youth needs

- Making necessary referrals for youth

- Documenting and maintaining all information regarding the plan of care and the cost plan, including revisions

- Presenting plan of care and cost plans to the plan manager for approval

- Providing copies of the plan of care to the youth and family/guardian

- Monitoring the implementation of the plan of care
- Maintaining communication between all wraparound team members
- Consulting with family and other team member to ensure the services the youth and family are receiving continue to meet the youth's needs
- Educating new members to the wraparound process
- Maintaining team cohesiveness

A wraparound facilitator who is a licensed mental health professional cannot provide any other waiver services or state plan services to the youth for whom they are facilitating. The licensed mental health professional must have attended the wraparound facilitation training sanctioned by the department and is either a certified wraparound facilitator or is working towards certification.

Selection into the PRTF Waiver:

Entrance into the PRTF Waiver will be on a first-come, first-served basis for those who meet the criteria for participation.

The department determines whether a youth who meets the eligibility criteria may be offered a service opportunity in the program. The department considers the following factors in selecting eligible youth to evaluate for placement into an available program service opportunity.

- The youth resides within the geographical coverage for the available service opportunity.
- The youth meets the eligibility criteria of this rule.
- The youth is actively seeking program and other mental health services.
- The youth is in need of the services available through the program.
- The youth is likely to benefit from the services available through the program.
- The youth's individual projected total cost under the preliminary plan of care is equal to or less than 100% of the cost of inpatient care in a psychiatric residential treatment facility.

Numbers Served

The following specifies the maximum number of youth who are served each year of the waiver.

- Year 1: Maximum number of youth served at any point during the waiver year: 20

- Year 2: Maximum number of youth served at any point during the waiver year:50
- Year 3: Maximum number of youth served at any point during the waiver year:100
- Year 4: Maximum number of youth served at any point during the waiver year:100
- Year 5: Maximum number of youth served at any point during the waiver year: 100

Consistent with the maximum number of youth specified above, the Department may limit to a lesser number of youth who will be served at any point in time during a waiver year.

Individual Cost Limit

In order to maintain the program cost within the cost neutrality limitation necessary for compliance with the federal legal authorization for the implementation of the program, the cost of plans of care for enrolled youth are collectively and individually subject to limitation in accordance with federal and state authorities and this rule.

The calculated cost to implement a plan of care for a youth may not exceed a sum calculated by dividing the total sum of monies available through legislative appropriation for funding during the current fiscal year by the number of service opportunities to be made available through the program during the fiscal year. The total annual sum of expenditures for program services and state plan services provided to a youth may not exceed a maximum amount set at 100% of the average individual cost calculated by the department to treat a resident of a psychiatric residential treatment facility in Montana.

The cost of services to be provided under a youth's plan of care is determined prior to implementation of the proposed plan of care and may be revised as necessary after implementation.

The cost determination for the services provided under a youth's plan of care may be revised at any time there is a significant revision in the plan of care or in the cost of the services being reimbursed through the program.

Transition Planning

The youth becomes ineligible for the PRTF waiver when s/he turns 18. When the youth reaches age 17, the Plan Manager and Wraparound Facilitator will begin developing a transition plan of care. The youth will be evaluated to determine the services needed as well as the appropriate service delivery models. PRTF Waiver service providers, the family, the youth and the Wraparound Facilitator will work together to create an individualized transition plan. If continued services are indicated, the youth will be connected to appropriate community services, including regular state Medicaid treatment services as medically appropriate. The services included in the transition plan may include some of the supports the youth has already connected with. Six months prior to discharge, as appropriate, the Wraparound Facilitator will gradually begin adjusting the frequency of contact and begin introducing the youth to the identified

alternative providers until contact is phased out and a positive, seamless transition has been achieved.

Qualified Providers

The Department establishes the qualifications needed for all providers who participate in delivering PRTF Waiver services. Medicaid Waiver providers must meet required licensure and/or certification standards and adhere to other standards in order to be approved to deliver Waiver services. ACS, the Department's contracted fiscal agent, is responsible for verifying licensure and compliance upon enrollment of service providers and provider agencies, and annually thereafter. If licensure, certification or other standards are not met during the annual re-verification, ACS will inactivate the provider number and notify the provider and the Department.

Geographical Factor: A waiver provider who is a family support specialist, wraparound facilitator, caregiver peer-to-peer specialist or a home-based therapist may be eligible for a geographical factor when traveling distances greater than 35 miles (one way) from their office to a youth's home to provide services. The geographical factor is reimbursement for mileage at .50 per mile and is specific for a provider who will be traveling out of the county where the provider has their regular office. The geographical factor is not designed to accommodate satellite offices where the provider routinely travels to as a part of their service area. All waiver services, including the geographical factor, are prior authorized and included in the youth's plan of care.

PRTF services are provided through a wraparound service model that includes the youth and family and is structured to provide the supports needed to safely maintain youth in their home and community.

Outcomes for Families and Youth Served

The following are reported outcomes from the PRTF Plan Manager (Yellowstone County) for the 28 youth and their families that have participated in the PRTF Program at that site.

- 26% of youth referred to the PRTF program were diverted from residential treatment placement.
- 74% of youth participating in the PRTF program were transitioned from a residential treatment program.
- Reduction in acute psychiatric hospital inpatient stays for youth participating in the PRTF Waiver Program
- Improved overall treatment outcomes for youth in the PRTF program due to high fidelity wraparound facilitation and the provision of individually tailored waiver services

IV. Analysis & Recommendations for the Montana Children's System of Care

This section of the report will include the following:

- Strengths of the Montana system of care overall and the KMA model in particular
- Weaknesses of the of the Montana system of care overall and the KMA model in particular
- Assessment of progress toward the overall Montana system of care as established in legislation (52-2-301)
- Recommendations

A. Strengths of the Montana System of Care Overall and the KMA Model in Particular

The Montana system of care overall has significant strengths, and the KMA model was successful in a number of key areas.

1. The Montana legislature has an established history of commitment to a system of care for children.

2. The State Agencies are committed to system of care concepts and ideals. Along with the KMA model described in this document, there have been other initiatives by state agencies that reflect this commitment to wraparound process and values and community-based care.

    a. Juvenile Probation is taking initiative in developing out-of-home alternatives for youth in the probation system. This has included using unspent dollars in the Juvenile Delinquency Intervention Program (JDIP) to fund prevention programs and other community based programs. JDIP funds are appropriated to the Department of Corrections and are allocated to district courts for delinquency intervention.

    b. The Child and Family Services Division is utilizing the Family Group Conferencing model, and using wraparound principles in its work with families and youth. This includes efforts to identify and utilize natural supports and community-based alternatives whenever possible as alternatives to out of home placements.

    c. The Children's Mental Health Bureau's PRTF Waiver program uses high fidelity wraparound to provide intensive services and supports in a community setting. Thus far the average cost per youth is far less than the average cost of a PRTF admission.

3. The leaders of the State Agencies have an established history of working together.

4. The KMAs worked diligently to involve a wide range of community stakeholders to address the needs of children and families, both from a system planning and case planning perspective. This culture of local community and stakeholder involvement is critical to effectively address the needs of children and families.

5. KMA staffs were strong supporters of community-based alternatives to out-of-home placements, and this was clearly reflected in their approach to case planning.

6. There have been a number of examples of KMAs effectively facilitating multi-agency problem solving, both at the system and individual case levels.

7. A number of stakeholders identified the effectiveness of the KMAs in working with "kids falling through the cracks" in the system. These were often youth and families who were not funded by one of other systems.

8. There are many examples of KMAs working to actively empower both parents and youth in the treatment process. These efforts reflect the "voice and choice" philosophy of empowering families and youth that is central to the system of care.

9. Both families and youth viewed the KMAs as advocates.

10. Youth spoke highly of the Youth Support Groups, and the general supportive atmosphere of the KMAs.

11. Parents report that case management provided by the KMA Parent Coordinator was instrumental in making the transition back home from acute hospitalization and residential treatment easier for both the child and the family.

12. Youth and family report that working with the KMA was as a simple and easy process. KMA staff provided as much assistance as is needed with each family to help that family navigate the system.

13. Families that utilize transportation assistance (i.e. gas cards) are more consistently attending required treatment, planning and support groups.

14. There has been a reduction in the use of out-of-state placements for youth, and in the length of stay for youth in residential facilities. (See August 24, 2010 "Out of State Placement and Monitoring Report to the Legislature" in Appendix A; and "Average Length of Stay Report, August 24, 2010 in Appendix B)

B. Barriers to the Successful Implementation of the Montana System of Care Overall and the KMA Model in Particular

1. The financial model of the KMA was not self-sustaining. As grant funding decreased the KMAs were unable to generate adequate revenues to continue to function.

2. The State's approach to relying on each community to replicate the KMA model did not allow for economies of scale.

3. While the local community focus of the KMAs allowed the KMAs to be very responsive to the needs of their specific communities, at the same time it is unclear whether lessons learned and best practices developed in individual KMAs were fully leveraged to other communities.

4. There does not appear to have been a consistent interpretation of the wrap-around model across all of the KMAs. This led to variations in approach which may or may not have reflected best practices.

5. Interviewees identified children with multiple needs who are involved in multiple systems as the most challenging in terms of developing a unified individual treatment plan. Contributing factors identified included:

    a. The challenges of coordinating multiple funding streams. The KMAs had limited funds to pay for services delivered, and so would be in a facilitator/negotiator role with other entities when attempting to determine payment for needed services.
    b. Lack of, or inconsistent attendance of key decision-makers at the local interdisciplinary team the meetings, which made it difficult to make decisions and implement planning in a timely fashion.
    c. Those attending the interdisciplinary team meetings did not have the authority to make funding or policy decisions, again slowing down the decision-making needed for planning.

6. The willingness to develop cross-departmental solutions to serve the needs of children and families involved with multiple systems often appeared to have been the result of strong leaders committed to teamwork and willing to try innovative solutions to problems. While this leadership is necessary and commendable, the sustainability of this approach appears to be reliant on the commitment and effectiveness of individuals rather than anchored in the system. It was reported that a change in leadership could often result in a significant change in commitment to a true cross-departmental problem solving model.

7. Funding rules remain a challenge for implementing a true system of care. Many of the supports and services utilized in a wraparound model may not qualify for payment as defined by funding rules. Also, Medicaid rules often have specific prohibitions against the blending of Federal funds with other dollars, making a "braided" model for funding streams required.

C. Assessment of Progress Toward the Goals for the Montana System of Care Established in Legislation (52-2-301)

As noted earlier, following are the goals for the overall Montana system of care are established in legislation (52-2-301):

1. To provide for and encourage the development of a stable system of care, including quality education, treatment, and services for the high-risk children of this state with multiagency service needs, to the extent that funds are available

   Montana has demonstrated a strong commitment to a stable system of care, and has been quite successful in a number of areas, as noted above. At the same time, there are still barriers which will need to be addressed.

2. To serve high-risk children with multiagency service needs either in their homes or in the least restrictive and most appropriate setting for their needs in order to preserve the unity and welfare of the family, whenever possible, and to provide for their care and protection and mental, social, and physical development

   There have been significant examples of initiatives in Montana to serve children in the least restrictive and appropriate settings, including the KMA model, the work of the Youth Courts, and the family group conferencing model used by the Child and Family Services Division.

3. To serve high-risk children with multiagency service needs within their home, community, region, and state, whenever possible, and to use out-of-state providers as a last resort

   There has been a reduction in the number of children in out-of-state placements, from 127 in FY 2009, to 100 FY 2010. (See Appendix A)

4. To provide integrated services to high-risk children with multiagency service needs

   While progress has been made towards this goal, families can still give examples of their experience with uncoordinated and unintegrated services.

5. To contain costs and reduce the use of high-cost, highly restrictive, out-of-home placements

   Along with the reduction in out of state placements , length of stay in residential placements has been decreasing over the last four years. (See Appendix B)

6. To increase the capacity of communities to serve high-risk children with multiagency service needs in the least restrictive and most appropriate setting for their needs by promoting collaboration and cooperation among the agencies that provide services to children

Collaboration and cooperation between agencies exists at the leadership level, and was implemented to varying degrees in selected local communities.

7. To prioritize available resources for meeting the essential needs of high-risk children with multiagency service needs

   Much of the work of the KMAs was focused on developing available resources at the local level. While there were significant examples of this being done very well, barriers still remain.

8. To reduce out-of-home and out-of-community placements through a children's system of care account to fund in-state and community-based services that meet the needs of high-risk children with multiagency service needs in the least restrictive and most appropriate setting possible

   While the Legislature created the system of care account, it does not receive a specific appropriation. The KMAs had limited resources to fund direct service provision.

D. Recommendations

1. Ensure that the principles of parent and youth involvement and empowerment remain central tenets of the Montana system of care for families and youth.

2. Continue to convene the System of Care Community Planning Committee and the System of Care Statutory Planning Committee. These committees should be clearly tasked with:

    a. Oversight of the Montana system of care for children and families

    b. Maintaining the balance between the development of programming that meets the unique needs of local communities and the need for consistency in key areas:

        i. Overall system quality assurance

        ii. Using outcome indicators to evaluate the effectiveness of the system of care

        iii. Overall system implementation of clinical and operational best practices

    c. Identification of barriers to implementing solutions to address the needs of children and families

    d. Developing policies and procedures to eliminate system barriers as appropriate

3. Expand the Psychiatric Residential Treatment Facility (PRTF) Waiver Program. This is a Medicaid 1915c waiver program with home and community based services with grant funding for start up and administrative costs. The program uses a high fidelity wraparound service model. Initial results have been very positive and this could be an excellent vehicle to more firmly anchor the system of care in Montana.

4. Explore methods to address the funding issues for children served by multiple agencies, such as the braiding of funding streams. This is a very high-need group of children who ultimately will be very costly to the overall state budget. This can include:

    a. Exploring waiver options that allow for flexibility in funding

    b. Carefully exploring braided funding models

Appendix A: Report to the Montana Legislature - Twelve Month Out-of State Placement and Monitoring Report

Report to the Montana Legislature

Twelve Month Out-of State Placement and Monitoring Report

July 1, 2009 through June 30, 2010

(No. 1.3) Submitted August 24, 2010

Youth in Out of State Placements: July 1, 2009 through June 30, 2010

Psychiatric Residential Treatment Facilities (PRTF) and Therapeutic Group Homes (TGH)

Source of Funding for placement:	Medicaid only	Medicaid plus one or more agency	Non-Medicaid	Total
Unduplicated number of youth in out of state PRTFs or TGH	28	45	27	**100**

- Information about youth in out of state acute psychiatric hospitals has been omitted. These admissions are generally brief and are either in border facilities or in a facility near a PRTF out of state.
- For purposes of reference, the total unduplicated number youth in an out of state PRTF or TGH in SFY 2009 (12 months) was **127.**

Medicaid funding was available for 73 of the 100 youth in out of state placements in SFY 2010. The chart below indicates placements by agency along with the funding source. Due to the fact that some youth were involved with more than one agency and some youth were place more than once during the SFY, the numbers below do not represent unduplicated youth.

System Utilization of Out of State Placements to Psychiatric Residential Treatment Facilities or Therapeutic Group Homes July 1, 2009 through June 30, 2010				
	Child and Family Services placements	Juvenile Probation Placements	Dept of Corrections Placements	School district placements
Used Medicaid funding. May have used additional agency or third party funding for room and board, or for additional days when Medicaid authorization ends.	22	23	4	0
Agency or third party funding only; non-therapeutic placements	11	21	0	0
Total out of state at any time during past 12 months	33	44	4	0

New Out-Of-State PRTF Admissions Funded by Medicaid

July 1, 2009 through June 30, 2010

Medicaid Admissions to Out of State Psychiatric Residential Treatment Facilities (PRTFs)

<u>Twenty-five (25)</u> youth funded by Medicaid were admitted to out of state placements during this period. The following information was collected about those twenty-five Medicaid admissions:

Legal Guardian	Bio family	Adoptive Parents	Child and Family Services
	12	5	8

Referral Source	Acute Care Hospital	Instate PRTF	Other
	21	2	2

<u>Highest level of previous treatment</u> prior to hospital	PRTF	TGH	Home and Community based services
	11	9	5

Medicaid Admissions to Out of State Therapeutic Group Home (TGH)

Eighteen (18) youth funded by Medicaid were admitted to Normative Services, Inc. in Wyoming during this period.

Administrative rule requires the youth must be denied admission by all three in-state PRTFs prior to going to an out of state PRTF.

Reason(s) given by in state PRTFs for not admitting the25 Medicaid funded youth who were subsequently admitted to an out of state PRTF:	
1. History of multiple PRTF placements without response to treatment.	**17**
2. Severe violence/physical aggression, Facility can't assure safety.	**18**
3. Disregard for limit setting by staff, requiring 1:1 staff more that 75% of time.	**4**
4. Minimal response to psychotropic medications in reduction of severe psychiatric symptoms.	**0**
5. Severe suicide risk based on multiple attempts over recent six month period.	**2**
6. Established pattern of antisocial behavior with no documented response to treatment.	**4**
7. Specific symptoms/diagnosis that is not responding to medical or psychological treatment.	**2**
8. Primary presenting problem is chemical dependency. No prior substance abuse treatment and inpatient CD treatment is indicated.	**0**
9. Developmentally disabled or IQ/neuron-psych deficits. Too impaired to benefit from treatment offered.	**9**
10. Medical condition requiring specialized services beyond the capacity of facility.	**3**
11. One or only presenting problem is sexually reactive or sex offending behavior.	**8**
12. Autism Spectrum Disorder	**3**
13. Fire setting behavior	**0**
14. Elopement risk	**0**
15. Fetal Alcohol Spectrum disorder	**0**
16. Neuro-psychiatric disorder	**0**
17. Lack of bed availability	**9**
18. Age inappropriate (too young or too old)	**0**
19. Other reasons: Youth needs both acute and residential levels of care in same facility Facility cannot manage youth's diabetes Youth needs PRN medications and physical restraint to manage aggression Facility not prepared to address youths conduct disorder Facility can't manage combination of youth's aggression, size and low IQ Facility requires youth be restraint and seclusion free for at least 48 hours Youth currently in instate facility that recommends lateral move to another PRTF Youth needs concurrent chemical dependency and psychiatric treatment Facility unwilling to admit youth when outpatient treatment team does not recommend admission to this facility.	

Cost of youth Medicaid funded youth placed out of state: 7/1/09 through 6/30/2010

Note: Data is based on paid claims data, not date of service

Psychiatric Residential Treatment Facilities (PRTF)						
Date of Payment	Net Payments		Youth Served (unduplicated count)		Total	
SFY	In-State	Out-of-State	In-State	Out-of-State	Net Payments	Youth Served
2007	$9,664,845	$5,531,384	339	104	$15,196,229	418
2008	$8,125,599	$4,603,668	329	92	$12,729,267	409
2009	$10,224,496	$2,751,270	368	70	$12,975,766	432
2010	$10,484,756	$2,641,886	401	62	$13,126,642	463

Therapeutic Group Home (TGH)						
Date of Payment	Net Payments		Youth Served (unduplicated count)		Total	
SFY	In-State	Out-of-State	In-State	Out-of-State	Net Payments	Youth Served
2007	$13,647,596	$1,993,662	454	13	$15,641,258	515
2008	$14,857,506	$2,181,274	479	14	$17,038,780	582
2009	$14,856,023	$1,071,911	478	13	$15,927,934	530
2010	$15,261,290	$847,179	563	34	$16,108,469	597

Efforts the Department has initiated to avoid out of state placements:

The Children's Mental Health Bureau has initiated a variety of efforts intended to control, and where possible, reduce out-of-state placements in a therapeutic group home and psychiatric residential treatment facilities. The following activities describe those efforts.

1. Most out of state PRTFs have completed a survey describing the specialty care available in their facility and how it is provided. The results will assist Montana in making appropriate referrals for specialty care to out of state facilities.
2. Montana Medicaid is not enrolling new out of state providers unless there is a youth with a specific clinical need that cannot be met by any already enrolled provider, and no other enrolled provider will accept the youth. All out of state PRTFs must be licensed, accredited, and certified. Currently there are only 11 out of state PRTFs and 1 therapeutic group home enrolled in Montana Medicaid.

3. Beginning July 1, 2010 all PRTF providers must complete and submit a Discharge Plan Review Form within 30 days of admission or Medicaid will not authorize additional covered days. This effort is intended to encourage more adequate discharge planning and shorter lengths of stay in both instate and out of state PRTFs.
4. The Children's Mental Health Bureau plans to open two new PRTF "waiver" sites (Helena and Great Falls) before 12/31/2010, in addition to the currently home and community alternatives to youth and families in these communities in lieu of admission to a PRTF. Some youth exit the PRTF while still eligible for that level of care to enroll in this program.
5. CMHB regional staff and the Utilization Management contractor's regional staff are involved with the community treatment team and referring service provider before a youth is authorized for admission to an out of state PRTF. This staff seeks alternatives to the out of state admission among qualified Montana providers. (In SFY 2010 admissions to out-of-state PRTFs averaged just over 6% of all admissions to PRTFs; in SFY 2006 OOS admissions were 26% of all admissions)
6. In SFY 2010 the average length of stay for youth in out-of-state PRTFs was 102 days, compared with an average length of stay of over 300 days in SFY 2004 for youth in out of state facilities. Aggressive management by the state's Utilization Management contractor Magellan Medicaid Administration has resulted in only 53% of the requests for continued stay authorization for PRTF level of care being fully approved and another 47% receiving either a denial or a partial denial which allows additional days to complete discharge planning.
7. CMHB is increasing the capacity for wraparound facilitation in community settings by offering wraparound facilitation training and coaching. The goal is to offer at least twelve training opportunities to providers during the next SFY.

Appendix B: Average Length of Stay Report

Average Length of Stay Report				
Therapeutic Group Homes (TGH) and Psychiatric Residential Treatment Facilities (PRTF)				
Based on discharge data received from Magellan Health Reports				
8/24/2010				
	SFY 2007	SFY 2008	SFY 2009	SFY 2010
TGH				
In-State	479	419	322	259
Out-of-State	228	415	360	inc
Combined	353	417	341	inc
PRTF				
In-State	139	126	137	114
Out-of-State	338	348	327	208
Combined	238	237	232	161

Appendix C: SOC Statutory Committee List

Children's System of Care
Statutory Planning Committee Members
Revised February 23, 2010

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Chemical Dependency Bureau	
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Alternate - Chemical Dependency Bureau	
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Early Childhood Services	
Mary Jane Standaert 111 N Jackson PO Box 202295 Helena MT 59601	Ph: (406) 444-0589 Fax: (406) 444-2547 Email: mjstandaert@mt.gov
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Alternate – Department of Corrections	
Bob Peake, Chief Youth Court 301 South Park Ave., Suite 328 Helena, MT 59601	Ph: (406) 841-2961 Fax: (406) 841-2955 Email: ropeake@mt.gov
District and Youth Court Services Bureau	
Sara Casey 1227 11th Ave P.O. Box 202501 Helena, MT 59620	Ph: (406) 444-0688 Fax: (406) 444-2893 Email: scasey@mt.gov
Office of Public Instruction	
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Board of Crime Control- Juvenile Justice	
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Mental Health Ombudsman	
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Addictive and Mental Disorders Division (AMDD)	
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Children's Mental Health Family Liaison	
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Branch Manager: DPHHS	
Hank Hudson, Economic Security 111 Sanders, Room 301 Helena, MT 59620	Ph: (406) 444- FAX: (406) 444- Email:
Branch Manager: DPHHS	

Appendix D: Draft 6 KMA Certification: 12/21/06

As a Kids Management Authority (KMA), we are committed to the following system of care values and principles:

- A system of care should be child centered and family focused with the needs of the child and family dictating the types and mix of services provided.
- The system of care should be community based with the focus of services as well as the management and decision-making responsibility resting at the community level.
- The system of care should be culturally competent with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the population they serve.
- The system of care has an array of services that are comprehensive, individualized for the child and family, provided in the least restrictive appropriate setting, coordinated at the system level and service delivery level, inclusive of families and youth as full partners and invested in early identification and intervention.
- The system of care uses a strength based approach.
- System of care efforts are directed to a community supported, family driven model that emphasizes independence rather that dependence and empowers families.

As a KMA, we are committed to:

- Full involvement of parents and families at all levels in the children's system of care.
- In collaboration with System of Care Planning Committee, we share responsibility to ensure the coordination of state and community resources to ensure comprehensive delivery of services to youth with emotional disturbances, including youth with serious emotional disturbances.
- We are committed to cultural competency. When the KMA is serving tribal communities, tribal representatives will have the opportunity to participate as full members of the KMA. Cultural competency is not limited to tribal populations but also includes race, religion, sexual orientation, age, gender and socioeconomic status.
- Partnering with the state to provide information on the system needs and development and participate in policy development and educate legislators on the needs of youth with serious emotional disturbance (SED) and the impact on their families. In collaboration with the state, we will disseminate public education materials and participate in media strategies to reduce the stigma associated with SED.
- Being available to serve as consultants/mentors by sharing ideas, experiences and expertise with other communities
- The preliminary focus of this project will include youth with SED that have multi-agency needs and are at highest risk for out of home placement or are currently

in an out of home placement. As the vision for KMA's unfold, all high risk, multi-agency youth including those who are abused or neglected, dependent, delinquent and in need of intervention, developmentally disabled, chemically dependent and/or emotionally disabled for special education purposes and their families will potentially be served.

Appendix E: Financials

SAMHSA Grant Expenditures
Fund: 03794
Expenditures per SABHRS
Grant to date as of: 30-Jun-10

FFY 2005 (Year One)	Federal funding available: $750,000	State match required: $250,000	Match Ratio: 75/25
	Budget	**Actual**	**Difference**
Salaries & Wages	$80,582.00	$19,166.35	$61,415.65
Fringe Benefits	$20,145.00	$6,421.69	$13,723.31
Travel	$136,150.00	$28,521.20	$107,628.80
Equipment	$29,783.00	$7,939.96	$21,843.04
Supplies	$31,380.00	$5,632.02	$25,747.98
Contractual	$292,483.00	$48,866.42	$243,616.58
Other	$143,925.00	$12,171.03	$131,753.97
Total Direct Expenditures	$734,448.00	$128,718.67	$605,729.33
Indirect Charges	$15,552.00	$8,688.47	$6,863.53
Totals	$750,000.00	$137,407.14	$612,592.86

FFY 2006 (Year Two)	Federal funding available: $1,125,000	State Match required: $375,000		Match Ratio: 75/25	
	Budget	**Carryover**	**Award with Carryover**	**Actual**	**Difference**
Salaries & Wages	$101,308.00	$61,416.00	$162,724.00	$129,031.23	$33,692.77
Fringe Benefits	$25,327.00	$13,723.00	$39,050.00	$42,532.83	($3,482.83)
Travel	$122,332.00	$107,630.00	$229,962.00	$56,690.07	$173,271.93
Equipment	$0.00	$21,843.00	$21,843.00	$4,299.18	$17,543.82
Supplies	$28,496.00	$26,155.00	$54,651.00	$2,090.41	$52,560.59
Contractual	$673,927.00	$244,863.00	$918,790.00	$483,629.76	$435,160.24
Other	$151,110.00	$130,099.00	$281,209.00	$30,475.45	$250,733.55
Total Direct Expenditures	$1,102,500.00	$605,729.00	$1,708,229.00	$748,748.93	$959,480.07

Indirect Charges	$22,500.00	$6,864.00	$29,364.00	$29,364.00	$0.00
Totals	$1,125,000.00	$612,593.00	$1,737,593.00	$778,112.93	$959,480.07

FFY 2007 (Year Three)

Federal funding available: $1,875,000

State match required: $625,000

Match Ratio: 75/25

	Budget	**Carryover**	**Award with Carryover**	**Actual**	**Difference**
Salaries & Wages	$89,587.00		$89,587.00	$141,690.84	($52,103.84)
Fringe Benefits	$22,397.00		$22,397.00	$47,747.53	($25,350.53)
Travel	$211,002.00		$211,002.00	$73,781.39	$137,220.61
Equipment	$0.00		$0.00	$3,337.72	($3,337.72)
Supplies	$42,358.00		$42,358.00	$6,434.83	$35,923.17
Contractual	$1,244,701.00		$1,244,701.00	$940,935.28	$303,765.72
Other	$199,330.00		$199,330.00	($21,090.60)	$220,420.60
Total Direct Expenditures	$1,809,375.00	$0.00	$1,809,375.00	$1,192,836.99	$616,538.01
Indirect Charges	$65,625.00		$65,625.00	$65,625.00	$0.00
Totals	$1,875,000.00	$0.00	$1,875,000.00	$1,258,461.99	$616,538.01

FFY 2008 (Year Four)

Federal funding available: $1,000,000

State match required: $1,000,000

Match Ratio: 50/50

	Budget	**Carryover**	**Award with Carryover**	**Actual**	**Difference**
Salaries & Wages	$69,369.00		$69,369.00	$50,172.09	$19,196.91
Fringe Benefits	$17,939.00		$17,939.00	$16,877.91	$1,061.09
Travel	$116,208.00		$116,208.00	$63,002.60	$53,205.40
Equipment	$0.00		$0.00	$0.00	$0.00
Supplies	$1,750.00		$1,750.00	$1,326.26	$423.74
Contractual	$704,448.00		$704,448.00	$603,105.74	$101,342.26
Other	$56,786.00		$56,786.00	$53,836.36	$2,949.64
Total Direct Expenditures	$966,500.00	$0.00	$966,500.00	$788,320.96	$178,179.04
Indirect Charges	$33,500.00		$33,500.00	$74,501.35	($41,001.35)
Totals	$1,000,000.00	$0.00	$1,000,000.00	$862,822.31	$137,177.69

FFY 2009 (Year Five)	Federal funding available: $495,000	State match required: $1,005,000	Award with	Match Ratio: 33/66	
	Budget	**Carryover**	**Carryover**	**Actual**	**Difference**
Salaries & Wages	$53,046.00		$53,046.00	$1,070.07	$51,975.93
Fringe Benefits	$17,149.00		$17,149.00	$13,950.22	$3,198.78
Travel	$49,004.00		$49,004.00	$4,449.23	$44,554.77
Equipment	$0.00		$0.00	$0.00	$0.00
Supplies	$2,310.00		$2,310.00	$56.28	$2,253.72
Contractual	$248,916.00	$745,500.00	$994,416.00	$362,792.64	$631,623.36
Other	$34,485.00		$34,485.00	$13,233.33	$21,251.67
Total Direct Expenditures	$404,910.00	$745,500.00	$1,150,410.00	$395,551.77	$754,858.23
Indirect Charges	$90,090.00	$74,500.00	$164,590.00	$62,652.43	$101,937.57
Totals	$495,000.00	$820,000.00	$1,315,000.00	$458,204.20	$856,795.80

FFY 2010 (Year Six) as of 6/30/10	Federal funding available: $330,000	State match required: $670,000	Award with	Match Ratio: 33/66	
	Budget	**Carryover**	**Carryover**	**Actual**	**Difference**
Salaries & Wages	$29,603.00		$29,603.00	$24,068.23	$5,534.77
Fringe Benefits	$7,963.00		$7,963.00	$9,607.35	($1,644.35)
Travel	$11,925.00		$11,925.00	$1,015.63	$10,909.37
Equipment	$0.00		$0.00	$0.00	$0.00
Supplies	$297.00		$297.00	$263.27	$33.73
Contractual	$184,081.00		$184,081.00	$95,469.90	$88,611.10
Other	$5,900.00		$5,900.00	$4,013.04	$1,886.96
Total Direct Expenditures	$239,769.00	$0.00	$239,769.00	$134,437.42	$105,331.58
Indirect Charges	$90,231.00	$0.00	$90,231.00	$20,977.19	$69,253.81
Totals	$330,000.00	$0.00	$330,000.00	$155,414.61	$174,585.39

Total	$5,575,000.00			$3,650,423.18	$1,924,576.82

FSR	Date	Federal	Match Reported	Total	Required Match	Difference
FFY 2005 80/20	2/16/2006	$137,407	$34,352	$171,759	$45,802	$11,450
FFY 2006 75/25	12/18/2007	$778,113	$270,821	$1,048,934	$259,371	($11,450)
FFY 2007 75/25	5/14/2008	$1,258,462	$419,487	$1,677,949	$419,487	$0
FFY 2008 50/50	2/25/2009	$862,822	$862,822	$1,725,644	$862,822	$0
FFY 2009 33/67	2/26/2010	$458,204	$919,892	$1,378,096	$917,784	($2,108)
FFY 2010 33/67		$330,000		$330,000	$660,991	$0
Total		**$3,825,008**	**$2,507,374**	**$6,332,382**	**$3,166,257**	**($2,108)**

	Projected through FFY10
REQUIRED MATCH	$3,166,257.00
Total Match Documented	$4,044,936.03
TOTAL EXCESS MATCH	**$878,679.03**
Excess In-Kind - Other	$764,957.01
Excess In-Kind for KMAs	
Crow Nation	$38,250.91
Hill County	$12,707.86
Rocky Mtn	$47,303.24
YBGR	$15,460.01
Total	$113,722.02

Fund	**01100 - GENERAL FUND EXPENSES**
Ledger	ACTUALS

Report Through: 30-Jun-10

Expenditures		HHS Proj Yr						
	Category	**F05**	**F06**	**F07**	**F08**	**F09**	**F10**	**Grand Total**
	Salaries & Wages				$93,274.91	$113,266.62	$24,180.96	$230,722.49
	Fringe Benefits				$31,332.09	$28,016.53	$9,625.73	$68,974.35
	Travel	$418.70	$3,200.68	$2,937.72	$29,895.29	$21,529.51	$6,840.34	$64,822.24

	Equipment					$4,632.33		$4,632.33
	Supplies			$56.14	$5,179.79	$3,545.61	$813.38	$9,594.92
	Contractual	$73,963.00		$59,219.62	$173,916.00	$284,712.65	$114,509.49	$706,320.76
	Other	$17.08	$257.37	$15.31	$38,045.79	$27,990.10	$12,479.13	$78,804.78
	Indirect Charges		$17,846.32	$17,797.32				$35,643.64
	Grand Total	**$74,398.78**	**$21,304.37**	**$80,026.11**	**$371,643.87**	**$483,693.35**	**$168,449.03**	**$1,199,515.51**
	Reported on FSR	**$13,912.00**	**$83,768.00**	**$16,887.00**	**$479,039.00**	**$483,693.35**		**$1,077,299.35**
	Difference	**$60,486.78**	**($62,463.63)**	**$63,139.11**	**($107,395.13)**	**$0.00**		**$122,216.16**

Appendix F: Montana Continuous Quality Improvement (CQI) – December 2009 Data Report

Montana Continuous Quality Improvement (CQI)

Montana System of Care (SAMHSA Grant # 5U79M056267-05)

I. Purpose of the CQI Progress Report: The CQI Progress Report is a data-driven tool designed to support dialogue within communities and between communities and federal program partners, as well as to promote continuous quality improvement.

II. Components of the Report: There are three components to the report: The numbers served, the performance domains, and the report findings.

A. Montana system of care served and enrolled in longitudinal study between December 2006 through December 2009.

TOTAL SERVED	ENROLLED IN LONGITUDINAL STUDY
December ‘08 159	December ‘08 100
July ‘09 242	July ‘09 151
December ’09 286	December ’09 163

Date services started by site: Crow: December 2006

Yellowstone: December 2006
Bear Paw: August 2007
Helena: January 2008
Butte: July 2008

B. Key Areas of Performance (Domains). There are five domains reported. These include (1) System Level Outcomes, (2) Child and Family Level Outcomes, (3) Satisfaction with Services, (4) Cultural and Linguistic Competency, and (5) Family and Youth Involvement.

III. Summary of Changes in the Reporting Periods (JULY '09 & DECEMBER '09)

1. **Increase in the number served and the number enrolled in the longitudinal study.**
2. **Improvements resulting in moving the percentiles out of the Lowest 25%:**
   a. School enrollment rate
   b. Caregiver overall satisfaction
3. **Improvements resulting in moving the percentile to the Top 25%:**
   a. Average reduction in employment days lost (intake to 6 months)
4. **Slippage resulting in moving the percentile to the Lowest 25%:**
   a. None

IV. Status Quo (remained the same) for the Top 25% in the Reporting Periods (JULY '09 & DECEMBER '09)

1. Agency involvement rate – service level
2. Agency involvement – treatment planning
3. Youth satisfaction outcomes
4. Individualized Education Plan (IEP) development
5. Emotional and behavioral problem improvement list (6–18 years old)
6. Youth arrest rate

V. Status Quo (remained the same) for the Lowest 25% in the Reporting Periods (JULY '09 & DECEMBER '09)

1. Caregiver satisfaction with access to service
2. Stability in living situation rate
3. Suicide attempt reduction rate – caregiver report
4. Caregiver strain improvement rate (intake to 6 months)
5. Youth involvement in service planning

VI. Current Reporting Periods all Top 25%; Comparison to National Aggregate Report

PERFORMANCE	MONTANA	NATIONAL
Agency involvement rate – service level	93.8%	74.9%
Agency involvement – treatment planning	62.2%	29.6%
Youth satisfaction outcomes	4.05	3.86
Individualized Education Plan (IEP) development	67.7%	54.5%
Emotional and behavioral problem improvement list (6–18 years old)	35.2%	29.2%
Youth arrest rate	72%	92.4%
Avg. reduction in employment days lost	-4.34	-2.40

VII. Current Reporting Periods all Lowest 25%; Comparison to National Aggregate Report

PERFORMANCE	MONTANA	NATIONAL
Caregiver satisfaction with access to services	**4.00**	**4.24**
Stability in living situation rate	**49.0%**	**77.2%**
Suicide attempt reduction rate–caregiver report (a negative number means a positive outcome)	**-22.2%**	**-40.7%**
Caregiver strain improvement rate	**24.4%**	**28.8%**
Youth involvement in service planning	**38.5%**	**84.4%**

FYI: *Under "VIII. Findings" all changes are reflected in **BOLD TYPE.***

VIII. Findings

State System Level Outcomes

Note: Percentile indicates where the Montana System of Care Community rates in comparison with other Phase IV System of Care Communities nationwide. **Top 25%** represents highest percentile and is highlighted in **green**. **Lowest 25%** represents lowest percentile and is highlighted in **Yellow.**

	Raw score (Jul' 09)	Percentile (Jul '09)	Raw score (Dec '09)	Percentile (Dec '09)	Change from July to December
System Accessibility					
Linguistic Competency	missing	missing	missing	missing	NA
Agency Involvement Rate-Service Level	93.2%	Top 25%	93.8%	Top 25%	↑ Increase
Caregiver Satisfaction with Access to Services	3.91	Lowest 25%	4.00	Lowest 25%	↑ Increase
Timeliness of Services (average days)	6.43 days	50% - 75%	8.64 days	50% - 75%	↓ Decrease; lower number (of days) is a better outcome
Service Quality					
Agency Involvement- Treatment Planning	68.8%	Top 25%	62.2%	Top 25%	↓ Decrease
Informal Supports Rate	28.4%	25% - 50%	32.6%	25% - 50%	↑ Increase
Caregiver Satisfaction Rate, Quality of Services	3.89	25% - 50%	3.94	25% - 50%	↑ Increase
Youth Satisfaction, Quality of Services	3.91	25% - 50%	3.92	25% - 50%	↑ Increase
Caregiver Satisfaction Rate, Outcomes	3.56	25% - 50%	3.63	**50% - 75%**	↑ Increase; **moved UP in Percentile Category**
Youth Satisfaction, Outcomes	4.01	Top 25%	4.05	Top 25%	↑ Increase
Service Appropriateness					
Individualized Education Plan (IEP) Development. (6 mo.)	65.0%	Top 25%	66.7%	Top 25%	↑ Increase

Child and Family Outcomes

Note: Percentile indicates where the Montana System of Care Community rates in comparison with other Phase IV System of Care Communities nationwide. Top 25% indicated a highest score unless otherwise noted. **Top 25%** represents highest percentile and is highlighted in **green**. **Lowest 25%** represents lowest percentile and is highlighted in **Yellow**.

	Raw score (Jul '09)	Percentile score (Jul '09)	Raw Score (Dec '09)	Percentile (Dec '09)	Change from July to December
Child Level					
School Enrollment Rate	92.1%	**Lowest 25%**	93.8%	**25% - 50%**	↑ Increase; **no longer at the lowest 25% (UP)**
School Attendance Rate	86.4%	**Top 25%**	83.1%	**50% - 75%**	↓ Decrease; **no longer at the Top 25% (DROP)**
Daycare or After School Attendance	Na	Na			Na
School Performance Improvement (intake-6mo)	33.3%	25%-50%	31.0%	25% - 50%	↓ Decrease
Stability in Living Situation Rate (intake to 6 mo.)	50.0%	Lowest 25%	49.0%	Lowest 25%	↓ Decrease
Inpatient Hospitalization Days per Youth (intake-6mo)	5.86	25%-50%	4.65	25% - 50%	Outcome positive; decrease in # of days (a lower # is better)
Suicide Attempt Reduction Rate (intake to 6 mo)—Caregiver Report	0.0%	Lowest 25%	-22.2%	Lowest 25%	A negative score represents a positive outcome
Emotional and Behavioral Problem Improvement List 6-18 (intake to 6 mo)	35.4%	Top 25%	35.2%	Top 25%	↓ Decrease
Emotional and Behavioral Problem Improvement List 1.5- 5 (intake to 6 mo)	Na	Na	Na	Na	Na
Youth Arrest Rate	70.0%	Top 25%	72.0%	Top 25%	↑ Increase
Anxiety Improvement Rate	17.1%	**25% - 50%**	18.6%	**50% - 75%**	↑ Increase; **moved UP in Percentile Category**

Child and Family Outcomes Continued	Raw score (July '09)	Percentile score (July '09)	Raw Score (Dec '09)	Percentile (Dec '09)	Change from July to December
Family Level Outcomes					
Average Reduction in Employment Days Lost (intake to 6 mo)	-3.53	25% - 50%	-4.34	Top 25%	Positive outcome; a lower score is better
Family Functioning Improvement Rate (intake to 6 mo)	3.9%	**25% - 50%**	4.4%	**50% - 75%**	↑ Increase; **moved UP in Percentile Category**
Caregiver Strain Improvement Rate (intake to 6 mo)	21.7%	Lowest 25%	24.4%	Lowest 25%	↑ Increase

Satisfaction with Services

Note: Percentile indicates where the Montana System of Care Community rates in comparison with other Phase IV System of Care Communities nationwide. **Top 25%** represents highest percentile and is highlighted in **green**. **Lowest 25%** represents lowest percentile and is highlighted in **Yellow**.

Satisfaction with Services	Raw score (July '09)	Percentile (July '09)	Raw Score (Dec '09)	Percentile (Dec '09)	Change from July to December
Caregiver Overall Satisfaction	3.92	**Lowest 25%**	3.97	**25% - 50%**	↑ Increase; **no longer at the lowest 25% (UP)**
Youth Overall Satisfaction	3.91	50% - 75%	3.93	50% - 75%	↑ Increase

System of Care Principle Fidelity

Note: Percentile indicates where the Montana System of Care Community rates in comparison with other Phase IV System of Care Communities nationwide. **Top 25%** represents highest percentile and is highlighted in **green.**
Lowest 25% represents lowest percentile and is highlighted in **Yellow**.

System of Care Principles	Raw score (July '09)	Percentile (July '09)	Raw Score (Dec '09)	Percentile (Dec '09)	Change from July to December
Family and Youth Involvement					
Caregiver Satisfaction Rate-Participation	4.17	**25%-50%**	4.22	**50% - 75%**	↑ Increase; **moved UP in Percentile Category**
Youth Satisfaction Rate-Participation	3.54	25% - 50%	3.58	25% - 50%	↑ Increase;
Caregiver and Other Family Involvement in Service Planning	92.6%	25% - 50%	93.4%	25% - 50%	↑ Increase;
Youth Involvement in Service Planning	39.2%	Lowest 25%	38.5%	Lowest 25%	↓ Decrease
Linguistic and Cultural Competence					
Caregiver Satisfaction Rate with Cultural Competence	4.38	25%-50%	4.42	25% - 50%	↑ Increase
Youth Satisfaction Rate in Cultural Competence	4.19	25%-50%	4.19	25% - 50%	same

December 2009 Overview of Report

Item	Top 25 percentile	50-75 percentile	25-50 percentile	Lowest 25 percentile
System Level	1) Agency involvement rate-service level 2) Agency involvement rate-tx planning 3) Youth satisfaction rate-outcome 4) Individualized Education Plan (IEP) development	1) Timeliness of services (average days) **2) Caregiver satisfaction rate, outcomes (moved <u>UP</u> from 25-50%)**	1) Informal supports rate 2) Caregiver satisfaction rate, quality of services 3) Youth satisfaction, quality of services	1) Caregiver satisfaction with access to services
Family Outcome	1) Emotional and behavioral problem improvement 2) Youth arrest rate 3) Average reduction in employment days lost	**1) School attendance rate (moved <u>DOWN</u> from top 25%)** **2) Anxiety improvement rate (moved <u>UP</u> from 25-50%)** **3) Family functioning improvement rate (moved <u>UP</u> from 25-50%)**	**1) School enrollment rate (moved <u>UP</u> from the lower 25%)** 2) School performance improvement 3) Inpatient hospitalization days per youth (intake to 6 mo.)	1) Stability in living situation rate (intake to 6 mo.) 2) Suicide attempt reduction rate (intake to 6 mo)—caregiver report 3) Caregiver strain improvement rate
Satisfaction with Services	none	1) Youth overall satisfaction	**1) Caregiver overall satisfaction (moved <u>UP</u> from lower 25%)**	none
Family Involvement	none	**1) Caregiver satisfaction rate-**	1) Youth satisfaction rate-	1) Youth involvement in service planning

		participation (moved <u>UP</u> from 25-50%)	participation 2) Caregiver and other family involvement in service planning	
Cultural Competence	none	none	1) Caregiver satisfaction rate with cultural competence 2) Youth satisfaction rate in cultural competence	none