

Alaska's FASD/RPTC Medicaid Demonstration Project

DRAFT MODEL DEVELOPMENT

3-M Service Delivery Focus:
Modeling, Mentoring, and Monitoring
Home and Community Based (HCB) Services
for Children with SED and FASD

DRAFT MODEL DEVELOPMENT

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Demonstration Financing

- \$210 million to 10 states over 5 years
 - \$15 million federal match to Alaska for life of project

- Regular FMAP reimbursement
 - Administrative activities @ 50/50
 - No extra money for additional start-up/IT system changes (MMIS/EIS)

- **Allows Alaska to reallocate from PRTFs to HCB services**

- **No new money overall!**

Demonstration Requirements

- “Demo Project” like traditional HCB Waivers
 - mostly same parameters
 - same federal application packet

- RPTC’s become recognized facilities under demo which enables children to
 - meet an RPTC-institutional level of care
 - remain financially eligible outside the institution;
 - if they get disability determination and their income is under 300% SSI

Alaska's Project

□ Problem:

- Target group is underserved and disproportionately experiences negative health and social outcomes.
- Children with co-occurring SED and FASD have more difficulty than others transitioning to adulthood, independent living and adult support systems.
- Data on specialized treatment interventions will be generated to provide evidence of effective practice
- **“Practice Based Evidence” will support 3-M Model and interventions.**

Alaska's Project

- **Target group:**
 - **14-21 year olds** placed in or at risk of placement in RPTC's with
 - **diagnosed** or **suspected** FASD

Participants may choose whether to enter waiver

- **Current Issues:**
 - Inappropriate placements for this population lead to ineffective interventions and larger social issues
 - Increased service capacity in home communities will lead to better outcomes

Implementation Process

- Alaska undertook Implementation Planning January 2007
 - Submission of draft 1915c waiver application to CMS as official implementation plan by July 1, 2007.
 - Final waiver application September 1, 2007 for final approval October 1, 2007
 - **Official Project start date: October 1, 2007**
 - **Provider training begins October 8, 2007.**

3M Design and Development

□ Values

- No child will fail
- Stability for child and family
- Predictable, responsive environment
- Plan for transition and sustainability
- Establish and enhance natural supports
- Simple and lean program design
- Mentor to independence vs. co-dependence

□ Epochs

- Recruitment/Acceptance
- Service Delivery
- Service to Transition

3-M Design and Development

Successful Interventions are based on:

□ Modeling-

- to learn desired behaviors

□ Mentoring-

- consistent reinforcement of desired behaviors

□ Monitoring-

- continual evaluation and data collection for gathering **practice-based evidence**
-

3-M Design and Development

Treatment plans and services are

- Strengths based
- Person centered
- Based on Wraparound model
 - Utilizing mainly natural supports and community inclusion strategies
- Culturally appropriate and competent

3M Design and Development

Services are centered on:

- Treatment and Intervention Mentors
- Community supports/natural supports
- Specialized services
- Specialized living arrangements
- Continual assessment and evaluation of case plans

3M Modeling-Mentoring-Monitoring

3M Design and Development

- Home & Community-Based (HCB) Placements
 - Family home-biological, relative, foster
 - Therapeutic group homes
 - “Supported” independent living

3M Design and Development

Implementation timetable for children not eligible for other waivers:

□ **Phase I:**

- RPTC residents, placed in state **or** out of state, in age group with **confirmed** FASD;

□ **Phase II:**

- **In-state** RPTC placements and those at risk for placement with **confirmed** or **suspected** FASD

□ **Phase III:**

- **Out-of-state** RPTC placements and those at risk for placement with **confirmed** or **suspected** FASD

3M Design and Development

- ❑ Children with confirmed or suspected FASD are ultimately diagnosed through

**Alaska's Multidisciplinary FASD
Diagnostic Teams-12 Teams**

3M Proposed Services

- ❑ **Treatment and Intervention Mentors (TI Mentor):**
An SED/FASD Intensive Habilitation Model will be utilized.
- ❑ **Habilitation:** Using modeling and mentoring techniques, provides assistance with acquisition, retention, or improvement in skills related to activities of daily living and reinforces TIM activities with recipient.
- ❑ **Training and Consultative Services:** training and consultative/counseling for unpaid & paid caregivers to provide and support therapeutic interventions using the “3-M” approach.
- ❑ **Respite Care:** Services provided to individuals on a short-term basis because of the absence of or need for relief of unpaid caregivers.

Treatment and Intervention Mentors (TIMs)

- ❑ **No PA; 12 charges per year.**
 - Every recipient has this services

- ❑ **Scope:** Service delivery components
 - **Modeling to youth:**
 - ❑ Social skill acquisition
 - ❑ Independent Living skills

 - **Modeling to family and other caregivers and providers**
 - ❑ Effective interventions with youth and providers
 - ❑ Behavioral supports

 - **Mentoring to success**
 - ❑ Independent choices
 - ❑ Building relationships for recovery

 - **Daily oversight/monitoring of service plan**

Treatment and Intervention Mentors (TIMs)

- ❑ Average Caseload: should be 3-5 recipients.
- ❑ Service delivery boundaries observed and controls built to prevent TIMs purpose from drifting...into simple "case management"...or habilitation services.
- ❑ Simple documentation and friendly forms:
 - make sure to design for rural areas so it will definitely work in urban ones.
- ❑ Provider agencies need backup plan to support TIMs coordinated with ISP and natural supports included in it.

Care Plan Coordination Services

- **Services are prior authorized**
 - Each recipient receives this service

- **Amount, Duration, Scope**
 - **Care Planning Function**
 - Works with family and community providers to develop an approvable plan of care
 - Leads interdisciplinary team and
 - Monitors Care Plan implementation

 - **Training/Supervision Function for TIMs**

□

Care Plan Coordination Services

Specially trained, licensed Mental Health professional clinicians operating under the scope of their license:

- **Monitoring development and implementation of Integrated Service Plan**

- Supervision of TIM,
- Ongoing TIM training
- Plan approval and review
- Family networking

- Services are prior authorized**

- Each recipient receives this service

Training and Consultative Services (TRaCs)

- Professional level or paraprofessionals who work under the direction of a licensed professional. (e.g., someone trained as a parent navigator)
 - Specific training for families/TIM's/other natural supports:
 - advocacy, skills training, consulting.
 - Patient Education, family stabilization
 - Home care training to home care client
 - TIM training to families and community supports
 - System navigation

Habilitation

Service Scope:

direct service worker helping with ADL's with youth. Engaging in activities at the ground level. Not activities adjunctive to case plan. Not a case manager; but our model includes mentoring and modeling at all levels.

- 1-to-1 services to learn daily living skills that maintain skill levels. (not rehab)

Services defined by location:

- Residential Habilitation- takes place where you live (sleep at night) out of home placement-res, foster care (adult and child), adult must be in AL licensed home. Services in biological family home
- Day Habilitation – takes place out of your home. Services out-of-home care...must be licensed care per Keyes amendment and you must have a way to prevent paying for services in unlicensed home.

Licensed residential care: Day rate

Non-licensed: Bio parent, relative - Independent living: 15 minute units of service

3M Proposed Services

Services specifically designed to support the transition to adulthood

are offered to youth **ages 17-21** in this demonstration project:

- **Supported Employment:** Paid employment for individuals for whom competitive employment at or above the minimum wage is unlikely, and who need intensive ongoing support to perform in a work setting.
- **Community Transition Services:** Pays non-recurring set-up expenses for transitioning into the independent community living placements. E.g., security deposits, etc.

A Day in the Life of Janie B.

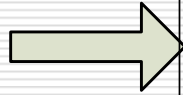
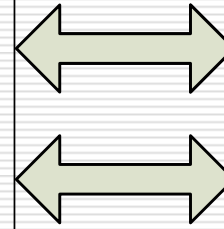
Data Pull: Id's Pool of Potential Recruits
 Janie B is:
 Medicaid Eligible
 Currently in RTPC
 FASD Dx

Centralized Coordination Contact for DHSS:

Care Coordination Function
 Current data on child
 Evaluate discharge plan with RTPC
 If more data needed
 Demonstration acceptance criteria
 -family/ guardian readiness
 -community readiness/geography
 Number and quality of supports
 -eligibility maintainence
 -other waiver eligibility

**RPTC Discharge
 Planner**

**Family
 OCS/DJJ
 DPA
 DSDS**



**Family contacts CPC who
 Provides list of qualified TIM's in their
 region**

CPC begins process of active case planning
 with family/RPTC/TIM and develops the
Integrated Service Plan.

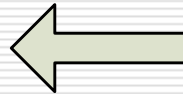
CPC continues in ACTIVE oversight role of the
 ISP and the TIM's activity, helping to insure
 fidelity to the model. Model will define minimum
 number of in-person visits w/ CPC and family/
 TIMS/youth ;telemedicine potential for ongoing
 supervision also.

Child is accepted into Demo.

Family notified w/ 30 days to respond (DOL approved notices)

RPTC gives family list of Agencies w/ Qualified Training and
 Consultation Clinician (CPC)

DHSS follows up to ensure contact is made and hand off is complete



TIM monitors **ISP** implementation and effectiveness.

(CPC monitors **ISP** and **TIM** effectiveness, and authorizes
 changes to ITSP.)

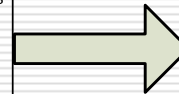
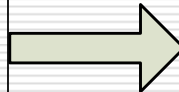
TIM will also do periodic Functional Assessments and
 monitor Medicaid eligibility issues while coordinating
 renewals with LOC/Func reassessments, POC reviews,
 etc...

TIM will report changes to DPA that affect eligibility, e.g.,
 hospitalization, jail, change in placement, state residency.

**Reassessment for continued eligibility in waiver
 must be**

- 1) done by State of Alaska
- 2) annually
- 3) include same criteria as entrance to waiver.
 - a. Needs to build a map for the feds that
 criteria is same at entry as at reassess.
 - b. Need to coordinate with SSI and Medicaid
 reauthorizations, to simplify

CAFAS appears to be preferred functional assessment-
 fencensus of group is for demonstration project, this
 needs to be a standardized tool to ensure valid data
 collection for our practice-based evidence.



Integrated Service Plan (ISP).

ISP builds on RTPC discharge plan and becomes transition plan and
 includes documentation of all other case plans e.g., IEP, health care,
 CMHC, OCS/DJJ, etc. eliminating: redundancy of services and
 efforts, double billing, various teams working at cross purposes. Is
 also transition plan for aging out of demo.

Serves as Plan of Care (POC) required by waiver and services in it
 must be in place before child can be discharged.

NOTE: 3 mo average for transition planning into community; TRaC's/
 TIMS are paid w/ admin money until child is discharged and on
 waiver....

Training

Training:

BH Professionals have a Master's or above and may be licensed

BH paraprofessionals have less than a masters and may be licensed or not

All service workers will be certified in FASD supports and the 3M model through process and program determined by DHSS.

Family members and other community supports should be certified in FASD supports and the 3M model through process and program determined by DHSS.

FASD Demo Project Service Definitions

Epoch 2: Service/ISTP Development & Delivery

April 11, 2007

DRAFT

3-M Design and Development

Treatment plans and services are

- Strengths based
- Person centered
- Based on Wraparound model
- Culturally appropriate and competent

Integrated Service Plan (ITSP)

- Case Planning
 - Plan of Care –ISP-as required by Waiver is person-centered plan developed by CPC/youth/family/TIM and all other supports.

- ISP required to be on waiver
 - Discharge from PRTF=waiver services must be authorized by state
 - All supports required to be in place, within ISP, to turn on waiver:
 - Providers enrolled and agree to provide services
 - Approved ISP delineates frequency, duration and scope of services
 - \$ amount and participant room on waiver is ensured with federal authorization (through overall budget approval)
 - LOC/Medicaid eligibility revisited to ensure continued eligibility must be approved and documented.
 - This review is a state function.

Integrated Service Plan (ISP) Model

- Central point of contact- DHSS
 - relays waiver acceptance to all other players identified: DPA, DSDS, youth and family, providers (CPC/TIM)
- ISP involves **all** providers of services, including regular Medicaid.
- TIM monitors plan implementation and effectiveness
- CPC monitors ISP effectiveness and TIM and
- authorizes changes to ISP
- Will also do quarterly Functional Assessments but reassessment for continued eligibility in waiver needs to be:
 - done by State of Alaska
 - annually
 - include same criteria as entrance criteria to waiver.
 - Needs to build a map for the feds that criteria is same at entry as at reassessment.
 - Need to coordinate with SSI and Medicaid reauthorizations, to simplify
- TIM will monitor Medicaid eligibility issues and coordinate renewals with LOC/Func reassessments, ISP reviews, reporting changes to DPA that affect eligibility, e.g., hospitalization, jail, change in placement, state residency.

Draft Training Model

- **Certification Training for TIMs, Tr/C and possibly other waiver providers:**

- **Long term plan:**
 - Training to be built into existing training resources including university program for credentialing in order to institutionalize it into existing systems (i.e. Center for Resource Families, BH Aid training, Rural Human Services training, etc..) and ensure that students can build on it for higher levels of education.

 - Waiver providers may be expected to obtain training independently prior to being hired OR they would have the option to obtain training within a set timeline after being hired.

Draft Training Model

- **Short term plan:**
 - New model and no workforce trained in it.
 - DHSS will host a 3-5 day training in October and will fund the training for the first group of TIMS and TraC's to attend. This session may be open to other providers in demo communities also.
 - This group may include: parents/foster parents for the first group of children to be served by the waiver, other in-state experts who are not working directly with the project but will be resources, FASD team members, DHSS staff working with the waiver, special education professionals, vocational rehabilitation, etc.

- **Training model utilizes local and national experts and Alaska families.**

Draft Training Model

□ Rough outline of training structure and content:

- Pre-requisite of FASD 101 and possibility some other listed topics to be completed via pre-or post-class.
- Pre-meeting: FASD 201 with Alaska FASD experts
- Person-Centered Planning and the ISTP
 - Care Coordination within the ISTP
- Overall trainer & facilitator: What the waiver is & how it will enhance our system: Intro to 3-M model
- Ethics and confidentiality training
- Service description : definitions and boundaries in practice
- Family track: supports & how to use the waiver, role of parent navigators, other non-Medicaid supports
- Physical (environmental) and program design
- Positive behavioral support for school success and in community and work settings

Draft Training Model

- Dx Team referral and evaluation information
- MH System & Clinical track: SED overview: behaviors
- Child development/Family dynamics
- Medication training-e.g., symptoms, side effects, prompting
- De-escalation techniques without restraints
- Restraint usage regulations/policies
- Billing training with billing manual/documentation
- Wraparound facilitation training
- Bringing it all together - How the waiver will function in communities

Alaska's RPTC Demonstration Project

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