CHCS
Center for
Health Care Strategies, Inc.

Care Management Entity Quality Collaborative
Technical Assistance Webinar Series

Reengineering Residential Treatment

December 8, 2011, 2:00 – 4:00 p.m., ET

For audio and to participate, dial: **(877) 668-4490**
Meeting/Event Number: **715 060 448**
In case of technical difficulties, call **(866) 229-3239**

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CHCS Priorities

Our work with state and federal agencies, Medicaid health plans, providers, and consumers focuses on:

- **Enhancing Access to Coverage and Services**
- **Improving Quality and Reducing Racial and Ethnic Disparities**
- **Integrating Care for People with Complex and Special Needs**
- **Building Medicaid Leadership and Capacity**

Maryland, Georgia and Wyoming Collaborative CHIPRA Grant Project

- Goal: Improving the health and social outcomes for children with serious behavioral health needs.
- Implement and/or expand a Care Management Entity (CME) provider model to improve the quality - and better control the cost - of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children's Health Insurance Program.

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Reengineering Residential Treatment

The Building Bridges Initiative: a model for systems transformation

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Building Bridges Initiative

- **Vision:**

  Community and residentially-based treatment and service providers share responsibility with each other, families and youth to ensure that comprehensive mental health services and supports are available to improve the lives of young people and their families.

BBI Joint Resolution

- Core values:
  - Respect for cultural differences
  - Family-driven and youth-guided
  - Prevent need for custody relinquishment
  - Multi-service, holistic, comprehensive, flexible
  - Decrease need for out-of-home care and integrate and coordinate with community providers
  - Utilize relationship-based approaches

BBI Joint Resolution

- In addition to the core SOC values resolution calls for:
  - Clinical Excellence and Quality Standards
  - Accessibility and Community Involvement
  - Transition Planning and Services (Between Settings and from Youth to Adulthood)
  - Effective Workforce Development
  - Assessment, Evaluation and Continuous Quality Improvement

Youth and Family Perspectives

- Treatment and process should be driven by family and youth voice - where the family and youth define success and have choices. If family is the customer, then they need to know what product they are buying when they admit the child.
- Need to ask: What is it that you want to happen? What would make your life better? What are the outcomes you are looking for?

Youth and Family Perspectives

- Desire respect and a central role in decision-making about **their** lives and treatment
- Seek compassionate and respectful care
- Need continuity of services from community > residential > back to community
- Want help to recover and live successfully in the community

Youth and Family Perspectives

- Progress toward **their** value-derived outcomes
- Need providers to listen, accurately diagnose, and provide/link them with the right services and supports to get on with their lives.
- See residential's role primarily as crisis stabilization and a short-term intervention.

Youth and Family Perspectives

- Many youth expressed concerns regarding medication (e.g. too many types, used without trying non-pharmacological approaches, prescribed without an accurate diagnosis).
- Youth want to clearly understand what is expected of them in order for them to return home.

Youth and Family Perspectives

- Frequent (daily) communication with family
- Written and verbal updates and reports.
- Phone call whenever there is something significant to report.
- Flexible policies regarding visitation with visits not having to be earned and families having 24/7 access.
- Education about the mental health issues impacting their family

Youth and Family Perspectives

- Connect families to other families to give them hope and answer questions, share concerns.
- Paid family member who had a child in the program to talk with youth and family.
- Provide other affected family members with the treatment, services and supports they need.
- Teach families strategies to help them manage their child's emotional and behavioral health needs.

Youth and Family Perspectives

- Link the treatment plan developed while in residential care with services and supports in the community for seamless aftercare.
- Focus treatment on the skills needed to succeed at home and in the community.
- For adolescents, focus on post-secondary education, job-training, housing, and transportation needs in aftercare planning.

Youth and Family Perspectives

- Provide someone for youth and families to contact after discharge to offer assistance and support as needed.
- Don’t confuse roles—families don’t want staff acting as surrogate parents, siblings, etc…but do want staff to be nurturing, affectionate and committed.

Transforming Practice

- **Transformation is already taking place** and there are communities and provider agencies which have successfully evolved, changing the way residential resources are used, implementing system of care principles and values in service delivery, and more fully integrating residential and community-based resources.

Transforming Practice

- **Transformation is about re-thinking what community-based services and supports need to be in place** both to reduce the reliance on residential resources and to shape how the system as a whole will support community integration for youth in various levels of residential treatment.

Transforming Practice

- **Transformation depends on leadership and broad, sustained commitment.** Effective leadership in system transformation must be committed to the vision and skilled at translating the vision into action. Leadership should be collaborative, bringing people together instead of asserting control, but also adept at using contracting and quality assurance mechanisms to bring practice in-line with the vision.

Transforming Practice

- **Transformation goals and values derive from the voice and wisdom of youth and families** who ask that care be delivered in a manner that is respectful, engaging, empowering, normative and flexible to meet the specific needs, desires, experiences and culture of each family and youth.

Transforming Practice

- **Transformation is done in partnership with families and youth**. The shift to family-driven and youth-guided care can be among the most challenging, but most important aspects of transformation as it involves fundamental organizational culture change and a great deal of learning and processing.
- Achieving a genuine shift in power is not a small matter.

Transforming Practice

- Bias and perceptions held by staff, agency-employed family members, community members and consumers must be addressed. An atmosphere of open communication should be fostered. Leadership should articulate clear expectations regarding how this principle will be operationalized. Families should be routinely asked for feedback.

Transforming Practice

- **Transformation can be scary and uncomfortable** for agency leadership, boards, staff, communities and families. Colleagues who have been through the process can provide valuable technical assistance and guidance. Thorough planning is critical. Leadership should anticipate and work through the pushback.

Transforming Practice

- **Transformation, ultimately, requires change at all levels**: national policy, state policy, community awareness and attitudes, local leadership and planning processes, workforce development, agency culture and every aspect of practice and service delivery.
- The lack of ‘external alignment’ makes transformation more difficult.

Transforming Practice

- Some critical infrastructure supports include state-of-the-art supervision, mentoring, fidelity monitoring, outcomes evaluation and quality assurance approaches to obtain the best results.

Transforming Practice

- **Transformation is responsive to the community.** There is no cookie cutter approach to implementing the goals of transformation because each community has different needs and resources, and each system of care context is unique. It will be important to invest in a process that engages a wide range of stakeholders and draws upon the experience of others (locally and nationally) to thoroughly plan for change.

Transforming Practice

- **Transformation embraces cultural diversity** as an imperative strength -- seeking always to understand, honor, and make healing use of the cultural assets of each child, family, staff member and community.

Transforming Practice

- **Transformation asks: does what we are doing make sense for children and their families?** Transformative practice takes a step back and looks closely at the goals for each child and family and then crafts an individualized response based on family and child needs, not the needs of the system.

Transforming Practice

- Evidence-based practices should be used when appropriate after carefully considering the needs of each child and family rather than just ‘plugging’ the child into an available ‘slot’.

Transforming Practice

- **Transformation is sustainable,** but requires creativity, persistence and data. The bottom line: funding this new approach is challenging, but possible and sustainable. Innovators have changed State Medicaid Plans, braided funding streams from multiple sources, worked differently within the traditional daily rate structure, used data to 'sell' the concept to third party payors, diversified the services the agency provides to meet the need and reduce financial risk, established case rates that include all services, and sought out grant funding.

Transforming Practice

- **Fiscal Strategies that Support the Building Bridges Initiative Principles** can be found at the Building Bridges website including current state, county and provider initiatives.

www.buildingbridges4youth.org

Transforming Practice

- **Transformation requires sufficient capacity in effective community-based services** to reduce unnecessary use of residential resources, to provide strong and ongoing community linkages throughout the time the child and family are receiving residential treatment and supports, to permit discharge in as short of time as possible and ensure sustained success living in the community, reducing recidivism.

Transforming Practice

- **Transformation utilizes the child and family team/wraparound process to** plan and coordinate care regardless of the physical location of the child and with participation from all providers. The continuity this affords is expected to improve outcomes and assures families a trusted ‘home-base’ to return to throughout their journeys. The child and family team tailors and customizes the treatment and support plan regularly.

Transforming Practice

- **Transformation produces positive outcomes and broadens the definitions of success to** look at multiple dimensions of what works in addition to the 'clinical functioning' of the child. Valued outcomes include the acquisition of skills and strategies that promote success in and generalize to life in the community; continuity in important relationships, personal and institutional; leadership and empowerment skills and roles; and youth and family satisfaction.

Transforming Practice

- **Transformation is a process that should be informed through the use of performance indicators and outcomes evaluation**. Communities engaged in transformation will want to create a culture that uses data wisely to guide different types of decision-making, inform resource allocation, suggest areas for growth and demonstrate success.

Centrality of the CFT

- A Child and Family Team (CFT) including youth, family, providers, and others chosen by the youth and family remains in place throughout this process. Pre, during, and post residential providers are on the team.
- Family and youth are involved directly in all aspects of treatment planning.
- Family and youth have choice in selecting members of their Child and Family Team.
- Family and youth have choice of providers and services whenever possible.

Governance

- Family and youth are involved in agency and system-level governance, planning, decision-making and evaluation (in general and concerning use of residential treatment interventions in the system of care).

Focus on Outcomes

- Next task—How to operationalize the BBI Joint Resolution?
- Performance Guidelines and Indicators Matrix
  - Meant to apply to both Community providers and RTCs
  - Focused on the interface of care: referral/entry, during and post-discharge
  - Specific, measurable performance indicators developed for all three phases of treatment

Focus on Outcomes

- **Performance Guidelines** are expectations of the practices and processes that occur in the provision of care, services, and supports. These can be assessed through observation, survey, interview, or chart review.
- **Performance Indicators** represent measures that can be tracked, producing 'hard data' with a numerator and denominator, typically using existing administrative data sets.

Examples of Performance Guidelines

- Referral/entry:
  - Formal and informal supports, services, and relationships *(existing and needed)* are inventoried in a comprehensive Community Resource Assessment (CRA).
  - The residential ‘intake’ process is coordinated with existing care providers to reduce duplication of assessments, paperwork, etc.
  - Discharge planning is initiated during intake and incorporated into the treatment and support plan.

Examples of Performance Guidelines

- During residential performance guidelines:
  - Families are consulted routinely regarding everyday care and support of their child *(e.g., haircuts; school achievements, etc.)*, and having regular and meaningful roles in key decisions that need to be made regarding their child's care.
  - Visits cannot be cancelled or abbreviated by staff without the approval of the Child and Family Team (CFT).
  - Leaders act upon quality improvement data to increase the degree to which best practices are implemented and effective in preventing the need for emergency safety interventions.

Examples of Performance Guidelines

- Post-residential performance guidelines:

  The transition plan is a component of the treatment plan. The transition plan:

  a) maximizes service and provider continuity;

  b) actively involves community providers and informal supports well before discharge;

  c) assures that youth who will live independently have demonstrated skills or are enrolled in a comprehensive community-based independent living program at discharge; and,

  d) specifies the supports families and youth will receive during transition and for as long as necessary to increase positive outcomes.

Examples of Performance Indicators

- Referral/entry:
  - Percent of youth and families provided with objective quality assurance and performance data about providers to inform choice.
  - Percent of treatment and support plans that specify a) purpose and anticipated outcomes of residential treatment and support; b) criteria for discharge.
  - Percentage of treatment and support plans that specify how family members *(or surrogate or significant support person)* will actively participate during residential treatment.

Examples of Performance Indicators

- During residential performance indicators:
  - Percent of direct care staff who received training in a) trauma-informed care, b) primary prevention strategies and other techniques to avoid the need for restraint and seclusion.
  - Percent of emergency safety interventions that have a formal debriefing with staff, youth and family members.
  - Percent of youth participating in typical community recreation and youth development programs.

Examples of Performance Indicators

- Post-residential performance indicators:
  - Percentage of youth and families who receive a care-coordination visit within 7 days post-discharge.
  - Percentage of youth and families who continue to receive planned aftercare services for three months post-discharge.
  - Rates of readmissions to the same/similar or higher level of care a) within 90 days, and, b) within one year of discharge.

Self-assessment tool

- Goal—to design an instrument so organizations and communities could evaluate themselves against the performance guidelines and indicators of the matrix.
- A performance guideline or performance indicator begs the question: who is responsible for its implementation and achievement?
- Often the responsibility is a shared one.

Self-assessment tool

- Should be completed by groups of staff, family members, youth and others in the community.
- Results should be reviewed by a cross-functional improvement team that includes residential, family, youth and community representatives and whose goal is to identify areas for improvement.
- Responses might include steps ranging from better communication with family members regarding existing policies, to adopting new treatment approaches, to redesigning professional development activities.

Next steps

- Continuing to ensure we are effectively linking residential (and by extension, inpt) treatment with community care.
- Massachusetts is rebidding 350 million dollars of contracts with BBI concepts written into the Request for Proposals.
- A future where the system is designed with the child and family in mind, rather than the needs of the provider community?

Building Bridges Tools

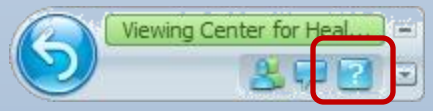
All of the instruments discussed in this presentation can be found at the Building Bridges website at:

www.buildingbridges4youth.org

Questions?

To submit a question please use one of the following options:

•***Ask a Question Online***: Click the ***Q&A*** icon located in the floating toolbar at the lower right side of your screen.



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New Jersey System of Care Re-engineering Residential Care

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Overview

- Principles of Care
- Community-Based Model
- Outcomes
- Model in Action

Redesigning Residential Principles

- Need For Residential Services
  - Clear Need in Community for Residential Care
  - Clear Need for Change in How Care Was Delivered
- System Of Care: Least Restrictive, Most Normative Environment Is For Residential Too
  - Need to Ensure Children and Youth Received Appropriate. and Effective Care
  - Used Best Available Evidence
- Need For More Intense Services, But Less Restrictive Services

Community-Based Model

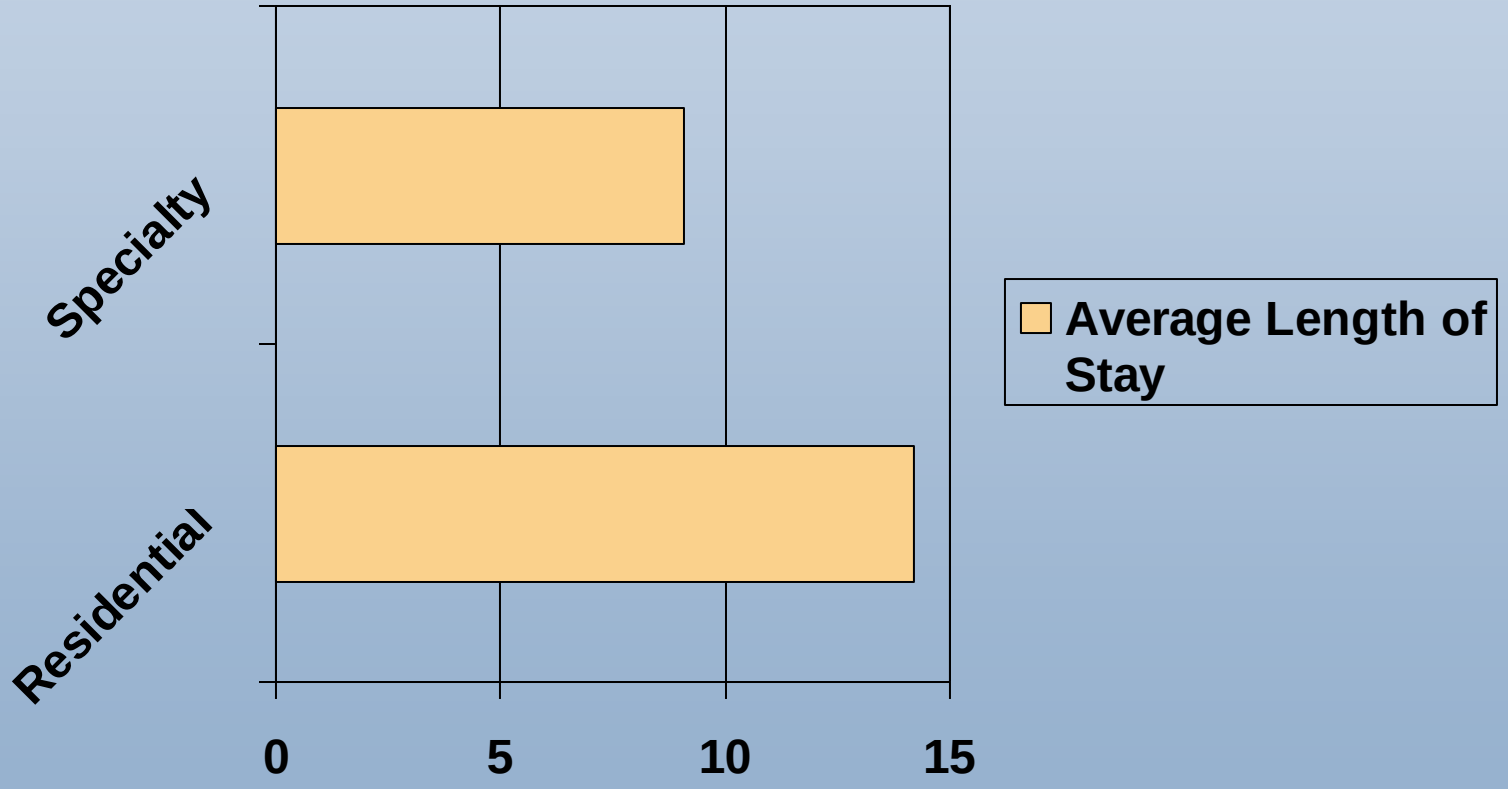
- Small, 5 bed homes
  - Ensure Intense and Individualized Care, with Opportunities for Collaboration
- Integrated with Community
  - Schools and Community Activities,
  - BUT, NIMBY
- Significant Therapeutic Resources
  - Require minimum number of hours of service
- Expectation of Family Involvement

Community-Based model

- Cost
  - Use a Market-Driven, Transparent Methodology for Arriving at Rates
- You Get What You Pay For

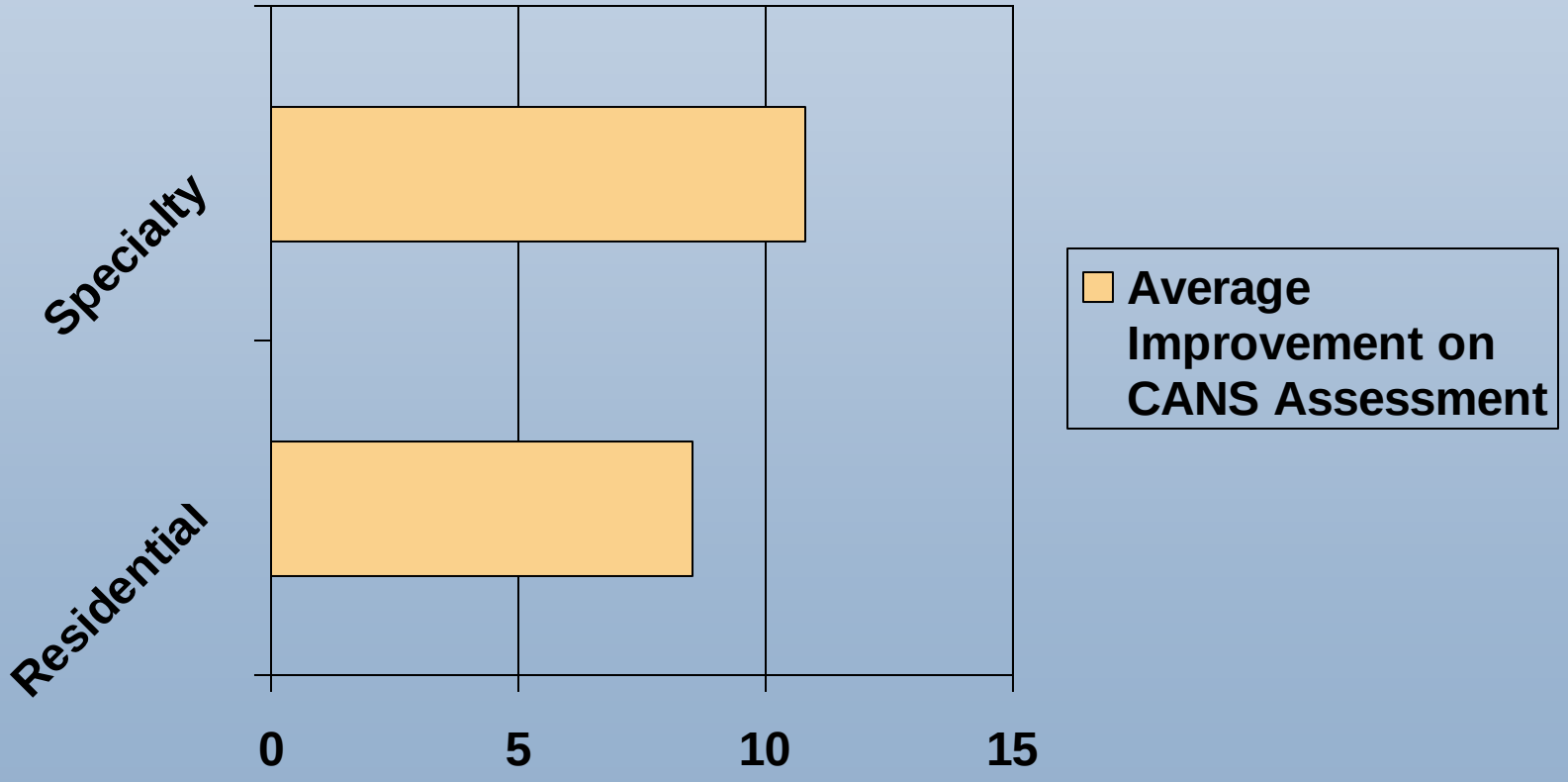
Outcomes: Length of Stay

Significantly Lower Average Length of Stay in Programs



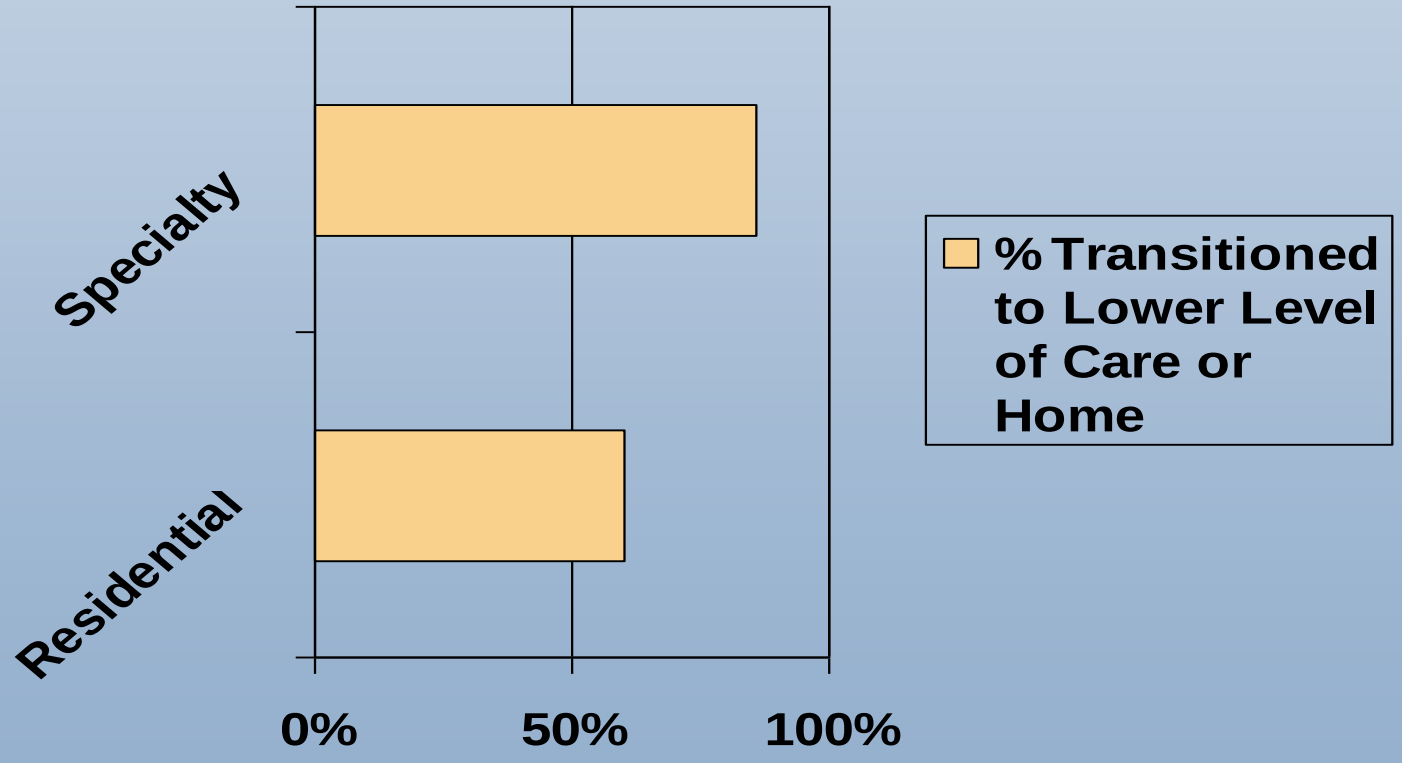
Outcomes: Functional Improvement

More Than 25% Better Improvement on CANS score During Stay



Outcomes: Reunification

Greater Percentage Transitioned to Less Restrictive Services or Home



Re-engineering Residential Care

A Provider's Perspective

Learning to Embrace Change

- Providers learn that the best method for survival is to mimic nature and **ADAPT**
- The first challenge is admitting the flaws of the current program modality in traditional residential care
  - Not community based
  - Large number of youth served in one location
  - Clinical Model is antiquated
  - Contracting Methods leave much to be desired from both the provider and state perspectives

Change in Philosophy

- Change the philosophy from “This is who we serve” to “What do we need to do to serve this child and family?” – as a system changes the youth needing residential care will become more intense
- Reduce the number of youth served in one program (typically no more than 5)
- Adopt a true clinical model and philosophy **program wide** (Trauma Informed Care, Sanctuary, Circle of Courage, etc).
- No eject – No reject

Benefits

- Opportunity for growth and expansion
- New contracting methodology updates old and stagnant rates for service
- Fixed-Rate Per Diem beds provide a stable cash flow and budgeting modality
- The programs are more community based, family friendly, and therapeutically sound
- Better outcomes for kids, families, providers, and the state
- Shorter Length of Stay

Challenges

- New system entities
  - Medicaid – billing difficulties, chase and pay, hospital based billing mentality
  - Case Management Entities – defining the role of each case management entity and establishing a means of accountability can be challenging
  - Tougher kids and families – can mean extended length of stay for certain youth
  - Educational placements can be difficult
  - NIMBY Issues

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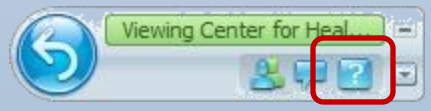

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