Reducing Reliance on Children's Residential Care Settings

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- American Indian Mental Health Council, AspireMN, DHS Asian Heritage Employee Resource Group, county juvenile probation and detention workers, children's residential administrative and direct care staff, managed-care organizations, NAMI Minnesota, tribal and county social service agencies, school professionals and the parents and youth who volunteered their stories and voices.

Recognition of Past Trauma and Abuse

- The state of Minnesota and the Department of Human Services recognize the trauma, medical abuse, and discrimination that have happened to our Black, Native/American Indian, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine and social service providers.

- The work of equity and antiracism requires that we are all actively committed to rebuilding trust with communities and bringing community members' voices to the table.

Study Overview

- The legislature allocated administrative funding for DHS to conduct an analysis of the utilization and efficacy of current treatment options for children under Minnesota's Medicaid program to identify systemic obstacles in transitioning children into the community and community-based treatment.
- The analysis identified crucial points during a child's care where the system missed the opportunity to transition the child to family-focused, community care models from residential settings.
- DHS collaborated with a wide variety of stakeholders including counties, tribes, the Department of Education, hospitals, children's treatment facilities, social workers, juvenile justice officials, and parents of children receiving care.

Demographics of Children Experiencing Residential Care

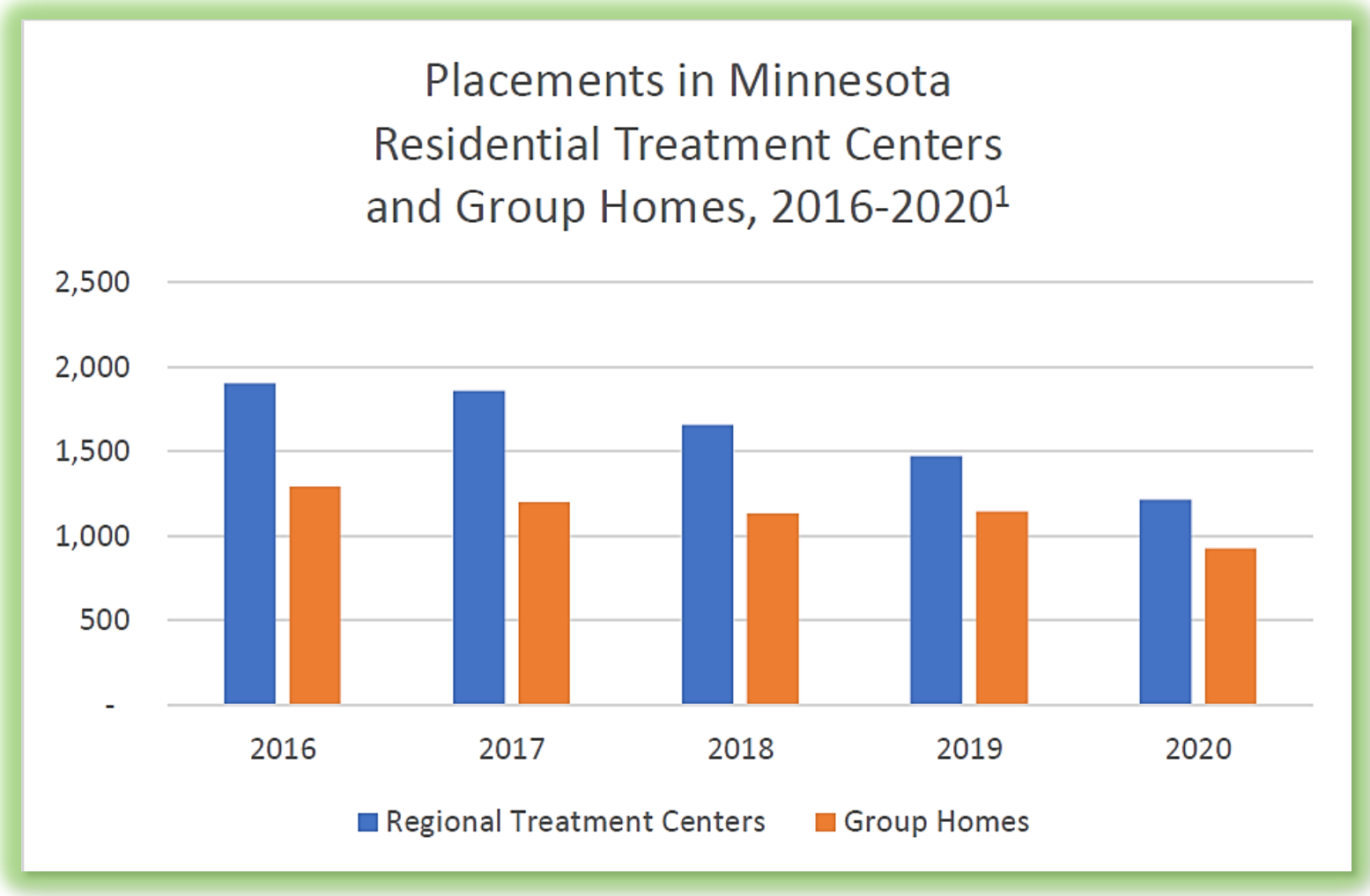
Minnesota:

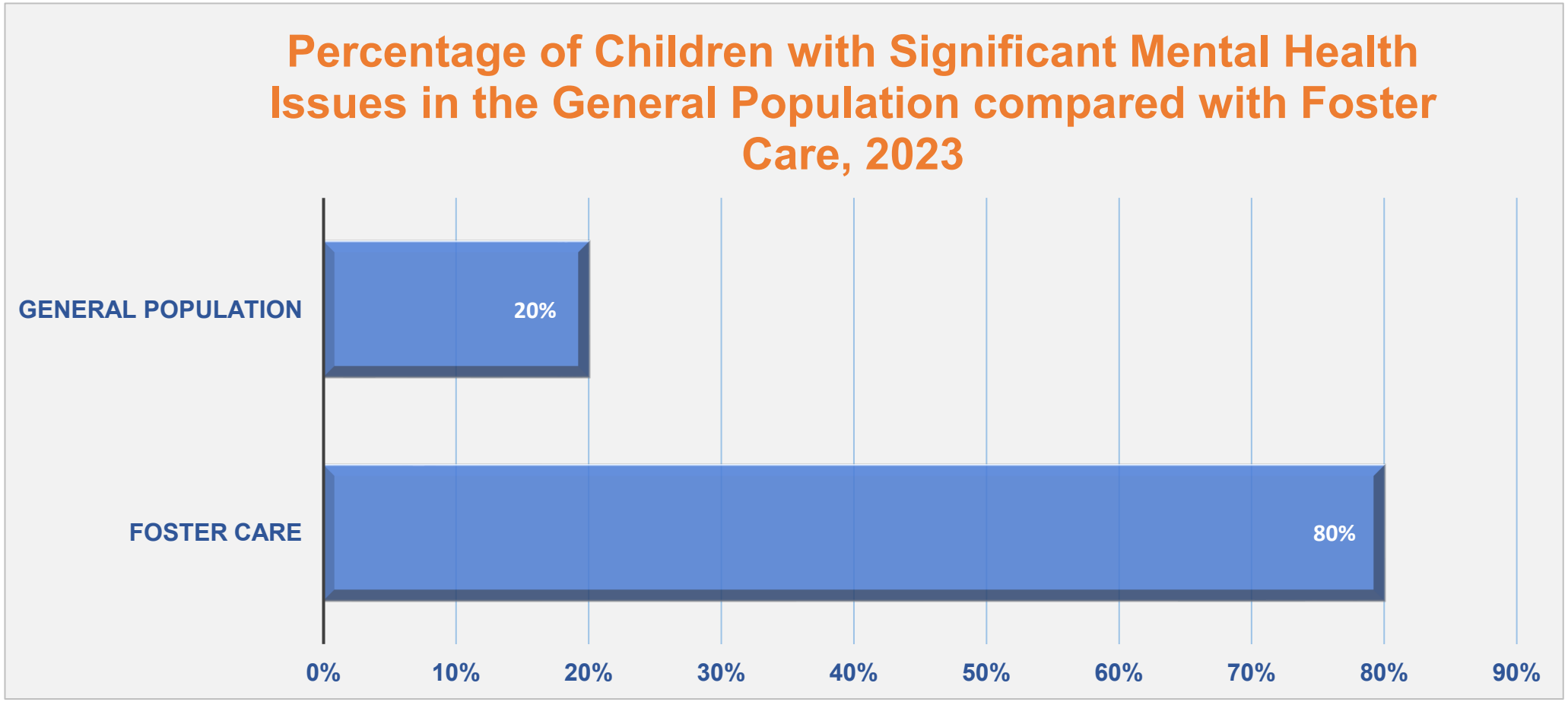
- Out of home treatment for American Indian and Black youth as 14.6 and 1.4 times the overall population (Children's Defense Fund, 2023)
- 29% increase in children experiencing foster care from FY2012-2021

Nationally:

- In 2019, Black children and youth comprised 26 percent of young people in residential care and only 14 percent of the total population (Children's Bureau, 2018)
- Black male youth are particularly overrepresented; they are almost 30 percent more likely to experience residential care than other young people (Capacity Building Center for States, 2020)

Number of Children in Minnesota Residential Treatment centers and Group Homes, 2016-2020





(Office of the Administration for Children & Families, 2023)

Top Medicaid Diagnoses for Children in Residential Care- MN

Minnesota Medicaid Data, Fiscal Year 2016 – 2022: Top 5 Diagnosis by Gender of all Races:

Female	Male
Stress disorder, unspecified	Hyperactivity disorder, combined type
Attachment disorder of childhood	Stress disorder, unspecified
Hyperactivity disorder, combined type	Defiant disorder
Depressive disorder, recurrent, moderate	Attachment disorder of childhood
Defiant Disorder	Unspecified psychosis not due to a substance or known physiological condition

Gaps in Care

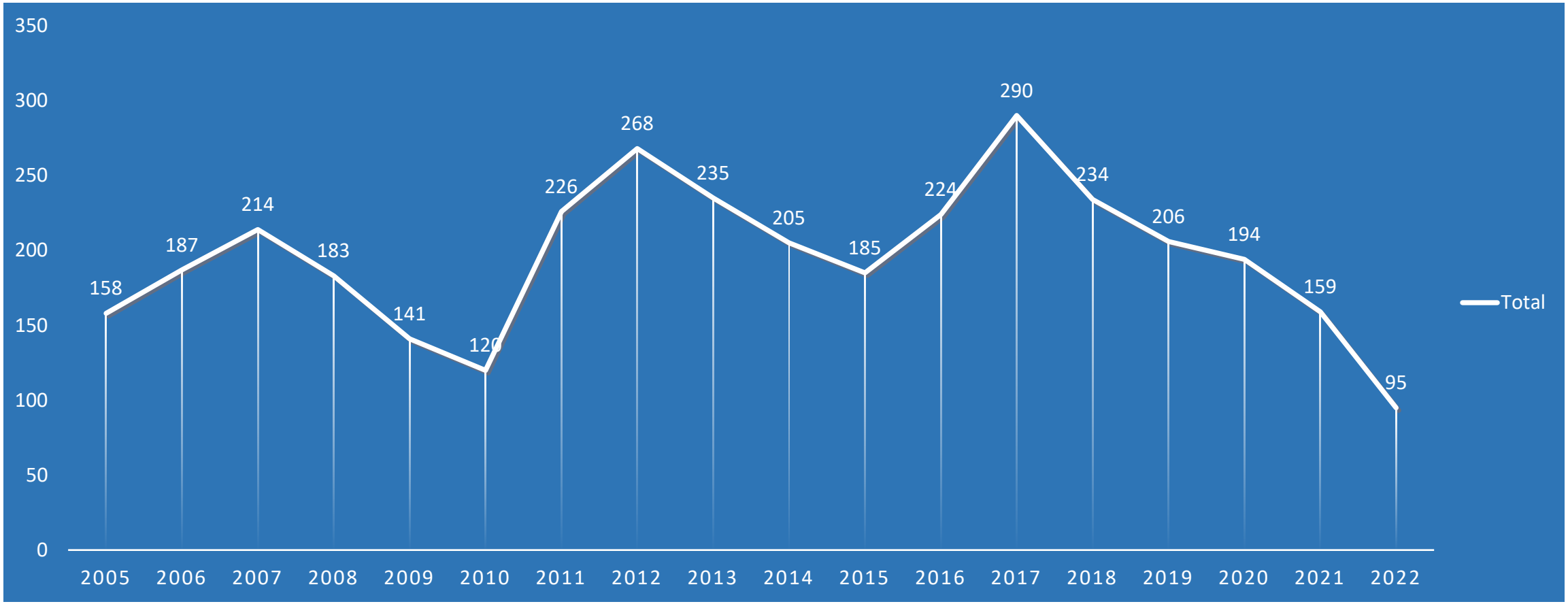
In 2021, there were a total of 501 children in residential treatment centers in Minnesota, of which 291 in Juvenile Correctional Facility.

159 children that same year were sent out of state for treatment due to being unable to access appropriate care in Minnesota.

In 2022 more than 700 youth involved in juvenile justice were referred for diagnostic assessment. Of these youth less than half received an assessment.

For youth that did receive assessments it is unknown as to what services, if any they were referred.

Graph: Number of Events where Children have been sent out of Minnesota over time, Minnesota Medicaid Data/ Interstate Compact on Placement of Children (ICPC), Calendar Year 2005 - 2022



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Demographics of Children sent out of the state of Minnesota, Minnesota Medicaid Data/ Interstate Compact on Placement of Children (ICPC), Calendar Year 2005 - 2022

Racial Group	Distinct Count of Individuals	Count of Events	% of Race Group Experiencing more than one out-of-Minnesota Experience
Blank Race – No record in MMIS	598	704	14.91%
American Indian/Alaskan Native	86	118	27.12%
Asian	25	31	19.35%
Black or African American	447	568	21.30%
Multiple	131	172	23.84%
Pacific Islander/Native Hawaii	Masked	Masked	Masked
Unable to Determine	478	581	17.73%
White	1,103	1,347	18.11%
Grand Total	**2,872**	**3,524**	**18.50%**

Top Receiving States by Numbers of Minnesota's Children, Minnesota Medicaid Data/ Interstate Compact on Placement of Children (ICPC), Calendar Year 2005 - 2022

State	Distinct Count of Individuals	Count of Events
Wisconsin	1,579	1,845
Iowa	427	482
South Dakota	315	360
Utah	300	347
Missouri	70	76
Indiana	50	56
Michigan	42	50
Texas	28	32

Community feedback

- Engagement with counties, tribes, providers and community members along with previous research has shown a lack of adequate support to help children and families seek appropriate level of care in their communities or to be able to remain in their communities
- Some of the issues identified in community discussions include:
  - Lack of capacity/ workforce to serve children and youth who have complex behavioral health needs
  - Limited availability of intensive services that have research-based effectiveness
  - Limitations in the availability of individual outcome data to assess effectiveness across the array of services

Highlights

States need to use their data strategically. Information about how youth enter and exit residential care is foundational to more effective management of residential care.

- No uniform data on outcomes, SSIS only captures date spans for residential stays, no reliable diagnoses and minimal demographic info
- CRF MA medical necessity is largely determined by county screening teams with great variability in practices
  - PRTF determined by AFMC (medical review agent)

Need to understand what populations of youth are most likely to use residential care, for what length of time, and what services they may need to stay in family settings.

- Children of color overrepresented
- Trend is overall lengths of stay are shortening but many children remain stuck due to lack of appropriate step-down services

Highlights

Ensure an array of community-based interventions are available to serve young people and their families as part of the work to reduce reliance on residential care

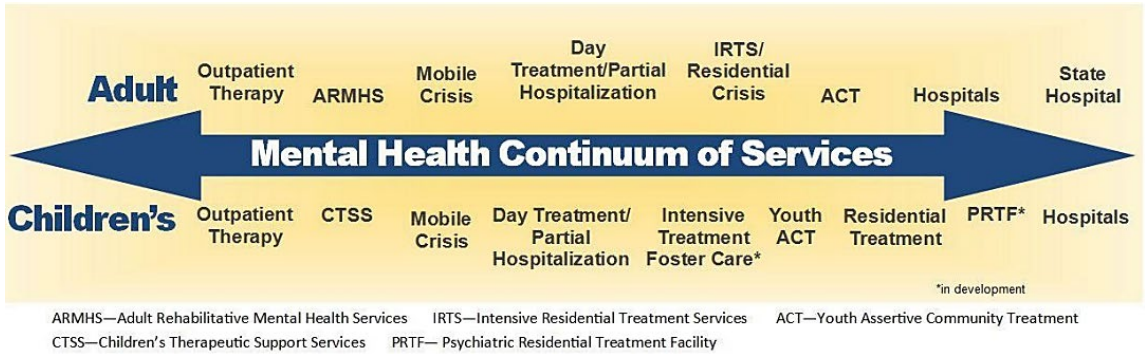
- Many children boarded in Hospital EDs and discharged due to aggression related to untreated psychiatric conditions end up in juvenile detention where they receive limited to no services or cared for by untrained correctional staff
- Children of color exposed to justice system and may enter school to prison pipeline as a result
- System silos between DHS and DOC contributing to problem
- Licensing for both admins needs to work together along with courts to find ways to obtain appropriate services for these children without being labeled as juvenile offenders

Highlights

Most successful approaches to managing residential care utilization are truly cross-sector in nature, putting young people and their families as the center of focus, rather than focusing on child welfare or mental health systems

- Minnesota does not currently utilize a centralized interagency out of home care committee or process

Timely, high quality, trauma-informed assessments conducted by trained clinical professionals are essential to understanding the situations of young people and to effectively plan for services/support they and their families may need



Highlights

Room to build quality-driven payment reform and new rate-setting strategies into the residential care treatment space.

- IMD situation where CRFs are not able to receive FFP and dependent on host county rate. This creates huge disconnect and lack of uniform standards/ processes for providers
- Counties with limited resources are at a disadvantage
- Current 2960 licensing rule not clear about clinical quality and lacks outcome measures
- 1115 waiver should be considered for increasing reimbursement options and improving standards of care

Investment in the workforces of residential care facilities is critical to ensuring young people receive high quality care

- Interviews with direct care staff revealed people are leaving the field due to lack of career path, impacts of vicarious trauma, exposure to violence and physical assault and lack of financial incentive
- Workforce will continue to suffer unless incentives created, and supports for impact of exposure to trauma

Highlights

Children's Residential Facility Capacity loss in MN
(defined by MN Rule 2960) [1]

YEAR	LICENSED BEDS
2005	2,474
2023	1,586

AspireMN, 2023

All partners involved in providing services to youth and their families need training in trauma-informed screening, assessment, service planning, and trauma-focused care

- Community-based services such as Youth ACT, Intensive Treatment Foster Care (Children's Intensive Behavioral Health Services) and CTSS operate in silos apart from residential care and each other

Recommendations

Financial Relief to Children's Residential Facilities:

- **Work force measures for Youth Care Professionals (YCPs):**
  - Explore and identify flexibilities through establishment of formal mentorship programs that will enable new staff to gain exposure to real-world working conditions while awaiting background check, particularly with children and youth.
  - Development of a strong and dedicated youth behavioral health workforce
    - Establishing youth direct care professional as a viable career path, offering attractive incentives and professional growth opportunities.
  - Increase recruitment for direct care professionals of diverse backgrounds through enhanced incentives and benefits.
  - **Establish a Youth Care Professional Training Institute**
    - Include opportunities for Juvenile Justice professional to receive trauma-informed care training.

Recommendations

Financial relief continued:

- **Grants to support physical environmental changes, retention and hiring of YCPs.**
  - Ex. Creating more therapeutic and welcoming environments for children with trauma and sensory issues.
- Onsite psychological support for YCPs
- Training grants for therapists working in residential facilities.
- DHS and MDH to work with different licensing boards to support the youth care professionals working in the residential settings to establish a path to become independent mental health professionals.
- Specialized grant programs focusing youth care professionals' retention in the work force across the State including DOC and DHS licensed facilities.

Recommendations

Invest in Aftercare and Community-Based Services

- Increase funding and grant opportunities for Community Based Organizations (CBOs) providing culturally relevant care to enhance prevention/ intervention and aftercare/ step-down services for youth transitioning out of residential care.
  - Community-based services are key to helping reduce the revolving door and recidivism that produce costly overreliance on hospitals and residential care
- Investment in kinship family settings
- Expand mobile transition services for children in residential facilities to mitigate risks of future out of home treatment.
- Continue to build and consolidate the changing philosophy in Minnesota programs to help families function more effectively rather than on fixing the child's problems.
- Investment in residential programs to provide resources for implementing innovative approaches such as the Building Bridges Initiative.
- Fix the Medicaid outpatient community-based rate structure so early intervention and transition care is available to children and families
- Expansion of family-centered in-home children's mental health services that can assist in transitioning youth away from institutional care

Investment in availability of high-quality, trauma-informed assessments to ensure tailored and effective treatment interventions with clear outcomes.

Recommendations

Increase funding and grant opportunities for Community Based Organizations (CBOs) providing culturally relevant care to enhance prevention/ intervention and aftercare/ step-down services for youth transitioning out of residential care.

- Community-based services are key to helping reduce the revolving door and recidivism that produce costly overreliance on hospitals and residential care

Counties using emergency departments as shelter for children in foster care who do not meet medical necessity to access hospital level of care, counties have had instances of staffing children in hospital EDs as a contribution to the shelter care at the hospital.

- Opportunity to develop more appropriate responses to children that meets their needs for care without accessing safety net care that is not medically necessary

Community-based group care is a desperately needed level of care for many children who require a step-down structured environment to sustain stability and also engage in developmentally appropriate growth in the community at the child's highest level of community engagement/least restrictive level of care

Many children whose needs exceed or are not aligned with what can be offered within the residential treatment milieu are children with disabilities, sometimes co-occurring with mental illness and more often the co-occurring need is behavioral in nature. There is an insufficient service array that can design treatment and individualized care responses to support these children – within group home care, residential treatment or an intensive care response within foster care settings, and, the flexibility to create this care between service silos is needed.

Recommendations

a. Fix the Medicaid outpatient community-based rate structure so early intervention and transition care is available to children and families

   i. With a functional rate structure providers can:
      1. deliver early interventions and prevent more acute care,
      2. grow the field to individualize treatment and respond to externalizing mental health symptoms (instead of simply identifying residential treatment as needed out of fear or a lack of other options)
      3. help design and provide needed aftercare, and,
      4. elevate the critical component of family engagement/care coordination and team-based responses to children's needs that currently are not attended to as they should be due to a lack of resources

Recommendations

Systemic/Administrative:

State to apply for 1115 waiver in partnership with community providers after seeking active engagement from parents and youth to do the following:

- Provide federal reimbursement for short-term residential treatment stays in children's residential facilities designated as IMDs (Institution for Mental Disease)
- Enhance treatment and outcome standards of care for participating providers
- Increase access through enhanced eligibility standards based on medical necessity

DHS to review and revise MN Rule 2960 standards of care. DHS to look at possible alignment between 2955 and 2960 to support serving youth with aggressive and inappropriate sexual behavioral concerns.

Recommendations

Systemic/Administrative continued:

DHS, DOC and counties to look at current system of screening children/youth for residential stays in the context of Third Path and identify the obstacles in having an objective, equitable system of determining need for residential interventions. This includes clarification and documentation of the process when youth are being sent out of State for treatment.

Explore revisions to MN 245.4874 statute to allow earlier access for juvenile-justice involved children to receive diagnostic assessment.

- Requires children to have committed three petty offenses before assessment

Explore and recommend a child-focused and uniform model of reimbursement for Children Residential Facilities to support the facilities in MN to treat children with complex needs and mitigate out of state need for treatment. Some examples could be "money follows the child" model with following options:

- Tiered reimbursement that incorporates gradient for working with more acute situations
- Need based rate that can include parents/ family needs such as housing, food, income stability, etc.
    - Incentives for building more diverse direct care staff.

Recommendations

Redefine and Revise Approach Data Utilization:

Initiate and sustain community driven models of seeking community input in co-creating treatment and prevention interventions for children and youth through use of tools such as Community Toolbox

Data system to track youth care professional work force and conduct analysis to mitigate loss of work force.

Development of a comprehensive statewide data system that tracks the treatment history of youth.

- Explore enhancements to SSIS or development of new system that meets needs of youth involved in multiple residential stays.
    i. Any recommendations regarding data including SSIS enhancements should consider the impact to the end user, which are our front-line case workers at the county level.
    ii. To effectively collect and use data to improve outcomes, we need an investment in an integrated data system that works across state departments and ideally supports a young person's treatment team members to input their respective data.
- Need to disaggregate data to understand needs based on gender, disability, ethnicity etc. to identify health inequities.
    - Need for community input, particularly for those most impacted by tracking this data.
    - Acknowledge and encourage the power of narratives of youth and families. Invest in qualitative data collection strategies to capture unique struggles, aspirations, needs and strengths of Medicaid enrollees, through an equity lens.

Your perceptions

- Are recommendations feasible?
- Feedback?
- What resources will be needed?

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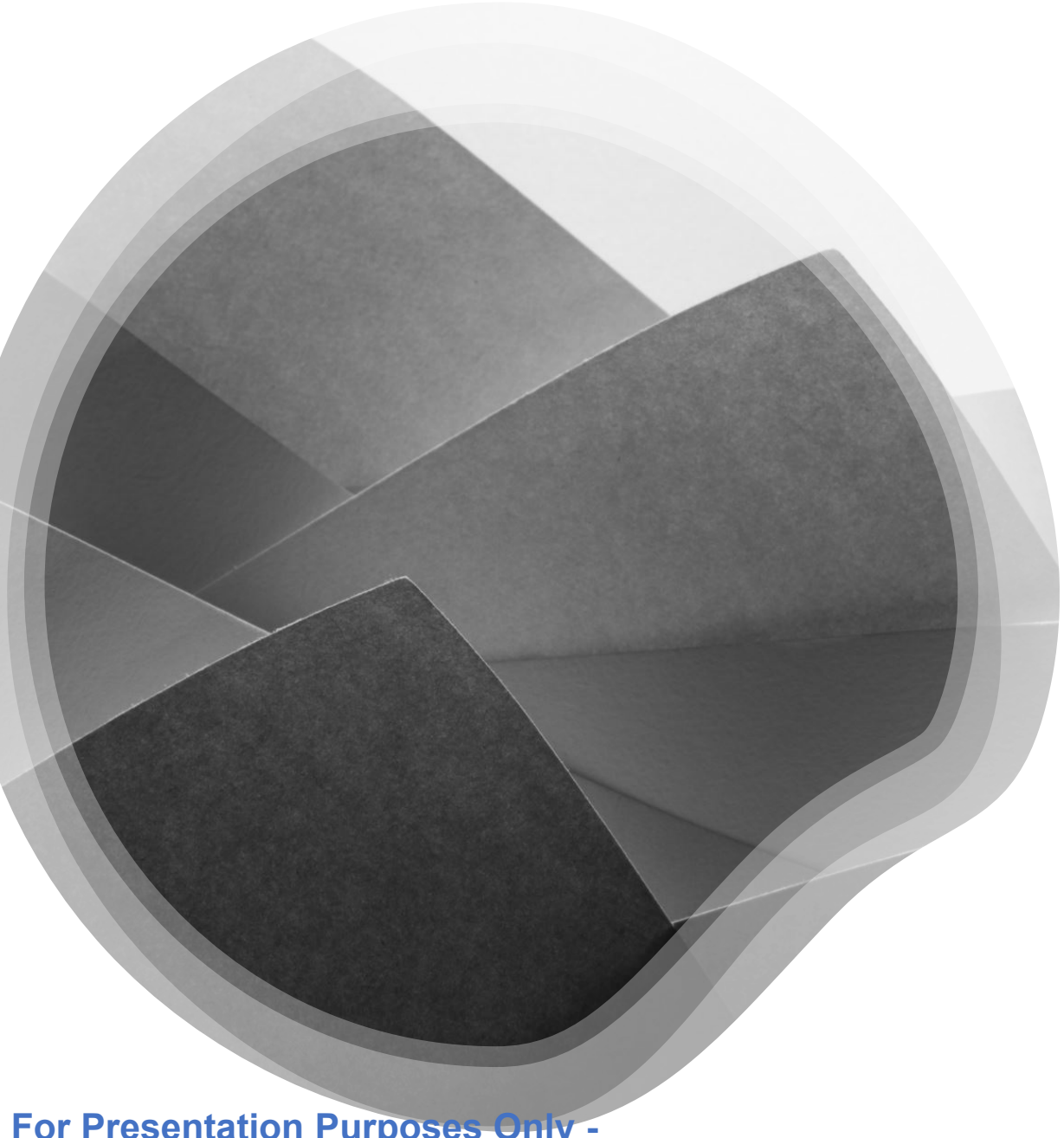

Comments or Questions

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