

Children's Continuum of Care Task Force
Report and Recommendations
Presented to Wes Cole, Chair, GBHSPC
December 7, 2017

The Children's Continuum of Care Task Force, CCC, was established at the request of Secretary Tim Keck of the Kansas Department for Aging and Disability Services. The CCC operated under the auspices of the Governor's Behavioral Health Services Planning Council in consultation with the Children's Sub Committee of the GBHSPC.

The charge for the CCC was to develop recommendations and specific plans of implementation for the delivery of behavioral health services to youth in Kansas. In our first meeting Secretary Keck stressed the importance of issues impacting youth in foster care, PRTF wait lists and other youth needing services and asked the CCC to focus on barriers and gaps that could alleviate concerns in those areas.

The CCC met five times between August 3 and November 15, 2017. During those meetings reviews of previous mental health and substance use disorder initiatives and current capacity and accessibility of children's behavioral health services and resources were completed. In reviewing those reports and recommendations obvious gaps and barriers in behavioral health services for children, mental health, prevention, substance use disorder treatment, housing and education were identified. The identified gaps were numerous. The CCC categorized the barriers and gaps into broad categories. The CCC then voted on three specific areas to focus our work where we believe the largest and most immediate impact could be achieved. Three workgroups were established to work on Early Childhood, Psychiatric Residential Treatment Facilities (PRTF) and Prevention. Those reports with recommendations are contained in this document.

A special thank you to all of the volunteers on the CCC Task Force and an extra thank you for the lead person on each of the three work groups; Ted Jester - PRTF Workgroup, Jane Adams - Prevention Work Group and Erick Vaughn - Early Childhood Workgroup.

While there is much work yet to accomplish within the multiple systems of care for children and families, much research, thought and planning went into this report. The CCC believes the recommendations within this report represent the most critical areas needing attention to improve the continuum of care for children and families in Kansas.

The CCC Task Force appreciates the opportunity to participate in this important work and stands ready to assist in further planning, refinement and implementation of these recommendations.

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SUMMARY OF RECOMMENDATIONS

1. Increase in PRTF bed capacity –
 - It is recommended that KDADS conduct data and trend analysis on PRTF bed utilization and waiting lists to determine the need. The number of additional beds should be planned to shorten or eradicate the waiting lists. Special populations such as pre-adolescents, children with developmental disabilities and females should be taken into consideration.
 - We recommend KDADS meet with PRTF stakeholders and support building capacity throughout the state where needed.
2. Re-establish the true purpose of PRTF –
 - Restore at least the minimum 60-day prior authorization period and subsequent utilization reviews within every 30 thereafter coinciding with the Individual Plan of Care until such time the youth is progressing toward completing treatment and discharge is imminent.
3. Use CMHC Clinicians and CBST as part of the Assessment, Utilization Review and Treatment and Discharge Planning process –
 - Require the utilization of the local case manager or QMHP to gather information (similar to what is gathered during a screen) and provide this information to the CBST and MCO prior to making a placement decision. MCOs will have a much more thorough picture of the situation to make a more informed decision, including what services are available and could be implemented in lieu of a PRTF admission.
 - If youth/family are unknown and not in services, have the CMHC enroll the youth/family (complete an intake) as part of this process so services may be provided prior to and after PRTF treatment, or in lieu of a PRTF admission altogether.
 - Convene the CBST as before and collectively with the MCO make a determination for admission or diversion.
 - Include the CBST in all URs, Plan of Care development, treatment and discharge planning (this will help with a warm handoff at discharge and the development of a community-based treatment plan).
 - Restore PRTF Liaison services: MCOs would subcontract with CMHCs to provide PRTF Liaison positions and services to facilitate discharges, warm handoffs, and continuity of services to support successful transition and long term stability.
 - Reimburse CMHCs accordingly and fairly.
 - i. QMHP billed T1023 for conducting screens. It is a flat rate of \$350 and covered travel and out of office time. Typical assessment took an average of 3 hours to complete.
 - ii. CBST billed H0032-HA; it is a flat rate of \$400.
 - iii. We provide these rates for informational purposes only and not as a recommendation. KDADS and KDHE should facilitate a meeting with MCOs and CMHC representation to negotiate appropriate reimbursement.
4. Promote and incentivize in-home family therapy and transition planning –
 - In order for there to be a bridge between the child/youth and family's residential treatment experience and their successful transition back into community life we recommend a planned process that includes in-home family therapy. This process would begin with the family as soon as the child entered a PRTF and continue through their stay. It would also

follow the child and family for several months after discharge. This could be arranged by the PRTF providing the therapy directly or by them subcontracting with a CMHC.

- We would also recommend the use of Parent Management Training of Oregon in the in-home family therapy process due to extensive research that demonstrates effectiveness with exactly this population.
5. Restore university contract to collect data and analyze trends such as the KU ROM, Ohio Scales and CMHC outcomes.
 6. Kansas should recognize the use of the Diagnostic Classification: Age 0-5 (DC:0-5) for diagnosis and treatment of children birth through 5 years of age.
 7. State should define, establish and identify a required credentialing and training program for early childhood mental health providers, and have such program in place before requiring its use.
 8. Re-evaluate and increase parent support service.
 - Re-evaluate the idea of persons with lived experience parenting a child with severe emotional disturbance and/or substance use disorders as a requirement for Parent Support and explore the barriers that CMHCs encountered in providing that service under that requirement.
 - Increase, at a minimum, the payment for parent support to a level commensurate with adult peer-to-peer services.
 - Require state or national certification with training needed to inform the full scope of work and maintain fidelity to practice.
 - Expand the availability of parent peer support specialists to all parents whose children with SED/SUD are enrolled in KanCare.
 - Explore national and state models of parent-to-parent peer support for best fit to Kansas rural, suburban and urban populations and the geographic and ethnicity of the state.
 9. Elevate and expand wraparound planning the national NREP/SAMHSA evidence based process for children's services across the continuum of care for all KanCare eligible families whose children have severe emotional disabilities.
 - Require that Kansas wraparound is based on the National Wraparound Initiative and directs the planning process used statewide for Kansas children with serious emotional disturbance.
 - Secure training from NWI endorsed wraparound trainers for facilitators, supervisors and coaches as well as service planning partners, including youth and their families.
 - Maintain fidelity to the national model by collecting data on team process as well as child outcomes, satisfaction of the family, and cost effectiveness of community based services.
 - Authorize funding for a pilot site to examine Kansas outcomes using national wraparound model with the intent of moving the NWI service planning model statewide.

Psychiatric Residential Treatment Facility Subcommittee Report and Recommendations

Under the guidance of the Children’s Continuum of Care Task Force, this subcommittee was tasked with examining and assessing psychiatric residential treatment facility (PRTF) utilization and identifying systemic issues related to accessing services, treatment, and outcomes.

Subcommittee Members include:

Kathy Mosher, Executive Director of Central Kansas Mental Health Center

Cheryl Rathbun, Chief Clinical Officer for Saint Francis Community Services

Dana Schoffelman, Chief Executive Officer of Florence Crittenton

Ted Jester, Director of Juvenile Services Center, Johnson County Department of Corrections

First, it is important to understand what defines a PRTF and understand its intended purpose. PRTFs are established under the Social Security Administration Psych Under 21 - Benefits Act and are governed under federal regulations.

PRTF defined – what does it look like?

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident’s chronic condition or prevent further regression so that the services will no longer be needed. Federal regulation, §483.352, states that a PRTF means “a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting.”

A PRTF means....

1. **“A facility other than a hospital...”**

“Facility” means a distinct, stand-alone entity providing a range of needed services to a distinct population. A PRTF is to provide a less medically intensive program of treatment than a psychiatric hospital or a psychiatric unit of a general hospital.

2. **“...that provides psychiatric services, as described in subpart D of part 441 of this chapter...”**

Pursuant to §483.352, the PRTF must meet all the requirements identified in subpart D, which include: State accreditation (§441.151), certification of need for the services (§441.152), the team certifying need for services (§441.153), active treatment (§441.154), components of an individual plan of care (§441.155), and the team involved in developing the individual plan of care (§441.156). The way a PRTF organizes itself is critical to its success in complying with federal regulations.

3. **“...to individuals under age 21...”**

In this case regulations at §441.151 specify that the service must be provided before the individual reaches 21, or if the individual was receiving services just prior to turning 21, and that the services must cease at the time the individual no longer requires services or the date at which the individual reaches 22. To further

clarify this point regulations at §483.352 define minor as “defined under State law and, for the purpose of this subpart, includes a resident who has been declared legally incompetent by the applicable State court.”

4. “...in an inpatient setting.”

It is the intent of both the psych under 21-benefit and the PRTF regulations that to meet the level of certification of need in §441.152 “(1) ambulatory care resources do not meet the treatment needs of the resident and that according to §441.152 “(2) proper treatment of the resident’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and (3) the services can reasonably be expected to improve the resident’s condition or prevent further regression so that the services will no longer be needed.” Under this law, PRTFs are excluded from the Institution for Mental Disease (IMD) rule and is Medicaid reimbursable. As CMS clarified in the 2001 interim final rule (66 FR 28111); payment for inpatient psychiatric services to individuals under age 21 includes the need for room and board as well as the provision of a comprehensive package of services.

There is an erosion of PRTFs in Kansas, including a shift from its intended purpose of treating sub-acute, chronic mental health issues to more of crisis stabilization and a drastic reduction in both the number of service providers and available beds.

Concern 1 – Significant reduction in capacity.

Since 2011, there has been a 65% decrease in capacity.

- In 2011, there were 17 PRTFs with a total of 780 beds.
- In 2017, there are only 8 PRTFs and only 272 beds.

Marillac, operating in Overland Park, KS, and serving the Northeast Region is the latest PRTF to close in October 2017; reducing another 33 beds where there is already a long waiting list to access needed services.

It is also worth noting that Lakemary Center accounts for nearly one-fourth (23.5%) of the 272 beds (64). Lakemary specializes in serving only youth with intellectual/developmental disabilities.

The PRTFs were over capacity in 2011, but now are significantly under capacity in 2017 resulting in waiting lists with long delays in accessing needed services, creating unintended consequences.

- Waiting Lists exist and vary by both provider and in length dependent upon gender, age, level of acuity, and other factors PRTF providers must consider to manage their current population and bed utilization.
 - Waiting Lists vary in length from a few weeks to 2 and 3 months.
 - Children on wait lists often times await placement bouncing from one foster care provider to another, in juvenile detention centers, and in some cases offices.
 - Conditions and symptoms can also worsen while waiting, going from non-emergent to emergent needing acute hospitalization.

Priority Recommendation 1 – Support an increase in bed capacity.

- It is recommend the State conduct data and trend analysis on PRTF bed utilization and waiting lists to determine needs; i.e., pre-adolescent, female, Intellectual/Developmentally Disabled, and to what capacity is needed to shorten or eradicate wait lists.

- We recommend the State meet with PRTF Stakeholders and support building capacity throughout the state where needed, as needed.

Adding additional beds will meet the short-term, immediate need. There are other recommendations in this report that if supported and implemented, would effectively reduce the need for additional beds and create stability in the long-term. If concern number 2 and recommendation occurs, the increase in capacity need could disappear.

Concern 2 – PRTFs are viewed more as crisis stabilization.

Pre-KanCare in Fiscal Year 2012, the prior authorization period for a PRTF stay was “up to 90 days” and average length of stay was between 90 and 120 days. Upon the implementation of KanCare, the policy decision made was to make the prior authorization “up to 60 days” thereby reducing it by 30 days. This allowed the Manage Care Organization (MCO) to begin its Utilization Review (UR) process and determine medical necessity for additional days of treatment beginning on day 61. The PRTF provider, as required under federal regulations, was still to do their own UR and determine medical necessity during the first 60 days.

The authorization period for an admission was reduced from 30 days to 14, meaning if the youth was not placed in PRTF treatment within this time frame the authorization for treatment expires. The positive intent behind this policy decision is if community services and treatment cannot meet the needs of the youth and this (PRTF) level of treatment is necessary, then do not delay the admission. However, this policy change was at a time when capacity was plentiful; the result is the process is being repeated over and over while a youth waits for a PRTF bed to become available.

Today, MCO prior authorization looks like this:

- MCO authorization period for an admission to occur is only good for fourteen (14) calendar days.
 - A new MCO review and authorization must occur after every 14 days awaiting placement.
 - This can be re-traumatizing for family, administratively laborious for all involved, and costly waste of resources.
 - The authorization is via phone, by an out-of-state person that is not familiar with local resources, and the opportunity to provide a personal intervention in hopes of ameliorating the crisis is lost.
- MCO prior authorization period was greatly reduced. The prior authorization period went from authorizing up to 60 days of treatment to only 7 to 14 days, resembling authorization periods more consistent with acute hospitalization/state hospital alternative and NOT a PRTF.

Utilization Review periods also changed from within every 30 days to within every 7 to 14 days. There are unintended consequences associated with this practice.

- The increased frequency of URs has increased an administrative burden on staffing and is costly, not to the benefit of client treatment
- PRTFs had to hire additional staff including clinicians to accommodate the increase frequency of the URs and to maintain appropriate levels of actual treatment provided to youth in their care.
 - In retro-review of PRTF costs and expenses, these additional costs are realized in increased daily reimbursement rates.

- This increased burden led to a number of PRTF providers changing their business model to operating Youth Residential Centers (e.g. Dodge – Youthville, Riverside Academy - Wichita) or closing altogether (e.g., Marillac).
- PRTFs are admitting more out-of-state youth who have longer lengths of stay than Kansas youth, decreasing access to services for Kansas youth.

Compounding the concern of sub-acute treatment for chronicity versus acuity is length of stays and the effect on outcomes for shorter lengths of stay versus longer. Shorter length of stays adversely impact treatment and placement success.

In a 2012 study conducted by the State’s division of Behavioral Health Services, youth that stayed in PRTF treatment an average of 90 to 120 days were more likely discharged to a family setting and remained in the community with no readmissions.

- 85% discharged to a family setting.
- Stayed in the community with no additional out-of-home placement/treatment.
 - 86% never readmitted into a PRTF
 - Over 90% never readmitted to higher level of treatment, i.e., acute psychiatric hospital and/or state hospital alternative

Priority Recommendation 2 – Re-establish the true purpose of PRTFs.

PRTFs exist under the Social Security Administration Psych Under 21 – Benefit Act. Adhere to the federal regulations governing them. PRTFs are not hospitals; PRTFs are sub-acute in-patient residential facilities treating chronicity; long-term chronic mental health issues, not acuity and not crisis stabilization.

- Restore at least the minimum 60-day prior authorization period and subsequent Utilization Reviews (URs) within every 30 days thereafter coinciding with the individual Plan of Care until such time the youth is progressing toward completing treatment and discharge more imminent.

This aligns with federal regulation 42 CFR Subpart D §441.151 and §441.152. If PRTFs are treating long-term, chronic mental health issues that cannot be effectively treated in a community setting then it stands to reason that these long-term conditions are not going to be significantly improved in 7 or even 14 days. It is administratively laborious for all involved and a costly waste of resources. As the youth progresses through treatment, the URs may become more frequent as necessary to support discharge planning and to ensure the youth is discharged as soon as treatment is concluded and this level of care is no longer medically necessary in accordance with federal regulations.

It is worth mentioning again, data supports longer stays in treatment have better outcomes:

- 85% discharge to a family setting, and
- Stay in the community with no additional out-of-home placement/treatment.
 - 86% never readmitted into a PRTF
 - Over 90% never readmitted to higher level of treatment, i.e., acute psychiatric hospital and/or state hospital alternative.

Concern 3 – Lack of collaboration between MCOs and Community Mental Health Centers (CMHCs)

Screening practices and accessing PRTF treatment changed significantly in October 2015. This change was due to the Center for Medicare and Medicaid Services (CMS) ruling that the State of Kansas was not in compliance with the Mental Health Parity and Addictions Equity Act by having a third party (the CMHC) screen for services and grant prior authorization in order for a provider to receive Medicaid reimbursement. Since PRTF treatment is a non-emergent, planned event, the insurer should be granting the prior authorization. In the case of Medicaid recipients, it is the members MCO that should be granting prior authorization.

Prior to MCOs authorizing treatment, “screening” was a two-step process at the local level involving a Qualified Mental Health Professional (QMHP) from the local CMHC and a Community-Based Services Team (CBST).

The general process was this:

- CMHC QMHP intervened to assess and triage;
- Provide a personal intervention;
- Face-to-face appraisal of the individual in crisis;
- Determine appropriate intervention; and,
- Develop treatment recommendation and activities for follow up, which may or may not include a recommendation for PRTF treatment.

The local CMHC QMHP was best to know what treatment and service options are available, how to navigate and access treatment and services, etc.

If after assessing the QMHP recommended PRTF treatment, then the CBST was convened. The CBST is an individualized team established to access and integrate community resources to meet the youth’s mental health needs in the least restrictive environment. The CBST is comprised of the resident (as appropriate), a responsible family member/guardian, a knowledgeable representative from the CMHC, other clinicians, the custodial case manager, and any other individuals considered to be helpful in determining how to best help the youth. The benefits of the CBST Team are:

- The local CMHC CBST team provided final approval of a PRTF admission;
- Used as a check-and-balance to ensure community programs and services do not exist, or if they do, are not sufficient to meet the needs of the youth and family; therefore, PRTF treatment is the most appropriate intervention; and,
- Often diverted PRTF admissions in order to provide increased, intensive community-based services (the development of a specific Community-based Services Plan).

KDADS attempted to preserve the CBST concept through Medicaid policy. MMIS Policy E2015-075 states in part:

“Effective with dates of service on and after October 12, 2015, and only for children’s psychiatric residential treatment facility (PRTF) admissions, completion of a pre-admission screening (billed using T1023) and community based services team meeting (CBST, billed using H0032-HA) are no longer required as the criteria for payment of a PRTF residential inpatient stay. Because PRTFs are designed to address chronicity and not acuity, admissions to a PRTF are planned events. The MCO shall facilitate consultation

with representation from the responsible CMHC, the parents (as appropriate) or caregivers (including child welfare contractor or juvenile services case manager, if applicable), other persons knowledgeable about the child or adolescent, and the child or adolescent as appropriate. This group serves as a quasi-CBST and the forum may be telephone conferencing, tele-video conferencing, combination thereof, e.g., GoTo Meeting or Adobe Connect, or any other means to more expediently involve all parties to determine if the child or adolescent can be treated and supported safely in the community in lieu of PRTF treatment.”

Although written in MMIS Policy, CBST is non-existent under the current MCO authorization process. Lack of CMHC involvement and its consequences are further compounded whenever a youth is moved from one PRTF to another treatment provider, or stepped down from an acute hospital or state hospital alternative to a PRTF. CMHCs have no idea where their youth is, is given no opportunity to provide input which may prevent unnecessary admissions, assist with treatment and discharge planning, or otherwise be a resource. At one time CMHCs had PRTF Liaisons that kept the CMHC connected and helped coordinate services upon discharge, creating a warm handoff from the PRTF back to the community. This was lost with the implementation of MCO Care Coordination.

Priority Recommendation 3 – Use CMHC Clinicians and CBST as part of the Assessment, Utilization Review, and Treatment and Discharge Planning processes.

The MCO authorization is via phone, by an out-of-state person that is not familiar with local resources, and the opportunity to provide a personal intervention in hopes of ameliorating the crisis is lost. Therefore, the following is recommended:

- Require the utilization of the local case manager or QMHP to gather information (similar to what is gathered during a screen) and provide this information to the CBST and MCO prior to making a placement decision. MCOs will have a much more thorough picture of the situation to make a more informed decision, including what services are available and could be implemented in lieu of a PRTF admission.
- If youth/family are unknown and not in services, have the CMHC enroll the youth/family (complete an intake) as part of this process so services may be provided prior to and after PRTF treatment, or in lieu of a PRTF admission altogether.
- Convene the CBST as before and collectively with the MCO make a determination for admission or diversion.
- Include the CBST in all URs, Plan of Care development, treatment and discharge planning (this will help with a warm handoff at discharge and the development of a community-based treatment plan).
- Restore PRTF Liaison services: MCOs would subcontract with CMHCs to provide PRTF Liaison positions and services to facilitate discharges, warm handoffs, and continuity of services to support successful transition and long term stability.
- Reimburse CMHCs accordingly and fairly.
 - QMHP billed T1023 for conducting screens. It is a flat rate of \$350 and covered travel and out of office time. Typical assessment took an average of 3 hours to complete.
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- We provide these rates for informational purposes only and not as a recommendation. KDADS and KDHE should facilitate a meeting with MCOs and CMHC representation to negotiate appropriate reimbursement.

Priority Recommendation 4 – Promote and incentivize In-Home Family Therapy and transition planning.

We believe that when a child is placed in an inpatient residential setting (PRTF), family-centered collaborative team planning and decision-making must remain the essential components in an inclusive process for children and families. Children, youth and families can make substantial gains in the context of high quality residential treatment. The challenge becomes helping the child/youth and family maintain their gains and continue to grow and develop as the child/youth transitions to a family-based setting. A bridge must be built between the child/youth and family's residential treatment experience and their life in the community. A successful transition back into community life can be greatly facilitated by a planning process that is thoughtful, comprehensive, and inclusive.

Discharges should be contingent upon the child/youth and family's having had sufficient opportunity to practice in order to feel confident about meeting the challenges at home and on the availability of community based supports (formal and informal) that can adequately address their needs, including any familial and community safety needs.

Transitions will include visits to help the child/youth reintegrate back into their home, community, school, social network, and recreational activities.

When indicated in the child's treatment plan (within the total number of days approved for the child's stay), a maximum of seven days per visit is paid at the contracted per diem rate. The frequency, duration, and location of the visits must be a part of the child's individual case plan developed by the facility before the visitation. An approved visitation plan must be documented in the child's official record at the facility.

Mental health services received during leave time are the PRTF's responsibility. Therefore, the PRTF must provide the service directly or sub-contract with a CMHC or other local provider to provide needed services to support the youth while on a home visit.

To assist with transferring these skills into the home, it is recommended as a best practice that:

- PRTFs send clinician into the home while the youth is on a home pass to provide in-home support and/or therapy during part of each home pass – or –
- PRTFs subcontract with local CMHCs to provide services while the youth is on home pass.

This recommendation is inclusive of existing foster care placements and even potential foster care placements.

It is also recommended to support and promote Parent Management Training – the Oregon model (PMTO).

PMTO is an evidence based parenting intervention that facilitates permanence in the lives of children with serious emotional disturbance (SED) by creating sustainable changes in families and larger systems. The intervention is used in family contexts including two biological parents, single-parent, re-partnered, grandparent-led, reunification, and foster families. An extensive 5 year research partnership between KU, DCF, and the private foster care contractors implementing PMTO demonstrated astounding results including:

- Hospitalization/PRTF rates were lower for the treatment group (11.4% vs 14.3%)
- Average number of hospital/PRTF admissions were lower for the treatment group (1.9 vs 2.7)
- Percent with readmissions was lower for the treatment group (37.9 % vs 47.9%)
- The average days in hospital/PRTF across all admission was lower for the treatment group (36.6 days vs 57.8 days)
- The cumulative total of days hospitalized was lower for the treatment group (2,124 days vs 2,774 days)
- Projected cost savings opportunity = \$2,681,734 per year

PMTO interventions have been tailored for specific youth clinical problems, such as externalizing and internalizing problems, severe school problems, antisocial behavior, conduct problems, deviant peer association, theft, delinquency, substance abuse, and child neglect and abuse.

It is an intensive, 2-3 times per week, 4-6 months long evidence-based program (EBP). A

The goals of PMTO include:

- Improving parenting practices
- Reducing family coercion
- Reducing and preventing internalizing and externalizing behaviors in youth
- Reducing and preventing substance use and abuse in youth
- Reducing and preventing delinquency and police arrests in youth
- Reducing and preventing out-of-home placements in youth
- Reducing and preventing deviant peer association in youth
- Increasing academic performance in youth
- Increasing social competency and peer relations in youth
- Promoting reunification of families with youth in care

Although it appears as is a costly intervention initially, cost savings are realized over time through less disruption in in-home and out-of-home placements, law enforcement involvement and detention, emergency room visits, and in-patient services.

Priority Recommendation 5 – Restore university contract to do data collection, trending, and analysis (KU ROM, Ohio Scales, CMHC Outcomes).

Part of this subcommittee’s charge was to study outcomes. Unfortunately, we are unable to adequately and accurately do so at this time. We have anecdotal narratives, depictions, and some pockets of data but nothing comprehensive that will allow us to measure outcomes. We requested data from KDADS to assist us but were told that KDADS did not renew the university contract and that these data sources and others that were to be brought in-house have yet to be realized. It is difficult to make data-driven recommendations and decisions when there is no data.

Therefore, we recommend at least restoring the KU contract. KU served as both a clearing house and repository for data, information and outcomes related to PRTFs. It could give us a global picture of how PRTFs are performing as well as the ability to drill down on an individual, micro level.

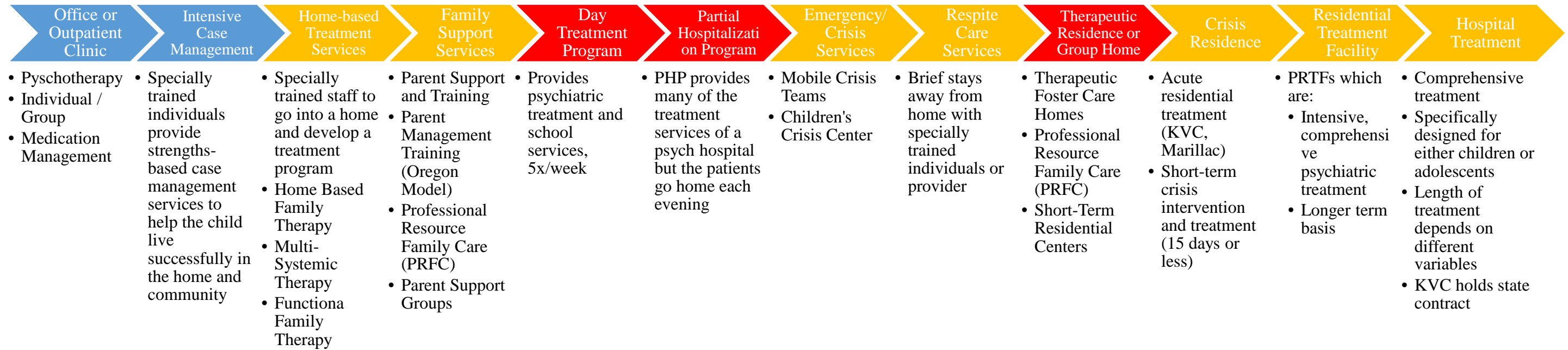
Data is critical.


Additional Strategies to Be Explored:

1. Pay foster care parents to hold beds open while child/youth is in treatment. When placement is disrupted due to mental health crisis or illness, continue to pay the foster parent so that the youth may return upon completing treatment. The youth then is going back to a familiar setting. Transition planning and in-home family therapy/support may be needed as recommended in this report. This could also include potential foster care placements when a youth is in PRTF treatment and is needing a foster care placement upon successful completion. In either case, reimbursement for holding a bed open could be for a reduced rate, but not substantially or the incentive is lost.
2. Allow Foster Care system to access Respite Care for therapeutic/ behavioral health related purposes. The Foster Care definition for Respite Care is not the same as it is under Behavioral Health. For Foster Care, respite services are for the foster care parents when they are going away on a planned vacation and not because of a crisis or a break from challenging behaviors.
3. Promote and implement Psycho-Social Groups. MCOs have discouraged these. However, afterschool and summer programming provide a therapeutic structure and engage the youth. These programs can and do prevent hospitalizations and PRTF placements.
4. Refer to Children's Continuum of Care Treatment Model and incentivize providers to build capacity and deliver programs/services where they do not exist or are in limited capacity.


Children's Continuum of Care on Treatment

Adopted from the American Academy of Child & Adolescent Psychiatry



 Represents these level of programs / services exist to a greater extent.

 Represents these level of programs / services may exist in part or limited capacity.

 Represents these level of programs / services are very minimal or do not exist.

Kansas should recognize the use of the *Diagnostic Classification: Age 0–5 (DC:0-5)*¹ for diagnosis and treatment of children birth through 5 years old. Specifically, this recommendation calls on the State (including state mental health director, state Medicaid director, and managed care administrators) to implement policies and changes in the Medicaid State Plan and associated policies and procedures to allow the use of DC:0-5 as medical necessity for reimbursing early childhood mental health services.²

Examples:

- Adopt its use in insurance plans and managed care contracts
- Adopt its use in the Medicaid State Plan
- State policies should crosswalk DC:0–5 with other diagnostic codes (i.e., DSM-5 and ICD-10) to facilitate billing through Medicaid, if the billing system cannot accommodate DC:0–5.

Several states, including Michigan, Minnesota, New Mexico and Oregon have successfully adopted the use of DC:0-5 (or its predecessor DC:0-3). A crosswalk for DC:0–5, DSM-5, and ICD-10 has been developed as a guide to enable payment for early childhood mental health services and is available at:

- Zero to Three’s DC:0-5 Crosswalk³
- Zero to Three’s Crosswalk from DC:0-5 to DSM-5 and ICD-10⁴
- Oregon Early Childhood Diagnostic Crosswalk⁵

Reasons to implement:

- Ensure quality for what is purchased. Payers are ensured they are getting a quality service.
 - Relationship disorders identified and addressed early
 - Accurate assessment and diagnosis which impacts appropriate and effective services
- Support better skills and methods for diagnosing children age 0-5
- The required and proper training for the necessary skills and knowledge is already available
- Consistent diagnosis criteria
- Ensures ICD 10 code accuracy

An additional recommendation is that the State define, establish and identify a required credentialing and training program for early childhood mental health providers, and have such program in place before requiring its use. Such credentialing should include existing training and endorsement programs (for example KAIMH’s Early Childhood Endorsement) but also provide the training program necessary for credentialing to include central topics such as the importance of early brain development, self-regulation, the fundamentals of early childhood development, attachment, and building resilience through early relationships. These training programs are intended to encourage the ongoing development of a network of appropriately trained early childhood specialty providers to augment the existing network of KAIMH endorsed providers.

Rather than creating something new, the State could look at existing work within the state for home visiting and other states. A good example is North Carolina’s Early Learning Network Training Modules: <http://modules.nceln.fpg.unc.edu/early-childhood-mental-health-modules>.

¹ <https://www.zerotothree.org/our-work/dc-0-5>

² The Baby Monitor: Zero to Three Policy and Advocacy News, February 9, 2017

³ <https://www.zerotothree.org/resources/1954-dc-0-5-crosswalk>

⁴ <https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0-5-to-dsm-5-and-icd-10>

⁵ <http://www.pcpai.org/sites/default/files/webinar-related/HSD%20200-5%20Diagnostic%20Crosswalk%2C%202017%203-1-17Final.pdf>

Initiatives for 2018 Legislative Action: Prevention

We have identified two key areas for 2018 Legislative Action. Both target the accessibility and effectiveness of community based services. Both impact the information and support offered to parents to make decisions and participate meaningfully in decision making across the children's continuum of care and create the basis for community wide system of care approaches that target parent driven/youth guided service planning and delivery, cultural and linguistic competence, strengths-based

A. Re-evaluate the use of parent-to-parent peer support

1. The current requirements for parent-to-parent peer support allow anyone with "experience" with children to hold these positions. The intent of the position in Kansas and nationally has been to offer a service to families that is shared experience plus training to do the work. Peer-to-Peer (parent-to-parent support is the essence of the service, the sharing of the service plus the training to help parents navigate child serving systems in Kansas: child welfare, court services, juvenile justice, mental health, primary health and substance abuse programming. In the past when this was a requirement, the CMHCs had difficulty working within those limitations. We ask that a committee would review the strengths and barriers to requiring parent support staff must have parented a child with SED and change the requirements accordingly if the strengths outweigh the barriers.

2. Increase, at a minimum, the payment for parent peer support to a level commensurate with adult peer-to-peer services.

The adult payment is higher than that offered to parent-to-parent peer services through Medicaid.

3. Require state or national certification with training needed to inform the full scope of work and maintain fidelity to the practice.

Parent-to-parent support is now an evidence-based practice. National and state researchers have studied its value extensively. This document provides a brief review of that research. One of the oldest and most researched models is from Keys for Networking in Kansas with 3000 juvenile offenders and their families with the American Institute for Research.

4. Expand the availability of parent peer support specialists to all parents whose children with SED/SUD are enrolled in KanCare.

Currently the service as Medicaid billable is restricted to only those families on the HCBS waiver for children with SED. We believe offering the service with parents with lived experience raising children with serious emotional disabilities and promoting it to all Medicaid families will prevent children from further penetrating the children's systems.

5. Explore national and state models of parent-to-parent peer support for best fit to Kansas rural, suburban, urban populations and the geographic and ethnicity of the state.

At this time, we have no model, just requirements to bill Medicaid for the service. Comparing appropriate models and cost effectiveness across child serving agencies would allow shared values, offer more opportunities for training to maintain fidelity to the model selected.

Background in Kansas

Keys for Networking, as the statewide family organization, has offered parent-to-parent peer delivered services for the last thirty years. With the contract with KanFocus, Keys for Networking recruited, trained, employed one parent peer support staff from each of the five mental health enter catchment areas: Chanute: Jacqui xxxx, Crawford County: xxxx, Independence: Marilyn Gonzales, Labette: Virginia Stanley, and Riverton: (I don't remember the names of individuals and some of the center names may have changed.)_Keys provided the training and supervision along with the children's director in each center. With experience from KanFocus and the addition of parent-to-parent peer support to the original HCBS waiver services, following the approval for the HCBS waiver, the majority of centers offered the service. Keys staff provided statewide wraparound and parent-to-parent peer support training. Dr. Adams trained over 600 people in a five year period. In addition the state mental health authority hosted monthly meetings of the parent support staff to renew skills, provide updated information and develop a cohesive service. At some point this stopped.

In 2009, Keys secured, with the American Institute for Research, a grant from the Centers for Medicare and Medicaid to enroll juvenile offenders returning home from residential placements in CHIP. Parent peer support mentors, many employed on work release from the Women's Correctional Facility, Keys parent-to-parent peer mentors contacted parents when notified that adolescents were returning home. Keys staff provided education, training, information and the support for families to help families reapply and secure medical cards.

As of the end of Q8, there were 758 families with TPA scores.

- Averaged across all 8 contact points, the overall TPA score for the treatment group (1.61) is higher than the score for the control group (1.51). This holds true for 5 out of the 7 PARENTS domains as well (Expectant and Networked do not differ between the two groups).
- Averaged across the two groups, scores for TPA and all PARENTS components all increase significantly over time.

- Looking at the change over time within each group, we found that both the TPA score and most dimensions of PARENTS increased more for the treatment group than for the control group. In general, the treatment group scores more than doubled by the 630-day contact.

For example, the overall TPA score for the control group increased from 1.15 at baseline to 1.93 at 630 days (an increase of 67%). The overall TPA score for the treatment groups increased from 1.21 at baseline to 2.46 at 630 days, for an increase of 104%. See the table below.

In addition, the American Institute for Research examined the difference between JJA youth whose parents had been served by Keys and those who had no contact with Keys. In brief, the results showed that the JJA data analyzed included a total 1,947 records with 43% in the JJA group, 28% in the Keys' Comparison group, and 29% in the Keys' Treatment group. Among those 1,947 records, over a thousand (n=1,249; 64%) were excluded from this analysis because they did not have a single in-home placement during the span of dates covered by the data.¹ Of the total 1,249 excluded youth, 592 were from the JJA group, 330 were from the Keys control group, 327 were from the Keys treatment group. That leaves 698 cases for analysis, with the following breakdown: 36% in JJA group, 30% in Keys control, and 34% in Keys treatment. In analyses that included 'risk', sample sizes are decreased by 28 for recidivism and by 23 for OOHP, due to missing values on the risk indicator.

¹ For OOHP, the overall interaction effect is not significant, but the individual ORs are. That means that the Keys youth are less likely to experience OOHP than the JJA youth across all risk levels, but we cannot say with certainty *whether* or *how much* the odds ratios differ across the 3 risk groupings. For Recidivism, the overall interaction effect is significant. The reported fractions are obtained by taking the inverse of the result from

¹ Or, in some cases, all of their placements were in the hospital or in residential drug/alcohol treatment, or the youth went AWOL after being placed in home, and there were no subsequent placements recorded in the data. Or, for Keys' youth, they did not have an in-home placement that occurred after their referral date. Of these 1,249 youth, most (n=754; 60%) did not have a single placement – either in-home or OOH – during the entire span of time covered by the data.

dividing the OR into 1 (e.g., $1/10 = 1/(1/0.10)$). This relation tends to be fairly obvious with the OR is 0.33 ($1/3^{\text{rd}}$), 0.10 ($1/10^{\text{th}}$) or 0.05 ($1/20^{\text{th}}$), but not as obvious when the OR is 0.14 or 0.

The Keys for Networking/AIR project is important because it includes clearly defined parent and child outcomes. Child outcomes include attending school, living at home, and securing/maintaining insurance. Parent outcomes include engagement (measured across a ten point continuum from 1) seeking information, 3) completing trainings or/and informational sessions, 4) solving problems, 7) offering to help others, 8) completing training to help others. Parent outcomes also include skill development in seven clearly defined advocacy attributes: Persistent, Articulate, Resourceful, Expectant, Networked, Transparent and Strategic.

Brief Literature Review

Within children's mental health, family support services delivered by veteran parents have gained rapid momentum, with a quarter of states making such family support services a billable service through Medicaid or federal block grants (Center for Health Care Strategies Inc., 2012). These family support specialists are typically caregivers who have "lived experience" of parenting a child with mental health needs and are able to "give back" to other parents (Hoagwood, 2005; Koroloff, Elliott, Koren, & Friesen, 1996; Koroloff, Koren, Elliot, & Friesen, 1994; Osher, Penn, & Spencer, 2008). They provide a range of supportive services and their primary function is usually to model, coach, and empower parents in their journey to cope with, advocate and negotiate the fragmented children's service systems. FSSs promote linkages to other families and to other children's services and can decrease family isolation, increase a parent's formal and informal support networks, and enable advocacy at the individual, systems, and policy levels. FSSs work primarily as community-based advocates working individually with a parent. When employed on teams, such as wraparound teams, FSSs may serve as "translators" and facilitators of productive partnership between families and providers on the team. Social support appears to directly affect parents' own mental health and functioning and improves access to resources to ultimately influence child adjustment

(Ireys et al., 2001a; Ireys et al., 2001b).

To help promote standards and competency of the skills needed for this emerging profession, the National Federation of Families for Children’s Mental Health established a Certification Commission for Family Support (<http://certification.ffcmh.org/>). To this end, a list of content and competencies that can be considered for certification has been identified. While certification of FSSs identifies the minimum skills and experience required to function as a FSS, the policies and procedures needed by an agency or organization to support the function of FSSs do not yet exist. While there is broad consensus about tasks performed by FSSs (Obrochta, Anthony, Armstrong, Kalil, Hust, & Kernan, 2011; National Federation of Families for Children’s Mental Health, 2011), local variation in roles, responsibilities and practices associated with the FSS within an organization hinder an organization’s ability to adequately support and supervise this new workforce. In short, agencies or organizations adopting this service component have limited guidance on how best to assess and promote quality services to families in mental health care settings.

- Peer support provides benefits of experiential learning and helps to connect families with each other. A.F. Hartman, M.B. Radin, and B. McConnell. “Parent-to-Parent Support: A Critical Component of Health Care Services for Families.” *Issues in Comprehensive Nursing*, 15 (1992), 55-67.
- Peer support programs help parents who have children with special needs find and become reliable allies for each other. They provide parents with the opportunity to connect with and support each other through informational and emotional support, and through reciprocity. B. Santelli, A. Turnbull, J. Marquis, and E. Lerner. “Parent-to-Parent Programs: A Resource for Parents and Professionals.” *Journal of Early Intervention*, 21, no.1 (1997), 73-83.
- Parent-to-parent support programs are valued by parents and may improve the emotional functioning of parents who have children with disabilities and help them improve their coping skills. V. Robbins, J. Johnston, H. Barnett, W. Hobstetter, K. Kutash, A.J. Duchnowski, and S. Annis. The Louis de la Parte Florida Mental Health Institute,

Department of Child and Family Studies. "Parent-to-parent: A Synthesis of the Emerging Literature." (Tampa, FL: University of South Florida, 2008). (p.6) FAMILY AND

- The self-efficacy and empowerment of families can be enhanced by providing family support, and this has been associated with a variety of improved outcomes such as service initiation and completion; increased knowledge about the youth's condition and relevant services; satisfaction; and youth functioning at discharge. L. Bickman, C. Heflinger, D. Northrup, S. Sonnichsen, and S. Schilling. "Long Term Outcomes to Family Caregiver Empowerment." *Journal of Child and Family Studies*, 7, no. 3 (1998a), 269-282. □L. Bickman, M.S. Salzer, E.W. Lambert, R. Saunders, W.T. Summerfelt, C. Heflinger et al. "Rejoinder to Mordock's Critique of the Ft. Bragg Evaluation: The Sample is Generalizable and the Outcomes are Clear." *Child Psychiatry and Human Development*, 29, no. 1 (1998b), 77-91. □C. Heflinger, L. Bickman, D. Northrup, and S. Sonnichsen. A Theory-Driven Intervention and Evaluation to Explore Family Caregiver Empowerment." *Journal of Emotional and Behavioral Disorders*, 5, no. 3 (1997), 184-191. □M.G. Resendez, R.M. Quist, and D.G.M. Matshazi. A Longitudinal Analysis of Family Empowerment and Client Outcomes." *Journal of Child and Family Studies*, 9, no. 4 (2000), 449- 460.

- There is encouraging initial evidence of the value of family education and support (FES) in reducing child symptoms and improving child functioning. Furthermore, there is evidence of some benefits to the parents and caregivers, including a reduction of stress, improved mental health and well-being, increased self-efficacy, perceived social supports, and increased treatment engagement.

- The use of formal peer supports or advocates to increase family involvement in children's mental health services appears to be increasing. For example, numerous accounts of programs are made in children's mental health systems of care publications, conference agendas and workshops. In addition Jensen and Hoagwood (2008) edited a book written by parents to teach other parents to become formal supports for parents with children experiencing mental health challenges, and Miles (2008) describes models that systems of care have used in hiring "family partners" as staff and integrating them into their wraparound processes. More recently, Munson et al. (2009) examined how parent advocates operating within a federally supported system of care framework describe their

role in working with families. fT. Davis, S. Gavazzi, S. Scheer, R. Uppal. “Measuring Individualized Parent Advocate Services in Children’s Mental Health: A Contextualized Theoretical Application.” *Journal of Child and Family Studies*, 20, no. 5 (2011), 669-684.

ROLES OF FAMILIES A large majority (over 90 percent) of agency directors believe the most important roles for families are educating other families, advocating for mental health services, and peer-to-peer support. Other key roles identified by over 79 percent of the directors include leading support groups, training other families, serving as a direct liaison with mental health providers, and direct advocacy on behalf of individual families. Noting the lack of advocacy-related research, Hoagwood et al. (2008) conducted a national survey study of 226 directors of family advocacy, support, and education organizations affiliated with children’s mental health and collected information on the types of services provided by the family advocacy organizations and their perceived impact on outcomes. The literature consistently reflects a general sense that peer support providers serve an important role. fT. Davis, S. Gavazzi, S. Scheer, R. Uppal.

“Measuring Individualized Parent Advocate Services in Children’s Mental Health: A Contextualized Theoretical Application.” *Journal of Child and Family Studies*, 20, no. 5 (2011), 669-684.

FAMILY SATISFACTION WITH PEER SUPPORT Parents who participated in peer support groups were overwhelmingly satisfied with their experiences. Participants in the Parent Connectors group who participated in the follow-up interview were asked three satisfaction questions. In regards to satisfaction with the Parent Connector assigned to them, parents were overall very satisfied, with 98 percent stating that they were very satisfied with their Parent Connector. When asked what they found most useful about having a Parent Connector, 97 percent of the responses were positive and described the Parent Connector as relaying information and connecting them to resources, being a good listener, and caring. fJ. Duchnowski, J. Ferron, A. Green, and K. Kutash. “Supporting Parents Who Have Youth with Emotional Disturbances Through a Parent-to-Parent Support Program: A Proof of Concept Study Using Random Assignment.” *Administration and Policy in Mental Health Services Research*, 38, no. 5 (2011), 412-27. Given shortages in the mental health work force, there may be opportunities to expand the role of families and service capacities within family organizations. Fiscal sustainability however was a major concern of these organizations

(Hoagwood et al, 2008). Creating stable support for family advisors, comparable to the Medicaid coverage for adult consumer-provided services, could address both workforce shortages and fiscal sustainability. The message that evidence is critical to such policy change is articulated in a guide for family peer-to-peer support programs (FFCMH, 2008a). □P. Gyamfi, C. Walrath, B. Burns, R. Stephens, Y. Geng, and L. Stambaugh. “Family Education and Support Services in Systems of Care.” *Journal of Emotional and Behavioral Disorders*, 18, no. 1 (2012) 14-26. NEED FOR MORE RESEARCH Family or peer support providers have the potential to effectively help alleviate some of the noted gaps in children’s mental health services; however, scant research literature exists to provide detailed documentation of the services rendered by peer support providers and their impact. fT. Davis, S. Gavazzi, S. Scheer, R. Uppal. “Measuring Individualized Parent Advocate Services in Children’s Mental Health: A Contextualized Theoretical Application.” *Journal of Child and Family Studies*, 20, no. 5 (2011), 669-684. Although family education and support is growing in availability within the children’s mental health field, it has been the advocates and leaders in public policy, not researchers, who have led the way in developing and facilitating their implementation in communities across the country. It is important that researchers become involved in examining these services so that the discussion on refining and improving these services for a high-need group of children and their families are informed by empirical investigations. fK. Kutash, L.G. Garraza, J.M. Ferron, A.J. Duchnowski, C. Walrath, and A.L. Green. “The Relationship between Family Education and Support Services and Parent and Child Outcomes Over Time.” *Journal of Emotional and Behavioral Disorders*, published online, August 2012.

B. Elevate and Expand Wraparound Planning to the national NREP/SAMHSA Evidence Based Process for Children’s Services Across the Continuum of Care for all KanCare eligible families whose children have severe emotional disabilities.

1. Require that Kansas Wraparound is based on the National Wraparound Initiative and directs the planning process used statewide for Kansas children with serious emotional disabilities and/or substance abuse disorders.
2. Secure training from NWI endorsed wraparound trainers for facilitators, supervisors and coaches as well as service planning partners, including youth and their parents.

3. Maintain fidelity to the national model by collecting data on team process as well as child outcomes, satisfaction of the family, and cost effectiveness of community based services.

4. Authorize funding for a pilot site to examine Kansas outcomes using national wraparound model with the intent to move the NWI service planning model statewide.

Background in Kansas

In the early 80's two sets of grants introduced wraparound to Kansas. Keys received the first from CASSP/SAMHSA to introduce the concepts in Kansas statewide. Keys piloted the concept in nine communities: Abilene, Independence, Kansas City, Parsons, Salina, Wichita, The National Wraparound Initiative awarded Keys their first national award for community initiatives. Following the completion of the pilots, five mental health centers in South East Kansas (Columbus, Crawford, Four County, Labette, and Chanute), with Keys for Networking, secured the five year system of care grant, KanFocus. With fiscal support from the KanFocus grant, Keys for Networking provided statewide training for wraparound teams. With the data from KanFocus, the state of Kansas secured the Home and Community Based Services Waiver for Children with Severe Emotional Disabilities to demonstrate cost neutrality—that living in the community costs no more for the state than residential placements.

With the expiration of the federal grants, the state department of mental health moved from face to face training to internet and minimum standards. By 2017, most practitioners who received the extensive hands on training—40 hours for facilitators, had moved into other positions including management and/or have retired. All that is left are misstatements such as that “wraparound is a service or that there are wraparound services.” Wraparound is not a service nor are there wraparound services. Wraparound is instead an evidence based practice with a national sophisticated, evidence-based model with proven results that increase positive outcomes for children with SED and their families.

Brief Literature Review

Wraparound is a community-based, family-driven collaborative team planning process that engages informal supports and formal services with families in culturally competent, individualized, strengths-based assessment and interventions. Outcomes of these efforts are monitored closely and guide adjustments to team composition and structure, as well as to team assessments and interventions (Burchard et al. 2002; Burchard and Clarke 1990; VanDenBerg and Grealish 1996; Walker et al. 2004). Wraparound has been a model for service delivery in over 100 federal systems of care children's mental health grants since 1992 (Center for Mental Health Services 2008). Estimated to serve approximately 100,000 youth annually in nearly 1,000 programs across the United States, wraparound has been the subject of more than 100 publications, and has been described as an evidence-based, a promising, or a best practice model (Walker and Bruns 2006; Walker 2008). intent of its value-based principles (Bertram and Bertram 2004; Bruns et al. 2004b; Malysiak 1997, 1998; Walker et al. 2004).