

Report to the Montana Legislature
Required Out-of-State Placement and Monitoring Report
January 1, 2015 through June 30, 2015
Submitted September 14, 2015

This report was prepared by Zoe Barnard, Children's Mental Health Bureau (CMHB) Chief, with data provided by several CMHB staff; and data provided by the Child and Family Services Division (CFS) of the Department of Public Health and Human Services (DPHHS), Department of Corrections, and Youth Court (juvenile probation).

The following statutorily required report is completed by the DPHHS, CMHB, in compliance with:

- 52-2-311. Out-of-state placement monitoring and reporting.** (1) The department shall collect the following information regarding high-risk children with multiagency service needs:
- (a) the number of children placed out of state;
 - (b) the reasons each child was placed out of state;
 - (c) the costs for each child placed out of state;
 - (d) the process used to avoid out-of-state placements; and
 - (e) the number of in-state providers participating in the pool.
- (2) For children whose placement is funded in whole or in part by medicaid, the report must include information indicating other department programs with which the child is involved.
- (3) On an ongoing basis, the department shall attempt to reduce out-of-state placements.
- (4) The department shall report biannually to the children, families, health, and human services interim committee concerning the information it has collected under this section and the results of the efforts it has made to reduce out-of-state placements.

Methodology

This report includes children placed out of state by *all State agencies and divisions*, though the report is compiled by the Children's Mental Health Bureau (CMHB), which is a Medicaid bureau within DPHHS. The CMHB is not a placement agency. The report distinguishes between youth who are placed by a parent or guardian (Medicaid only), those placed by a State agency using Medicaid funds, and those placed by a State agency using that Agency's funds (either general fund or braided funding).

The report includes only children who were placed out of state (OOS) on or after January 1, 2015 and on or before June 30, 2015. This is the biannual report to the Legislature covering the second half of SFY15 (1/1/15 through 6/30/15).

Organization

The organization of this report follows the list of required report variables prescribed in statute. The number of youth placed out of state by agency is discussed first, followed by the cost and reasons each youth was placed out of state. Care is given to describe the reasons for placement in OOS psychiatric residential treatment facilities (PRTF) for youth receiving Medicaid funds. Then, the report focuses on potential factors relating to placement in an OOS PRTF. Finally, attention is given to ways that the CMHB is working to reduce OOS placements.

Number of Youth Placed in Out-of-State PRTF's

Table 1 shows the number of youth placed in OOS for the last three six-month periods.

****Note:** During this reporting period there were youth who were placed in more than one out-of-state placement. These youth are counted *each time they entered a new placement if more than 30 days had elapsed between the discharge from one facility and entrance into another*. Thus, a single youth may be counted twice if s/he had more than one placement during the studied time period. In this time period one youth, placed by his parent(s) was counted twice.

In Table 1, the youth with both Child and Family Services and juvenile justice involvement is only counted once in the total placements. So the total number of youth placed with Medicaid funding (47) is equal to the number placed by Parent or Guardian (31) plus the number placed by each agency (9 + 2 + 6) minus the number with joint agency involvement (1).

Table 1. Number of Youth Placed in OOS Residential Treatment Facilities

	1/1/14-6/30/14	7/1/14-12/31/14	1/1/15 to 6/30/15
Placed by Parent or Guardian with Medicaid Funding	25	30	31
Placed by Child and Family Services (CFS) Division with Medicaid Funding	9	12	9
Placed by Tribal Social Services with Medicaid Funding	unknown**	unknown**	2
Placed by Department of Corrections (juvenile parole) with Medicaid Funding	0	2	0
Placed by District Court (juvenile probation) with Medicaid Funding	0	4	6
Placed by Child and Family Services ineligible for Medicaid Funding	2	0	0
Placed by Department of Corrections ineligible for Medicaid Funding	1	2	1
Placed by District Court ineligible for Medicaid Funding	0	2*	0
Number of youth with both CFS and either Department of Corrections or District Court involvement	0	0	1
Total youth placed during period with Medicaid funding	34	48	47
Total youth placed during period without Medicaid funding	3	4	1

*One of the two District Court placements was placed with HMK (CHIP) funding.

**Tribal social services placements would have shown as parent or guardian placements in previous reports.

Looking at the number of youth placed in out-of-state PRTFs during a given time frame is one way to look at the population of youth placed out of state. It can occasionally be somewhat misleading because all Medicaid providers have 365 days to bill Medicaid, so youth not billed for at the time of report might be missed. We know that some out-of-state placements have been missed in previous reports because of a billing lag.

Another way to look at placements in OOS PRTF is seen in Tables 2 and 3, which show the number of youth in placement in- and out-of state over time, *as a point in time*. As one can see from the table the percentage of youth in out-of state placements has grown, but so has the overall number of youth in in-state placements. In the past two years, about 30% of the youth in PRTF placement have been in OOS placement.

Table 2. Youth in Placement In State and Out of State as of December*

Number of Youth in:	In-State PRTF	Out-of-State PRTF	Total Placements	Percent Out-of-State Placements (%)
December 2009	104	8	112	7%
December 2010	94	19	113	17%
December 2011	83	22	105	21%
December 2012	104	30	134	22%
December 2013	118	45	163	28%
December 2014	113	46	159	29%

*Note: Some historical data on this table has been corrected from previous reports.

Table 3. Youth in Placement In State and Out of State as of June

Number of Youth in:	In-State PRTF	Out-of-State PRTF	Total Placements	Percent Out-of-State Placements (%)
June 2009	92	31	123	25%
June 2010	91	15	106	14%
June 2011	94	19	113	17%
June 2012	104	32	136	24%
June 2013	97	39	136	29%
June 2014	125	53	178	30%
June 2015	133	48	181	27%

Due to the efforts of the staff in CMHB (discussed later in this report), the percentage of youth in OOS placement has gone down in the past six months. However, the percentage may not be statistically significant and will need to continue to be monitored in the latter half of calendar year 2015 (SFY2016, first half).

A final way to look at the numbers of youth OOS is to compare the number of youth who received PRTF services through Medicaid in state versus out of state in a given fiscal year. In SFY2014, 549 unduplicated youth received PRTF services. Of these, 455 of the youth were served in-state. For reference, 16,771 unduplicated youth received Medicaid mental health services in SFY2014. So the

percentage of youth receiving PRTF services was just over 3%, and the percentage of youth who received PRTF services who received them in state was approximately 83%.

The Children's Mental Health Bureau follows the aforementioned metrics in watching trends to determine actions to take regarding youth placement.

Out-of-State Montana Medicaid PRTFs

In April 2015, Montana was alerted that Cottonwood Treatment Center, Utah, was going to close its doors effective July 2015. The State later discovered that the facility had been cited by the state of Utah for licensure violations. Montana Medicaid (Children's Mental Health Bureau) also determined that Copper Hills Treatment Center, Utah, would no longer be utilized for Montana youth based on license violations. All told these facilities were serving 27 Montana youth. Fourteen youth from Cottonwood and four youth from Copper Hills were identified as high priority for securing appropriate discharge placements because discharge placements had not yet been secured. Magellan Medicaid (MMA) care coordination was involved in this process. Eighteen treatment team meetings were set up. The MMA care coordinator moderated each meeting and was identified as the point of contact. Of the 18 youth in total identified, all recipients had collaborative discharge planning meetings that were held with therapists, legal guardians, juvenile probation, case managers, State Regional Resource Specialists and the MMA care coordinator. Plans were developed for each youth with back up plans identified, and follow up meetings as necessary. Of the eighteen identified youth, five transitioned to their home or to an identified foster home, five transitioned to a therapeutic group home, one transitioned to an in-state PRTF in Montana, and the remaining seven were laterally transferred to out-of-state PRTF's.

The OOS residential treatment facilities that remain Montana Medicaid providers as of the end of this period are: Provo Canyon School (Provo, Utah), Benchmark (Woodscross, Utah), Desert Hills (Albuquerque, New Mexico), National Deaf Academy (Mount Dora, Florida), Coastal Harbor (Savannah, Georgia), Kids Peace (Schnecksville, Pennsylvania), and Teton Peaks (Idaho Falls, ID). The following is a description of each program.

Coastal Harbor, Savannah, GA

Coastal Harbor provides specialized units for males and females who have developmental delays or mild to moderate intellectual disabilities. They also have specialized units for treatment of sexually aggressive or reactive behaviors; aggressive behaviors; self-harming/suicidal behaviors; psychotic symptoms; and histories of trauma.

Provo Canyon, Orem, UT

Provo Canyon's Behavioral Hospital adolescent continuum of care offers a variety of programs targeted to meet the needs of youth with conditions such as: conduct and oppositional defiant disorder; comorbid medical disorders; social development disorders; and reactive attachment disorders.

Benchmark, Woodscross, UT

Benchmark serves adolescent and young adult males, ages 13 to 20, providing treatment for a variety of psychiatric and behavioral disorders including conduct disorder, sexual disorders/sexual misconduct issues, fetal alcohol spectrum disorders, Asperger's disorder, developmental disorders, mood disorders, anxiety disorders, personality disorders and substance abuse issues.

Desert Hills, Albuquerque, NM

Desert Hills provides treatment to youth with serious emotional disturbance, ages 5 to 21. Specialized units provide for: sexually maladaptive behaviors, PTSD, intellectual disabilities, depression, substance abuse, and behavioral disturbances resulting in multiple treatment failures.

National Deaf Academy, Mount Dora, FL

NDA Behavioral Health offers specialized treatment for youth with serious emotional disturbance that are Hearing, Deaf, Hard of Hearing, Autistic, or dually diagnosed with psychiatric disorders and addiction, as well as offering services for those with developmental disabilities. As of the writing of this report NDA is not being used by Montana Medicaid as a provider due to an ongoing retrospective clinical review initiated as a result of licensure violations.

Kids Peace, Schnecksville, PA

Kids Peace addresses a wide range of issues requiring specialized care, including: Bipolar disorder, Borderline personality disorder, Conduct disorder, Co-Occurring disorders (psychiatric/substance abuse), Depression, Dissociative identity disorder, Learning disabilities, psychiatric disorders, PTSD, Severe attention-deficit/hyperactivity disorder, Sexual abuse victims/perpetrators.

Teton Peaks, Idaho Falls, ID

Teton Peaks provides treatment for a variety of disorders, specializing in the treatment of depression, mood disorders, anxiety, post-traumatic stress, psychosis, medical issues complicated by a psychiatric disorder and drug or alcohol related issues associated with a primary psychiatric disorder.

Number of Youth Placed in Out-of-State Therapeutic Group Homes

Normative Services in Sheridan, Wyoming is the only OOS therapeutic group home (TGH) provider that is approved through Montana Medicaid. Normative Services specializes in youth 13 to 17 who present with psychiatric or behavior problems. The program has a substance abuse component. Table 4 shows the number of youth placed in this group home between January and June of 2015.

Montana Medicaid is working on approval for a second OOS TGH, in Mountain Home, Idaho. This facility works with boys with sexually reactive behaviors. No youth were placed at the Mountain Home facility during this time period.

Table 4. Number of Youth Placed in OOS Therapeutic Group Home (Normative Services), 1/1/15 to 6/30/15

Placed by Parent or Guardian with Medicaid Funding	0
Placed by Child and Family Services (CFS) Division with Medicaid Funding	7
Placed by Department of Corrections (juvenile parole) with Medicaid Funding	0
Placed by District Court (juvenile probation) with Medicaid Funding	9
Placed by Child and Family Services ineligible for Medicaid Funding	0
Placed by Department of Corrections ineligible for Medicaid Funding	0
Placed by District Court ineligible for Medicaid Funding	1
Number of youth with both CFS and either Department of Corrections or District Court involvement placed	0
Total youth placed during period with Medicaid funding	16
Total youth placed during period without Medicaid funding	0

The number of youth in Normative Services is dramatically smaller than it has been in previous six-month periods. There were no private placements during this six-month period.

Number of Youth Placed in Out-of-State Non-Therapeutic Placements

District Court (juvenile probation), Department of Corrections (juvenile parole), and Child and Family Services, the State agencies who are statutory placement agencies, occasionally place with non-Montana Medicaid providers. Usually these programs are not able to be Medicaid mental health placements because they specialize in treatment of offenders (sexual or conduct), substance abuse, or physical health issues. Sometimes they are mental health placements that have not become Montana Medicaid providers. There was only one reported placement in a non-Medicaid facility by any agency during this period: Department of Corrections (juvenile parole) placed a youth in Kidspace Mesabi, which is a combination PRTF/Corrections Facility in Minnesota.

It should be noted that the DPHHS has no way of keeping track of youth placed by private entities out of state in non-Medicaid placements.

Costs for Each Youth

Table 5 lists the costs associated with OOS PRTF placements. Please note that the costs listed for Medicaid clients include both the general fund (state-funded) portion, and the federal match. The federal match is based on the FMAP (federal matching assistance percentage) and for FFY15 (10/14 to 9/15) is 65.90. This means that about one third of the cost for Medicaid placements was covered by state general fund dollars. The table includes non-Medicaid placements, but does not include OOS TGH placements.

Table 5. List of Total Costs of Stay (as of February 2015) per Youth Placed in PRTF, 1/1/15 to 6/30/15

1. \$15,750*	2. \$21,270*	3. \$24,150*
4. \$1,803*	5. \$31,125*	6. \$43,461*
7. \$33,887*	8. \$43,200*	9. \$721*
10. \$18,746*	11. \$64,350*	12. \$20,293*
13. \$3,375*	14. \$9,450*	15. \$37,125*
16. \$9,373*	17. \$5,250*	18. \$57,500*
19. \$3,500*	20. \$24,514*	21. \$9,373*
22. \$40,600*	23. \$31,724*	24. \$2,884*
25. \$18,000*	26. \$54,546*	27. \$42,750*
28. \$33,750*	29. \$30,375*	30. \$33,000*
31. \$40,600*	32. \$64,350*	33. \$43,800*
34. \$36,771*	35. \$11,176*	36. \$52,650*
37. \$41,650*	38. \$11,250*	39. \$41,300*
40. \$21,270*	41. \$15,000*	42. \$32,806
43. \$54,075*	44. \$54,436*	45. \$6,750*
46. \$24,260*	47. \$49,759*	48. \$38,718
49. \$49,875		

*Medicaid Placement

Reasons Youth are Placed in OOS PRTF

Placement in an OOS PRTF through Medicaid can only occur after a youth has been certified as needing treatment at the PRTF level of care but denied at all three in-state PRTF's. In order to be certified as needing care at the PRTF level, a youth must exhibit behaviors or symptoms of serious emotional disturbance of a severe and persistent nature requiring 24-hour treatment under the direction of a physician. In addition, for a youth to be certified at this level of care, the prognosis for treatment at the PRTF level of care must reasonably be expected to improve the clinical condition/ serious emotional disturbance of the youth or prevent further regression based upon a physician's evaluation.

When an in-state PRTF denies admission to a youth, a letter is generated by the provider indicating the reason for denial. The actual letters were not available for review; the following data was retrieved from the MMA system.

For the period of January through June of 2015, there were 69 initial prior authorizations for out of state PRTF's entered into the Magellan Medicaid Administration (MMA) site. Several youth had initial prior authorization requests for multiple out of state PRTF's in the period. Of the 69 requests, 12 prior authorization requests were denied, no data on these requests is included below as the youth were not placed in the out of state PRTF. The MMA system was reviewed for reasons of denial from in state PRTF's for the balance of 57 requests. Of the 57 requests, 10 requests were for youth who were required to discharge from either Cottonwood or Copper Hills Youth Center,

in state denials were not required for these 10 youth. Thus, the data on reasons for denial at in state PRTF's is based on 47 initial prior authorizations. In many cases, multiple reasons for denial were noted.

The first MT PRTF noted the following reasons for denial:

- 26%: History of PRTF placement without benefit, youth unlikely to benefit from admission
- 18%: Youth appears to have conduct disorder
- 14%: Severe violence/physical aggression; facility can't assure safety of youth, peers, staff
- 12%: Facility can't manage youth in the current milieu
- 7%: Sexually reactive or sexually offending behavior
- 4%: Medical condition (one case noted diabetes, the other did not specify)
- 4%: Youth met admission criteria for the PRTF but no bed available
- 4%: Youth was pulled from previous PRTF placement against medical advice
- 2%: Disregard for limit setting, requiring 1:1 staffing more than 75% of time
- 2%: Established pattern of antisocial behavior with no response to treatment
- 2%: Developmentally delayed, IQ too low to benefit from program
- 2%: Fire setting behavior
- 2%: Elopement risk
- 2%: Not screened for admittance because no bed available
- 2%: Self injurious behavior

The second MT PRTF noted the following reasons for denial:

- 80%: Not screened for admittance because no bed available
- 6%: Severe violence/physical aggression; facility can't assure safety of youth, peers, staff
- 4%: History of PRTF placement without benefit, youth unlikely to benefit from admission
- 2%: Florid psychosis
- 2%: Sexually reactive or sexually offending behavior
- 2%: Developmentally delayed, IQ too low to benefit from program
- 2%: Moderate violence/physical aggression
- 2%: Moderate sexually reactive of sexual offending behavior

The third MT PRTF noted the following reasons for denial:

- 20%: Severe violence/physical aggression; facility can't assure safety of youth, peers, staff
- 17%: History of PRTF placement without benefit, youth unlikely to benefit from admission
- 12%: Not screened for admittance because no bed available
- 8%: Sexually reactive or sexually offending behavior
- 7%: Fire setting behavior
- 5%: Elopement risk

- 5%: Florid psychosis
- 5%: Youth appears to have conduct disorder
- 3%: Developmentally delayed, IQ too low to benefit from program
- 3%: Age inappropriate for program (both cases too young for program)
- 3%: Youth met admission criteria for the PRTF but no bed available
- 3%: Cruelty to animals
- 3%: Facility can't manage youth in the current milieu
- 2%: Disregard for limit setting, requiring 1:1 staffing more than 75% of time
- 2%: Primary problem is substance abuse
- 2%: Sexual involvement with another youth in current placement

Substance Abuse Disorder was noted in 24 individual youth cases, this indicates either a formal diagnosis or a reference to a history of substance abuse in almost 50% of the cases in the study. (Tobacco use was noted in some cases, but unless there was an additional substance noted, tobacco was not counted in the total.)

Regarding primary diagnosis, 60% fell in the category of mood disorders, primarily in the depressive disorder or bipolar disorder categories. Post-traumatic stress disorder was the primary diagnosis in 14% of the cases. Interestingly, while Mood Disorder NOS is not a covered SED diagnosis, 13% of the cases indicated it as the primary diagnosis (the youth had multiple SED covered diagnoses listed, though not as primary). Childhood Schizophrenia and Oppositional Defiant Disorder accounted for 4% of the cases each, and Autistic Disorder, Reactive Attachment Disorder, Generalized Anxiety Disorder and Intermittent Explosive Disorder accounted for 2% of the cases each.

The youngest youth in the study in an out of state PRTF during this time period was eight years of age; 4% of youth were age 10; 4% of youth were age 11, 4% of youth were age 12; 12% of youth were age 13; 25% of youth were age 14; 25% of youth were age 15; 16% of youth were age 16; and 11% of youth were age 17 (These data reflect the age of youth as of 6/30/15).

While not listed as a primary diagnosis, four youth had a diagnosis of Autistic Disorder and one youth had a diagnosis of Neurodevelopmental Disorder. Borderline IQ and Moderate Mental Retardation were noted in one case each.

One lateral move was made from a MT PRTF to an out-of-state PRTF and six lateral moves were made from an out of state PRTF to another out of state PRTF due to the closure of Cottonwood Treatment Center or Montana's decision to transfer youth out of Copper Hills Treatment Center.

A study of claims data was undertaken to look at claim diagnosis. Table 6 shows the primary diagnosis of 76 clients who were in OOS placements from January to June. It includes some clients who were already in the placements prior to the studied time period.

Table 6. Primary Claims System Diagnosis on 76 Clients in OOS Placements, 1/1/15 to 6/30/15

Psychiatric Residential Treatment Center (PRTF) PRTF Out-of-State Clients from 01/01/2015 to 06/30/2015 Primary Diagnosis on PRTF Claims		
Total Clients in Out-of-State PRTFs 01/01/2015 to 06/30/2015		76
Primary Diagnosis Code on PRTF Claims		% of Clients
309.81	POSTTRAUMATIC STRESS DISORDER	17 22.4%
296.60	BIPOLAR I RECENT EPI MIXED, UNSPECIFIED	11 14.5%
296.33	RECUR DEPR PSYCH-SEVERE	10 13.2%
296.90	UNSPECIFIED EPISODIC MOOD DISORDER	10 13.2%
296.80	BIPOLAR DISORDER, UNSPECIFIED	8 10.5%
296.32	RECURR DEPR PSYCHOS-MOD	6 7.9%
296.64	BIPOL I RECENT EPI MIXED SEVERE W PSYCHO	6 7.9%
313.81	OPPOSITIONAL DEFIANT DISORDER	6 7.9%
296.7	BIPOLAR I RECENT EPI (OR CURRENT) UNSPEC	5 6.6%
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	3 3.9%
296.34	REC DEPR PSYCH-PSYCHOTIC	3 3.9%
296.40	BIPOL I MOST RECENT EPI MANIC, UNSPEC	3 3.9%
296.89	OTHER & UNSPECIFIED BIPOLAR DISORDER OTH	3 3.9%
298.9	PSYCHOSIS NOS	3 3.9%
299.00	AUTISTIC DISORDER CURRENT OR ACTIVE	3 3.9%
296.30	RECURR DEPR PSYCHOS-UNSP	2 2.6%
296.35	RECUR DEPR PSYC-PART REM	2 2.6%
296.44	BIPOL I RECENT EPI MANIC SEVER W PSYCHOT	2 2.6%
296.53	BIPOL I RECENT EPI DEPRESS SEVER WO PSYC	2 2.6%
312.34	INTERMITT EXPLOSIVE DIS	2 2.6%
313.89	EMOTIONAL DIS CHILD NEC	2 2.6%
296.23	DEPRESS PSYCHOSIS-SEVERE	1 1.3%
296.25	DEPR PSYCHOS-PART REMISS	1 1.3%
296.50	BIPOLAR I RECENT EPI DEPRESSED, UNSPEC	1 1.3%
296.52	BIPOLAR I RECENT EPI DEPRESSED MODERATE	1 1.3%
296.63	BIPOL I RECENT EPI MIXED SEVERE WO PSYCH	1 1.3%
299.80	OTHER SPEC PERV DEVELOP DIS CURRENT/ACTV	1 1.3%
312.9	CONDUCT DISTURBANCE NOS	1 1.3%
314.01	ATTN DEFICIT W HYPERACT	1 1.3%

*Note that since clients will have multiple PRTF claims, that there can be more than one primary diagnosis for clients.

CMHB analysts also looked at the secondary diagnoses of clients in OOS PRTF and then *all diagnoses*. Of special concern were the number of youth with either a DSM-IV diagnosis of 304.x (substance dependence) or 305.x (substance abuse, nicotine dependence 305.1 excluded). Anecdotal data suggests that clinicians are hesitant to diagnose substance use disorders in many cases, yet almost a quarter of clients in OOS PRTF placement for mental health disorders not only met abuse criteria but also the substance abuse diagnosis made it onto a claim. Almost a fifth of clients in OOS PRTF during this time period met dependence criteria and the dependence diagnosis made it onto a claim. And, as Magellan data show, Substance Abuse Disorder was noted in 24 individual youth cases out of 47. Clearly co-occurring disorders in adolescence are an area of concern for OOS placements.

What does it mean that almost a quarter of OOS clients met criteria for Post-traumatic stress disorder? For clients this young to meet these criteria, they had to have witnessed or been the victims of significant abuse and/or neglect. Clients who have witnessed or been the victims of abuse are the most likely to learn aggressive or antisocial behaviors. And, indeed, we see that aggression, violence, and antisocial behaviors that may be characterized as conduct disorder (which is a controversial diagnosis) are reported as one of the most common reasons for in-state denial.

The increasingly younger age of clients going to PRTF (whether in- or out-of-state) is a cause for concern. Possible factors include children getting sicker and providers in Montana have not found an effective way to treat behavior associated with early childhood mental illness.

Process Used to Avoid OOS Placements

Historically, it was assumed that children who have low IQ coupled with mental health diagnoses ("dually diagnosed") were being sent to residential placement. To this end, for some time, CMHB staff persons have reviewed the diagnoses of youth who have both a mental health diagnosis and an intellectual disability and are in a PRTF (in or out of state). Youth who meet criteria are being referred to the Developmental Disabilities Program (DDP) so that they can be moved into the Developmental Disability waiver as they near adulthood. The Division has set a goal of serving up to 20 youth per year. We have not been able to find enough youth meeting the criteria for waiver to cap out the 20 waiver slots. Instead, it seems that most of the youth meeting dual diagnosis criteria are receiving in-home services (which seems positive). This population should receive even more population-specific in-home treatment as the autism state plan amendment begins to be implemented. It is worth noting that while youth meeting dual diagnosis criteria can generally be served in their homes, youth at the extreme end of this spectrum (one or two in the population served per year) have extremely specific needs. CMHB is still trying to find a facility that does not have an extremely long waiting list that can serve this population effectively.

Clearly there is a need to address the population of youth with co-occurring disorders. CMHB has been piloting some programs through two grants but more work needs to be done. The need for a concerted partnership between the Chemical Dependency Bureau and the CMHB has been identified and an effort to work together is underway.

In the first half of SFY2015, we added a "caseload of 10" to our utilization review contractor's (Magellan Medicaid Administration's) responsibilities. In order to be on the list, youth had to have been in a PRTF for an extended period of time, had multiple placements, or be difficult to place. Our purpose in creating the caseload was to see what impact we could have on PRTF numbers with relatively small effort. The regional care coordinator (RCC) who took this on for us through Magellan also followed youth post-discharge from PRTF to see how many ended up being back in a secure placement. CMHB believes that the model has had initial success as the number of youth in PRTF is flat relative to the CMHB population, which is growing. We are now proposing to have 2.0 FTE RCCs who will work with our regional staff to follow all the youth who are placed out of state. This change will go into effect in October 2015.

In this half of SFY15, CMHB moved youth out of two facilities in Utah. All told, these facilities contained 27 Montana youth, 18 of whom were not already in the process of being discharged. Due to intensive treatment planning led by Magellan Medicaid Administration and CMHB, of the 18 youth discharged from Cottonwood and Copper Hills, fifty-five percent, or ten youth, transitioned to a lower level(s) of care. Aftercare tracking will be utilized for these ten youth. The seven youth that continued treatment in PRTF were added to the current list for ongoing

monitoring and follow-up. It was evident in the discharge planning meetings that many of the youth did not appear to continue to meet the PRTF level of care. It was also noted that inadequate documentation existed for the lateral transfers to take place, and multiple PRTFs complained that information they received was not the most recent clinical information on the recipient. Because of this, we have prioritized ongoing care coordination for every out-of-state placed youth as a requirement starting October 1, 2015.

CMHB staff is reviewing the process by which youth go to residential treatment, including out-of-state treatment. We are considering a two-step process by which youth are first determined to be eligible for residential (secure) treatment and then we determine where they will go. We are hoping the process will become more consultative and involve more people so that decisions are thoughtful (not driven by crisis) and influenced by people who have known the youth outside of a hospital or secure environment.

CMHB staff has proposed taking on the prior authorization of therapeutic group home services. We currently review continued stays for therapeutic group homes, but reviewing initial authorizations would help to ensure that youth are in the least restrictive level of care throughout the system.

CMHB leadership is interested in exploring how PRTF assessment services (short-term PRTF stays for the purpose of determining diagnosis, medications, etc.) might be used more effectively, trying to identify on-the-ground issues and address them in individual communities, and in learning what crisis diversion models can do.

Next Steps

CMHB would like to make an impact on the snapshot number of youth out of state, not just the percentage of youth in OOS PRTF relative to the number of youth in PRTF.

The Department continues to be interested in expanding programs already in place and building capacity in state to handle youth transitioning out of OOS placements.

With regard to building capacity, CMHB and Child and Family services are actively exploring the possibility of increasing the therapeutic foster care room and board rate and align the rules with the needs of the population. Therapeutic foster care is an important diversionary and step-down service.

We are also exploring placing additional limitations on OOS placement, such as an age restriction for placement of young children.

The development of an autism program that is an entitlement is likely to reduce, over time, the number of youth with autism who escalate to needing the PRTF level of care. The Department does not anticipate that we will be able to see the effect of such a program for five to ten years.

More long term, CMHB is working with the Health Resources Division to develop a system to monitor polypharmacy in higher levels of care. Right now, because the billing is in a bundle, we can't see what medications youth are taking. This is a problem, because youth in higher levels of care can have five to eight medications they are taking, including multiple psychotropic medications. Many of these medications haven't been studied or approved for use in children. They can lead to all sorts of medical issues, including metabolic dysfunction that can have lifelong effects. The Department will be developing a system to monitor medications first, with an eye towards pharmacist consult and possibly review and approval of medications.

CMHB intends to further study the movement of youth throughout the continuum of care as well as the placement of post-adoptive youth, the latter with the assistance of the Child and Family Services Division of DPHHS.

Number of Youth Participating in the Pool

Pursuant to HB565 and effective October 26, 2012, Children's Mental Health Bureau supplied the posting of a secure HIPAA-compliant, Department-approved data management system to allow treatment plans for youth who are currently placed out of state or who are at risk of being placed out of state for mental health services in a therapeutic youth group home (TGH) or psychiatric residential treatment facility (PRTF).

Mental health providers, such as psychiatric hospitals, TGHs, mental health centers, and PRTFs have the opportunity to use this secure system to share and review confidential health care information about youth who are placed out of state or who are at risk of being admitted to an out-of-state facility. In-state providers have the option to use this information to provide alternate opportunities for youth to use in-state mental health services.

To date, this resource has not been accessed or used by any providers.