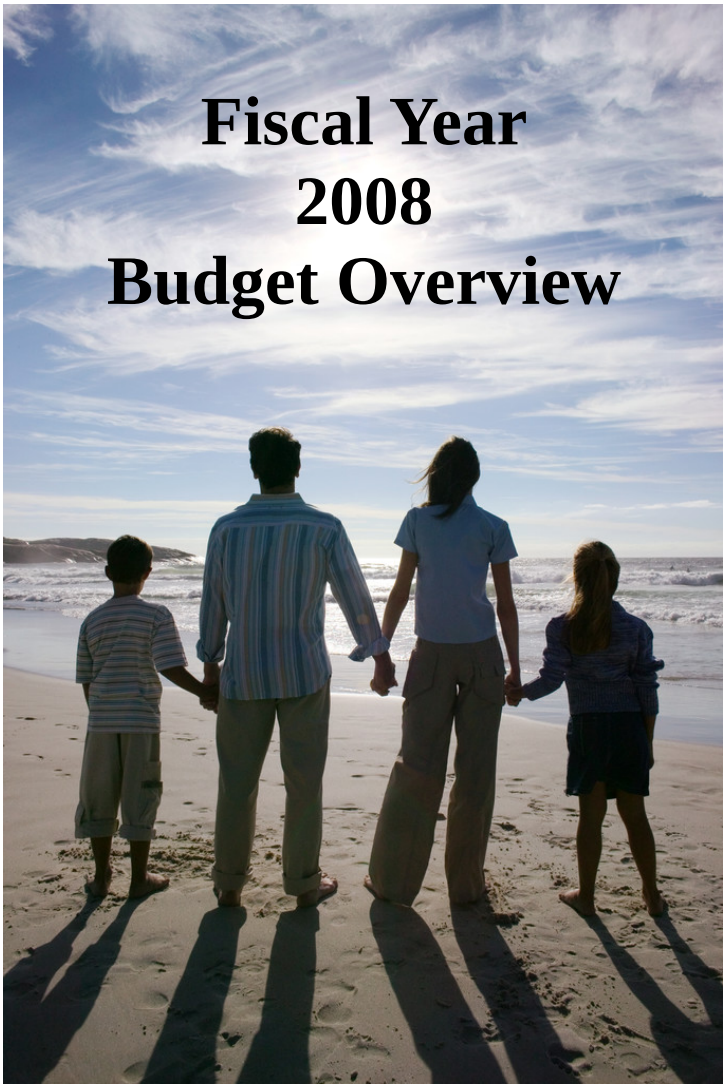
State of Alaska
Department of
Health and Social Services



To promote and protect the health and well-being of Alaskans.

Sarah Palin
Governor

Karleen Jackson
Commissioner

Introduction to Department

Mission

To promote and protect the health and well-being of Alaskans.

The Department of Health and Social Services was originally established in 1919 as the Alaska Territorial Health Department. With the formal proclamation of Statehood on January 3rd 1959, the department responsibilities were expanded to include the protection and promotion of public health and welfare. These core duties are reflected in the mission of the department – to promote and protect the health and well-being of Alaskans – and are outlined in Article 7, Sections 4 and 5 of the Constitution of the State of Alaska.

The largest reorganization in the history of the department was undertaken in 2003, and included the decentralization of Medicaid functions; integration of behavioral health services; and the addition of five programs formerly operated by the Departments of Administration and Education/Early Development. The goals of the reorganization were to:

- Improve the effectiveness of services funded through the department; and
- Contain costs by increasing efficiencies and maximizing federal funding.

An assessment of the reorganization began in FY07 and refinements – primarily to functions associated with the Commissioner's Office – will be made in FY08 to more fully achieve the goals of the reorganization, and the goal of the incoming Administration to increase transparency in government operations.

The major focus for the department during FY2008 will include working with stakeholders to develop a system of health care and social services for Alaska that balances the competing needs of access, quality and cost of care. Past experience has shown that unless all three of those factors are considered in policy and budget decisions - unintended consequences occur which weaken the service delivery system.

A second focus is preventing future costs by identifying ways to proactively increase health and well-being for individuals and communities - rather than reactively treating sickness or intervening after harm has been done.

The FY2008 budget has been prioritized by the department under four themes that are all critical to achieving the mission of the department. Those themes are: sustaining health and social services; ensuring safety and compliance; providing quality assurance; and promoting healthy futures for individuals and communities in Alaska.

The department budget structure parallels the organizational structure:

Alaska Pioneer Homes
Behavioral Health
Children's Services
Health Care Services

Adult Preventative Dental Medicaid Services
Juvenile Justice
Public Assistance
Alaska Longevity Bonus Program
Public Health
Senior and Disabilities Services
Commissioner's Office
Finance and Management Services

Three main principles guide the delivery of services funded by the department: promoting self-sufficiency and self-responsibility; providing basic supports to vulnerable individuals who can not provide for themselves; and fostering collaboration among stakeholders to develop and maintain a strong health care and social services delivery system in Alaska.

Core Services

- Provide eligible Alaskans with quality assisted living in a safe environment.
- Collaborate with stakeholders to ensure an integrated behavioral health care system.
- Promote stronger families, safer children.
- Manage health care coverage for low-income Alaskans.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Promote self-sufficiency and self-responsibility while providing basic supports to those who can not provide for themselves.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative support services to help accomplish the department's mission.

The department is committed to improving performance management through evaluation of measurable outcomes to further the successful achievement of our mission.

We Create Public Value By

- Promoting optimal health for children and adults.
- Ensuring children and vulnerable adults are safe.
- Assisting low-income individuals and families to achieve economic self-sufficiency.
- Collaborating with stakeholders to ensure that Alaska has a health care and social service delivery system that balances access, quality, and cost of care.
- Preventing and mitigating threats to public health.

The Scope of Services Provided by the Department Includes

- Benefit payments distributed to over 120,000 eligible individuals annually – with an additional 12,613 individuals anticipated to receive Longevity Bonus payments in FY2008.
- Health care payments for more than 131,000 eligible individuals annually.
- Management of 43 state-owned buildings throughout the state including six pioneer homes with a combined total space exceeding 928,000 square feet; and 71 leased spaces that the department is responsible for equipping and configuring.
- Annual management of $136.0 million of funds provided through grants to communities and non-profit entities throughout Alaska.

- Oversight of receipt and expenditures of more than $1.1 billion of federal funds from multiple sources such as Medicaid, Temporary Assistance, Title IV-E and Child Welfare funds.

The department has over 3,600 positions budgeted; however, recruitment/retention issues create challenges to maintaining an effective workforce as the following information shows:

Direct Field workers

108	Public Health Nurses
295	Social Workers & Children's Svcs Spec
310	Eligibility/Work Services
274	API staff
664	Pioneer Homes Staffing
261	Youth Detention/Treatment Workers
92	Juvenile Probation Officers
2004	TOTAL

Program Support Services

104	Mental Health and Substance Abuse
79	Senior Programs
409	Public Health
42	Disability Programs
248	Children and Family Services
108	Juvenile Programs
10	Facilities Management
239	Benefit Payments/Systems
1239	TOTAL

Administrative/Management Support

183	Division Support Services
151	Information Technology
72	Quality Assurance / Program Oversight
406	TOTAL

Calendar Year 2005 Vacancy/Turnover by Division

Division	Vacancy Rate	Turnover Rate
Pioneers' Homes	7%	16%
Behavioral Health	21%	18%
Children's Services	10%	32%
Office of the Commissioner and Boards	10%	14%
Finance and Management Services	17%	32%
Health Care Services	22%	8%
Juvenile Justice	7%	15%
Public Assistance	11%	24%
Public Health	19%	25%
Senior and Disabilities Services	22%	15%

Source: DOA/DOP Employee Movement Report for CY 2005
Note: Includes permanent and exempt employees only.

Department employees are located across the state as shown below. Additionally, many employees (i.e. public health nurses, social workers) provide itinerant service in the smaller rural communities.

Position Information

Permanent Full-Time:	3,314
Permanent Part-Time:	107
Nonpermanent:	228

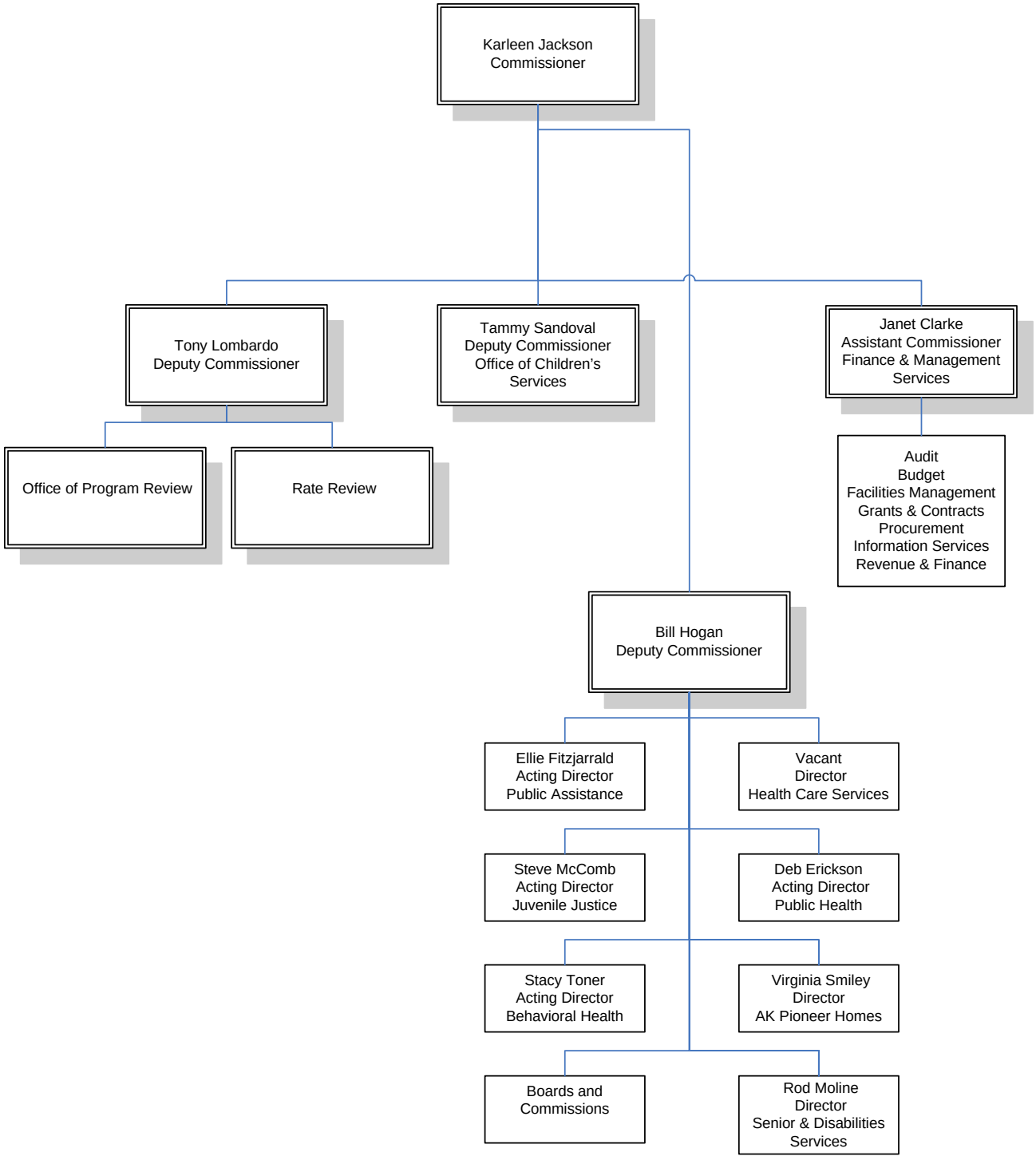
Department employees are located across the state as shown below. Additionally, many staff provides itinerant service, i.e. public health nurses, in the smaller rural communities.

FY2008 Position Summary by Location

Location	Total Full Time	Total Part Time	Total Non Perm	Total Position Counts
Anchorage	1615	33	110	1758
Aniak	3	0	0	3
Barrow	8	0	0	8
Bethel	92	0	2	94
Cordova	2	0	0	2
Craig	6	0	0	6
Delta Junction	6	1	0	7
Dillingham	11	1	0	12
Eagle River	1	0	0	1
Fairbanks	355	6	21	382
Fort Yukon	0	1	0	1
Galena	2	1	0	3
Glenallen	1	0	0	1
Haines	2	0	0	2
Homer	12	2	0	14
Juneau	589	26	50	665
Kenai	80	1	1	82
Ketchikan	110	13	15	138
King Salmon	2	0	0	2
Kodiak	14	2	0	16
Kotzebue	9	1	0	10
Mat-Su Areawide	14	0	0	14
McGrath	3	0	0	3
Nome	37	1	1	39
Palmer	120	17	17	154
Petersburg	4	0	0	4
Saint Marys	6	0	0	6
Seward	3	0	0	3
Sitka	98	0	11	109
Soldotna	1	0	0	1
Tok	2	0	0	2
Unalaska	1	0	0	1
Valdez	5	0	0	5
Wasilla	97	1	0	98
Wrangell	3	0	0	3
Totals	**3,314**	**107**	**228**	**3,649**

Executive Management Organization

January 2007



Major Accomplishments in 2006

- Completed the conversion of the Palmer Pioneer Home to the Alaska Veterans and Pioneers Home.
- Increased the use of Medicaid as an alternative to state general fund, thereby reducing the general fund requirements to operate the Homes.
- Continued efforts to promote an integrated behavioral health care system.
- Expanded the behavioral health Designated Evaluation and Treatment program to Bethel and the Designated Evaluation program to South Peninsula Hospital.
- Implemented an outcomes and evaluation process for behavioral health prevention grants.
- Exceeded the national goal of reducing illegal tobacco sales to youth for the 3rd year in a row (2003-10%, 2004-12%, 2005-9.4%).
- Successfully achieved all seven performance improvement goals for the OCS Performance Improvement Plan (PIP).
- Completed the OCS Workload study, which provides recommendations for giving front line workers reasonable caseloads.
- Improved the performance of the ORCA system to rural areas, reducing reaction times of the system from 37 seconds to 8 seconds.
- Juvenile Justice successfully implanted a new assessment program to aid in determining the likeliness of a youth's risk to re-offend.
- Significant progress by all Juvenile Justice facilities toward reaching "Level 1 Data Certification" in Performance-based Standards (PbS) sponsored by the national council of Juvenile Correctional Administrators and US Office of Juvenile Justice and Delinquency Prevention.
- In Public Assistance the Alaska Temporary Assistance caseload declined 5% from FY05.
- Public Assistance exceeded federally mandated work participation rates for federal FY06. Alaska is one of sixteen states that continue to meet the federal All Family participation rate.
- Public Assistance Fraud investigation unit resulted in cost-avoidance, direct savings and overpayments totaling nearly $2 million.
- Public Health distributed more than 4,500 smoke alarms with the potential of 43 lives saved, and 489 "Kids Don't Float" life jacket loaner sites were maintained. Since 1998 this program has resulted in 12 documented cases of prevented drowning.
- Of all newborns in Alaska, 99.9% were screened for metabolic disorders and nearly 90% were screened for hearing loss.
- The Division of Senior and Disabilities Services implemented regulation changes for the Personal Care Attendant Medicaid program based on several audits and legislative direction.
- The Office of Faith Based and Community Initiatives were awarded a $500,000 federal grant for a demonstration project.
- The department developed a long term Medicaid forecast model from a contract with the Lewin Group/ ECONorthwest.
- The department initiated phase II of the grants database (eGrants) and worked with the Rasmuson foundation on improving the grant process.
- The audit unit recovered $2.6 million of unexpended or misspent grant funds.
- Re-instated a department safety program to manage OSHA and other employee safety issues.
- Implemented several components of a comprehensive IT network security program.

Program Prioritization

Statutory Reference AS 37.07.050(a)(13)

Prioritization of programs is based on importance to:

- Providing direct services to clients.
- Protection of vulnerable populations.
- Areas where State Government is ultimately responsible for providing service.
- Relevance of the activity to the department's mission.

1. Alaska Psychiatric Institute
2. Protection and Community Services
3. Epidemiology
4. Alaska Temporary Assistance Program
5. Tribal Assistance Programs
6. Pioneer Homes
7. HCS Medicaid Services
8. Senior and Disabilities Medicaid Services
9. Behavioral Health Medicaid Services
10. Children's Medicaid Services
11. Senior Care
12. Probation Services
13. Adult Public Assistance
14. Community Developmental Disabilities Grants
15. Foster Care Base Rate
16. Foster Care Augmented Rate
17. Foster Care Special Need
18. McLaughlin Youth Center
19. Delinquency Prevention
20. Fairbanks Youth Facility
21. Johnson Youth Center
22. Bethel Youth Facility
23. Nome Youth Facility
24. Ketchikan Regional Youth Facility
25. Mat-Su Youth Facility
26. Kenai Peninsula Youth Facility
27. Public Health Laboratories
28. Residential Child Care
29. Psychiatric Emergency Services
30. Behavioral Health Grants
31. Rural Services and Suicide Prevention
32. Services for Severely Emotionally Disturbed Youth
33. AK Fetal Alcohol Syndrome Program
34. Services to the Seriously Mentally Ill
35. Catastrophic and Chronic Illness Assistance
36. Nursing
37. Adult Preventative Dental Medicaid Svcs
38. Subsidized Adoptions & Guardianship
39. Child Care Benefits
40. Work Services
41. Chronic Disease Prevention/Health Promotion
42. Energy Assistance Program
43. Bureau of Vital Statistics
44. Emergency Medical Services Grants
45. Human Services Community Matching Grant
46. Senior Community Based Grants
47. Women, Infants and Children
48. Family Preservation
49. Infant Learning Program Grants
50. Youth Courts
51. Certification and Licensing
52. State Medical Examiner
53. Senior Residential Services
54. General Relief Assistance
55. Longevity Bonus
56. Community Health Grants
57. Community Action Prevention & Intervention Grants
58. Designated Evaluation and Treatment
59. Commissioner's Office
60. Administrative Support Services
61. Facilities Management
62. Office of Program Review
63. Information Technology Services
64. Rate Review
65. Quality Control
66. Fraud Investigation
67. Hearings and Appeals
68. Governor's Advisory Council on Faith-Based and Community Initiatives
69. Health Planning & Infrastructure
70. Facilities Maintenance
71. Pioneers Homes Facilities Maintenance
72. Children's Services Training
73. Public Assistance Field Services
74. Child Protection Legal Svcs
75. Community Health/Emergency Medical Services
76. Tobacco Prevention and Control
77. Assessment and Planning (Medicaid)
78. Women, Children & Family Health
79. Medicaid School Based Administrative Claims
80. HSS State Facilities Rent
81. Alaskan Pioneer Homes Management
82. Behavioral Health Administration
83. Children's Services Management
84. Medical Assistance Administration
85. Public Assistance Administration
86. Public Health Administrative Services
87. Senior and Disabilities Services Administration
88. Permanent Fund Dividend Hold Harmless
89. Council on Faith Based & Community Initiatives
90. Children's Trust Programs
91. Alcohol Safety Action Program (ASAP)
92. Alaska Mental Health/Alcohol & Drug Abuse Brds
93. Commission on Aging
94. Governor's Council on Disabilities
95. Pioneers Homes Advisory Board
96. Suicide Prevention Council

FY08 Budget

The Department of Health and Social Services (DHSS) faced tremendous challenges in the last few years to provide a balance between reducing the reliance on state general funds and providing services to vulnerable populations.

Proposed budget for 2008 compared to 2007

	2007	2008 Proposed
DHSS budget		
General Fund	**$ 748.5 million**	**$ 861.4 million**
Federal Funds	**1,075.2 million**	**1,142.1 million**
Other Funds	**152.5 million**	**156.8 million**
Total	**$ 1,976.2 billion**	**$ 2,160.3 billion**
Increased Federal Revenue		**66.9 million**
Increased General Fund		**112.9 million**

While the proposed budget for FY2008 increases by over $112 million in general funds, the department has identified three main causes of the increase: First, just to sustain the same level of services in FY2008 as in FY2007 will cost $34 million in state general funds. This is primarily due to increases in the Medicaid program. Second, re-establishing the Longevity Bonus program is expected to cost $33.7 million in FY2008. Third, retirement system costs increases for DHSS cost $24.9 million in state general funds (although in addition we expect federal and other funds will pay $8.7 to the retirement fund as well). All in all, these three main cost drivers account for 83% of the general fund increases in the DHSS budget.

To assist in understanding the DHSS budget we have separated general fund budget items into the following categories:

Sustain Services:

Budget items in this category include: those driven by increased caseload (Medicaid and Child Care); providing annualized funding for FY2007 increases that were only funded for a portion of FY2007 (Pioneer Homes), and impacts from changes in federal policy that reduce federal funds in matching programs. So just to maintain the same level of service in FY2008 as FY2007 DHSS requires $34 million in additional state general fund for this category.

Safety and Compliance:

Budget items in this category include additional staff in the Pioneer Homes to meet federal Veteran's Administration requirements for the new Veteran's Home and Level of Care licensing requirements to effectively implement the Bring the Kids Home initiative.

Quality Assurance:

Quality Assurance improvements continue to be a priority of the department. Efforts are underway to improve resources in this area.

Healthy Futures:

The department is proposing investments to assist in a healthy future for Alaskans. This includes: re-establishment of the Longevity Bonus program, Medicaid Rate increases for facility based services and primary care providers, and continuing improvements for the Bring the Kids Home program.

Category	Division	Budget Item	GF
Sustain Services			
	AKPH	Annualized Funding for FY07 New Positions	390.0
	DBH	Restore Grants to Continuation Levels	696.8
	DBH	FY08 Projected Medicaid Growth	2,446.2
	DBH	FFY08 Medicaid SCHIP Allotment Shortfall	1,305.0
	OCS	Implement Federal Deficit Reduction Act	3,844.8
	HCS	Upper Payment Limit Decline – ProShare	4,044.0
	HCS	FFY08 Medicaid SCHIP Allotment Shortfall	2,612.1
	HCS	FY08 Projected Medicaid Growth	7,696.2
	DPA	Child Care Program Caseload Growth	1,547.7
	DPH	2nd Year Fiscal Note (HB109) Newborn Hearing Screening	37.7
	SDS	FY08 Projected Medicaid Growth	7,642.2
	DSS	Re-establish Faith Based Council	414.3
	DSS	Deficit reduction Act for Title IV E	251.0
	HCS	Year 2 Fiscal Note (HB105) Adult Dental Prev Medicaid Svcs	1,089.5
	DSS	Faith Based council Quarterly Meetings	24.0
		SUSTAIN SERVICES SUBTOTAL	34,041.5
Safety and Compliance			
	AKPH	Additional Positions to Meet Veteran Home Requirements	162.5
	DBH	Bring the Kids Home (BTKH) Level of Care Licensing	100.0
	HCS	Year 2 Fiscal Note (HB426) Medical Assistance Eligibility and Insurance Coverage	(3,931.7)
	DPA	2nd Year Fiscal Note (HB426) Med Assistance Eligibility and Coverage	66.4
	SDS	Year 2 Fiscal Note (HB426) Medical Assistance Eligibility and Insurance Coverage	(158.8)
		SAFETY AND COMPLIANCE SUBTOTAL	(3,761.6)
Healthy Futures			
	ALB	Alaska Longevity Bonus Program	33,709.2
	DBH	Increase Residential Psychiatric Treatment Center in-State Provider Medicaid Rates	654.9
	DBH	Medicaid Facility Rates Rebased – Inpatient Psychiatric Hospital	323.5
	DBH	Bring the Kids Home (BTKH) Residential Aide Training	105.0
	DBH	Bring the Kids Home (BTKH) Training Academy	200.0
	DBH	BTKH Community Behavioral health Centers outpatient Grants and Training for Special Populations	1,000.0
	DBH	BTKH Youth Intensive outpatient, Residential and Continuing Care Services	1,000.0
	DBH	BTKH Individualized Services/Home and Community Based Start up Grants	950.0
	DBH	BTKH Anchorage Crisis Stabilization	184.0
	DBH	BTKH Expansion of School-Based Services	250.0
	DBH	BTKH Peer navigators Funding to Non-Profits/Parent and Youth Navigators	200.0
	HCS	Increase Disproportionate Share Hospital	11,201.9
	HCS	Medicaid Rate Increase – Primary Care	3,742.4

HCS	Medicaid Facility Rates Rebased – Hospitals	2,779.4
SDS	Medicaid Facility Rates Rebased – Nursing Homes	1,441.3
	HEALTHY FUTURES SUBTOTAL	57,741.6

Salary Adjustments

DEPT	FY 08 Health Insurance Increases for Exempt Employees	6.6
DEPT	Retirement and non-covered Employee health insurance increases for Division of Personnel	399.7
DEPT	FY 08 Retirement Systems Rate Increases	24,511.3
	SALARY ADJUSTMENT SUBTOTAL	24,917.6

Transfer to/from Other Agencies

DEC	Transfer Funding from the Department of Environmental Conservation for Lease	23.6
	TRANSFER TO/FROM OTHER AGENCIES SUBTOTAL	23.6

TOTAL DEPARTMENT GF ADJUSTMENTS **112,962.7**

Expenditure Category Comparisons

For purposes of historical comparisons we have broken out expenditures into five categories of funding:

Formula Programs
Includes all programs with specific eligibility standards which guarantee a specific level of benefits for any qualified recipient: Alaska Temporary Assistance Program (ATAP), Adult Public Assistance, General Relief Assistance, Tribal Assistance Programs, Medicaid Services, Catastrophic and Chronic Illness Assistance, Child Care Benefits, Foster Care, and Subsidized Adoption and Guardianship.

Grants
Includes the components with major grants to other organizations or major contracts for service delivery, such as Residential Child Care, Energy Assistance Program, Community Health Grants, and various treatment programs.

Program Services
Includes both administration and delivery of direct services, such as public health nursing and social services, and the program management of entitlements and grants.

Administration
Administration includes departmental administrative oversight and support programs, including the Commissioner's Office, Administrative Services, and Boards and Commissions.

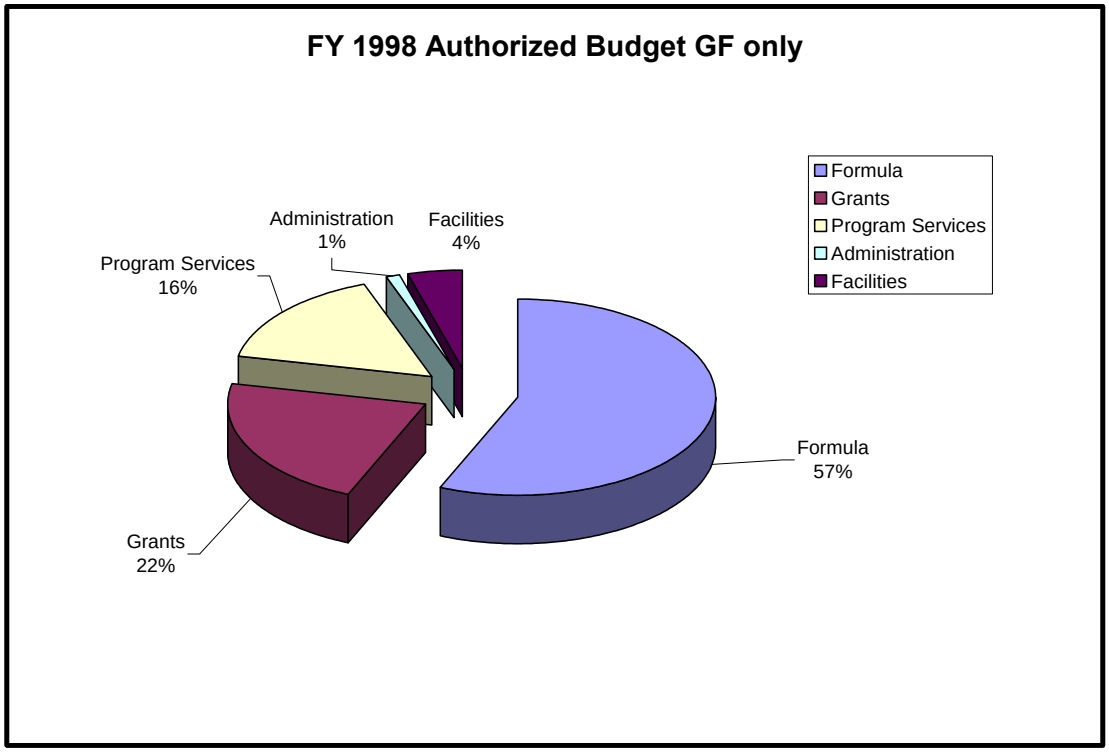
Facilities
The department manages and operates 24-hour facilities and institutions. These include youth correctional facilities, Alaska Psychiatric Institution, and Pioneer Homes.

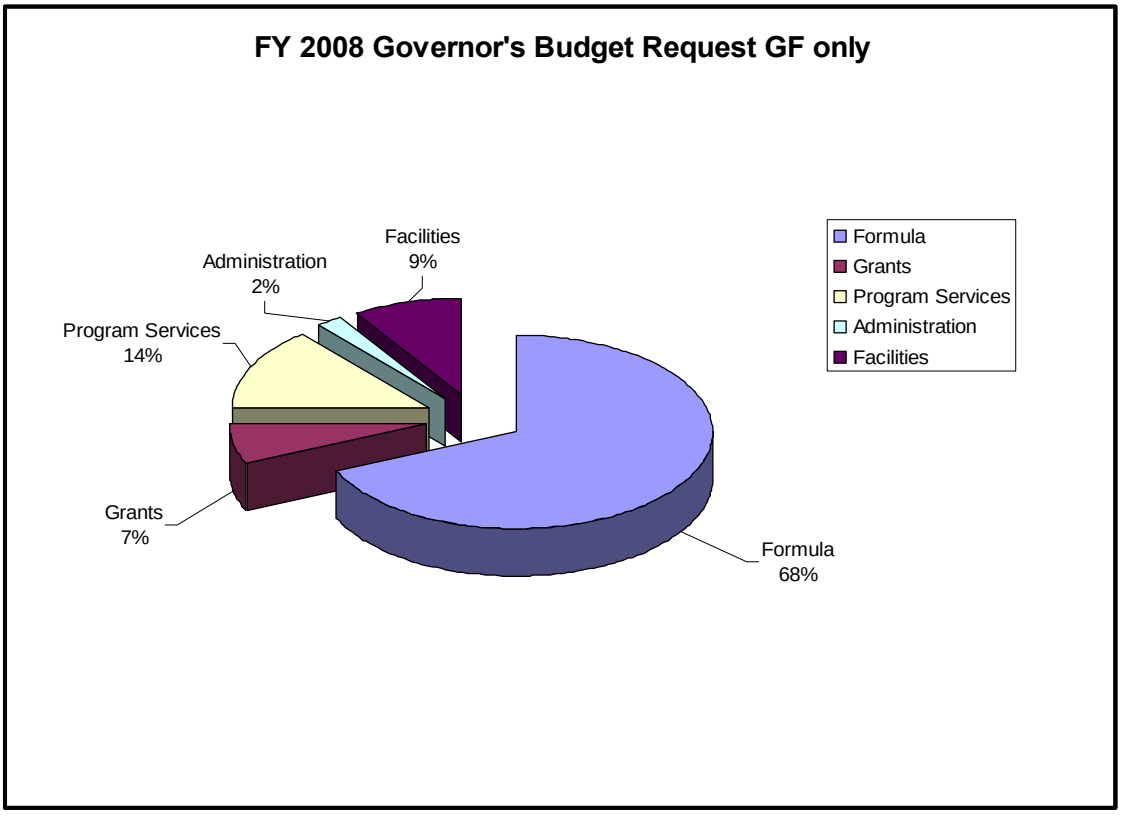
Budget Charts and Graphs

The table below shows the comparison of total funds for FY1998 and FY2008.

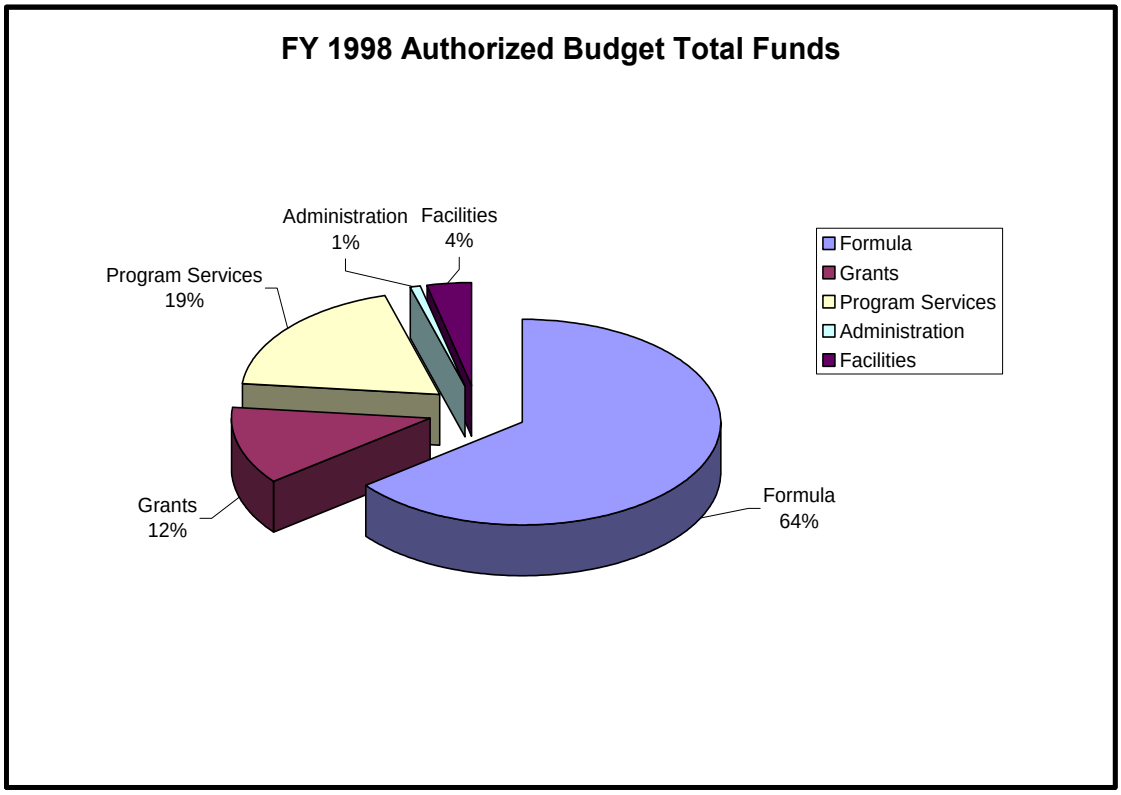
	FY1998 Authorized		**FY2008**		
	Total Funds	**% of Total**	**Total Funds**	**% of Total**	**08 to 98 Change**
Formula	564,669.9	64.4%	1,579,096.3	73.1%	180%
Grants	108,395.3	12.4%	120,887.3	5.6%	12%
Program Services	164,572.0	18.8%	303,083.0	14.0%	84%
Administration	6,902.5	0.8%	44,820.8	2.1%	549%
Facilities	32,450.7	3.7%	112,448.7	5.2%	247%
Total	**876,990.4**		**2,160,336.1**		**146%**

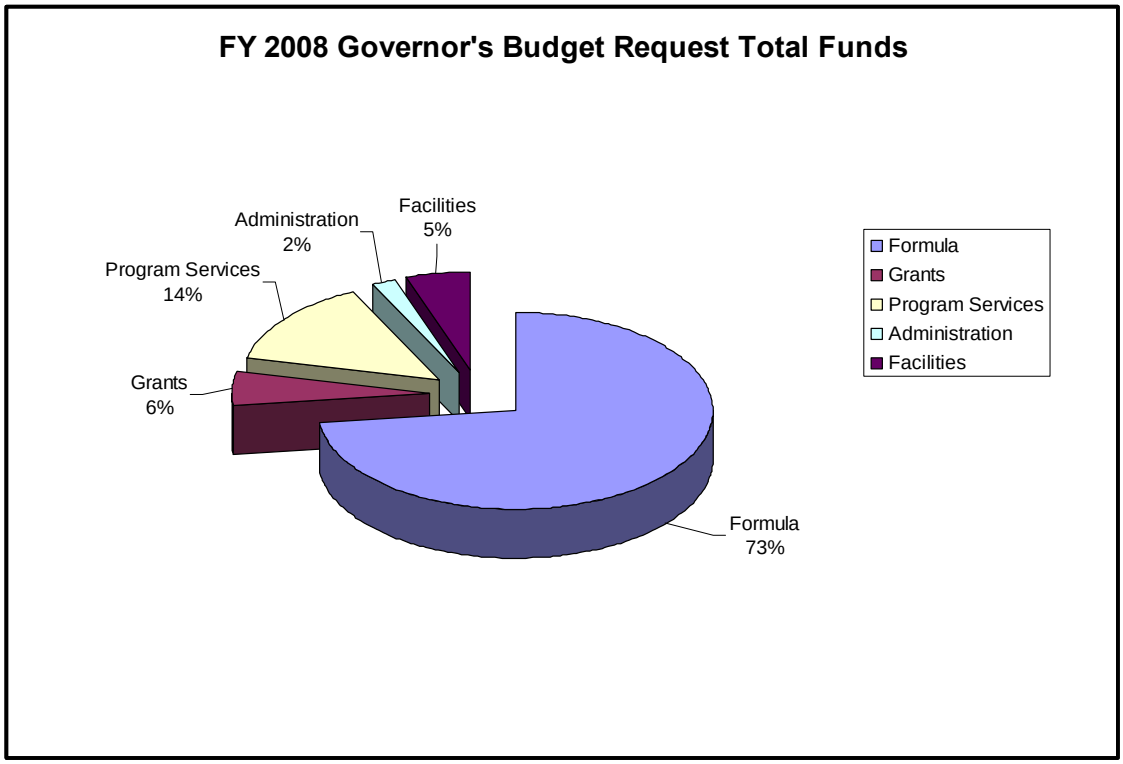
Expenditure Category Comparisons of General Fund Authorization





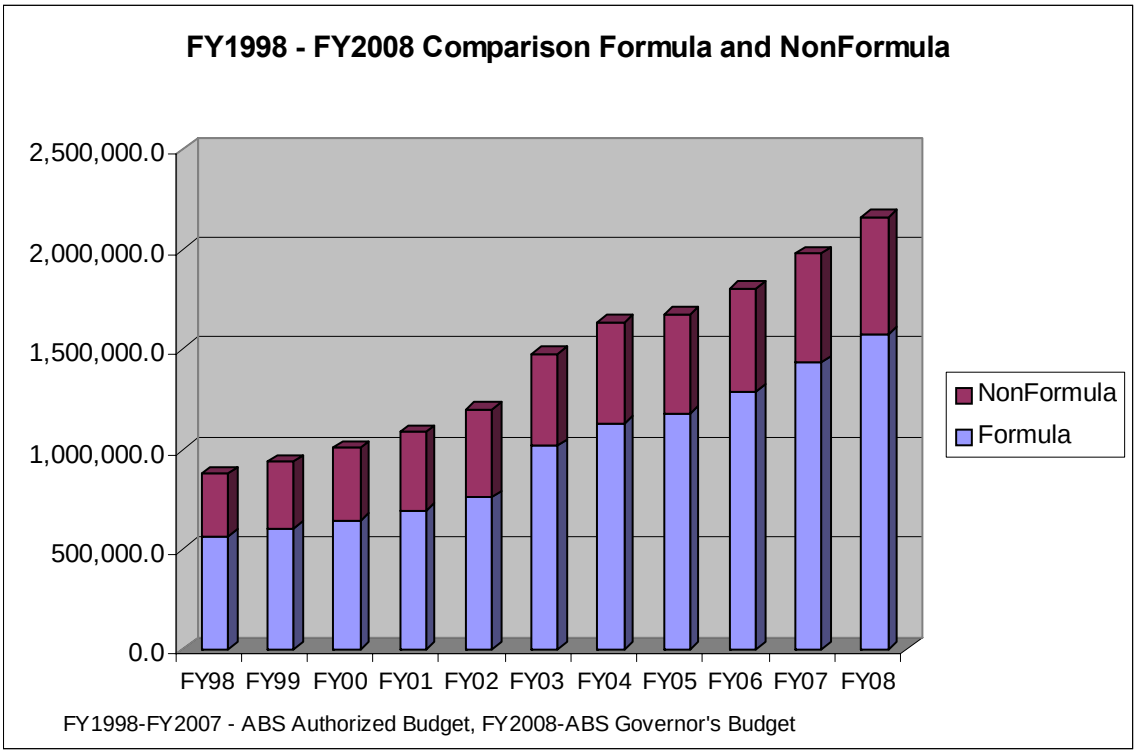
Expenditure Category Comparisons of Total Funds Authorization





As the previous charts show, formula programs make up more than half of the department's expenditures. Looking back to FY98, formula programs made up approximately 57% of the department's general fund budget in comparison to FY2008 of 68% of the general fund budget.

The chart below breaks out formula and nonformula categories of budget.



From FY1998 – FY2002 formula programs were fairly consistent between 63% - 65% of the department's overall budget. In FY2003 and FY2004 it was closer to 69% and FY2008 is 73% as reflected on the earlier charts. Medicaid is the largest formula program in the department, totaling 84% of the total Formula program category in the proposed FY2008 budget.

Medicaid

Introduction

In this section, we review the Medicaid program department-wide. Additional detailed descriptions of programs and budget changes, as well as more in-depth statistical analyses, are found in later chapters of the Budget Overview covering the four divisions that oversee direct service delivery: Behavioral Health, Children's Services, Health Care Services, and Senior and Disabilities Services.

Program Overview

Medicaid is an entitlement program created in 1965 by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into specified eligibility categories. It covers aged, blind, or disabled persons and single parent families. In addition, Medicaid expanded coverage in 1998 through the State Children's Health Insurance Program (SCHIP) to children and pregnant women whose income is too high to qualify for regular Medicaid, but too low to afford private health insurance. SCHIP enrollment is administered through the Denali KidCare office.

Alaska's Medicaid program affects the service delivery of every division within the Department of Health and Social Services, as well as six[1] other departments within the state government. Four main divisions manage benefits: Health Care Services, Behavioral Health Services, Senior and Disabilities Services, and Office of Children's Services. All other divisions have Medicaid administration activities, which the Division of Health Care Services oversees.

Medicaid Benefit Programs by Division

Behavioral Health	Mental health, substance abuse, residential psychiatric treatment centers, and inpatient psychiatric facilities
Children's Services	Behavioral rehabilitation
Health Care Services	Hospitals, physician services, pharmacy, transportation, dental, vision, physical/occupational/speech therapy, chiropractic, medical equipment, home health, hospice, laboratory, X-ray, state-only Medicaid, premium assistance, third-party recoveries, supplemental hospital payments, and Medicaid administrative management
Senior and Disabilities Services	Nursing homes, personal care, and four home and community based waiver programs

As a joint federal-state program, the federal and state governments share the cost of Medicaid. Federal financial participation rates are set at the federal level, and are largely outside of state control. The State's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called the Federal Medical Assistance Percentage, or FMAP.

The FMAP is based on a three-year average of per capita personal income, ranked among states. While each state has its own FMAP, it can be no lower than 50%. Although the majority of benefits are reimbursed at the regular FMAP rate, certain subgroups have higher reimbursement rates (i.e., qualified Indian Health Services claims are reimbursed 100%). Where possible, the state contains costs by taking advantage of higher reimbursement rates.

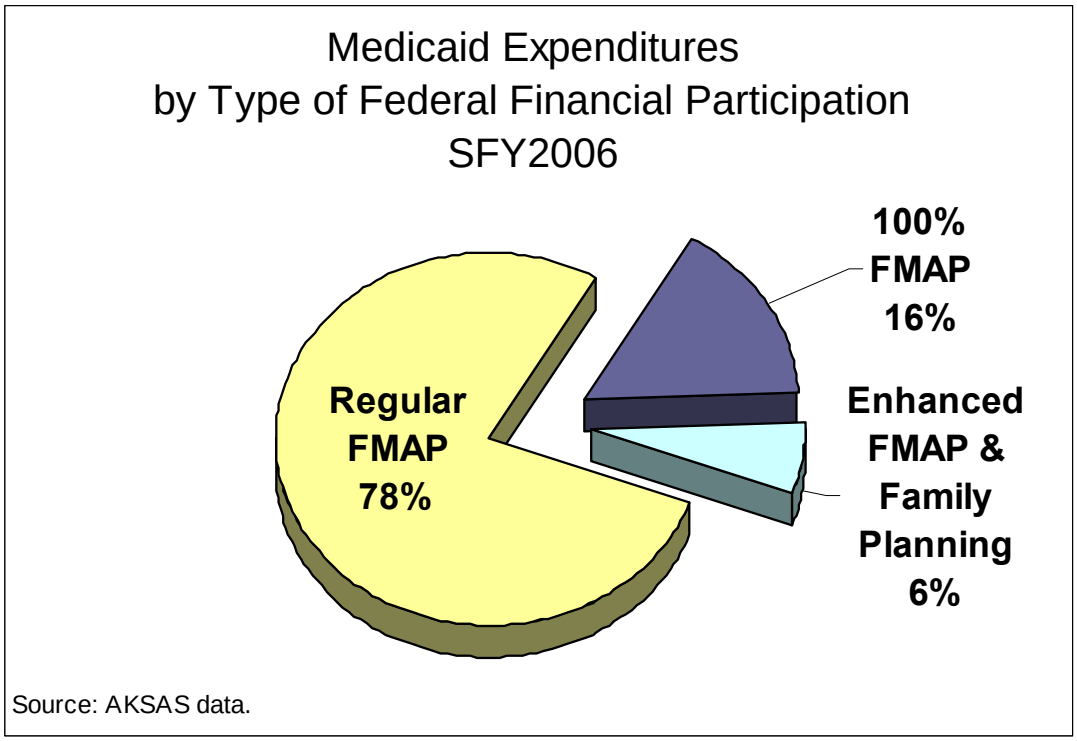
[1] Departments of Administration, Courts, Corrections, Education and Early Development, Law, and Labor and Workforce Development.

Federal Medical Assistance Percentages for Claim Payments

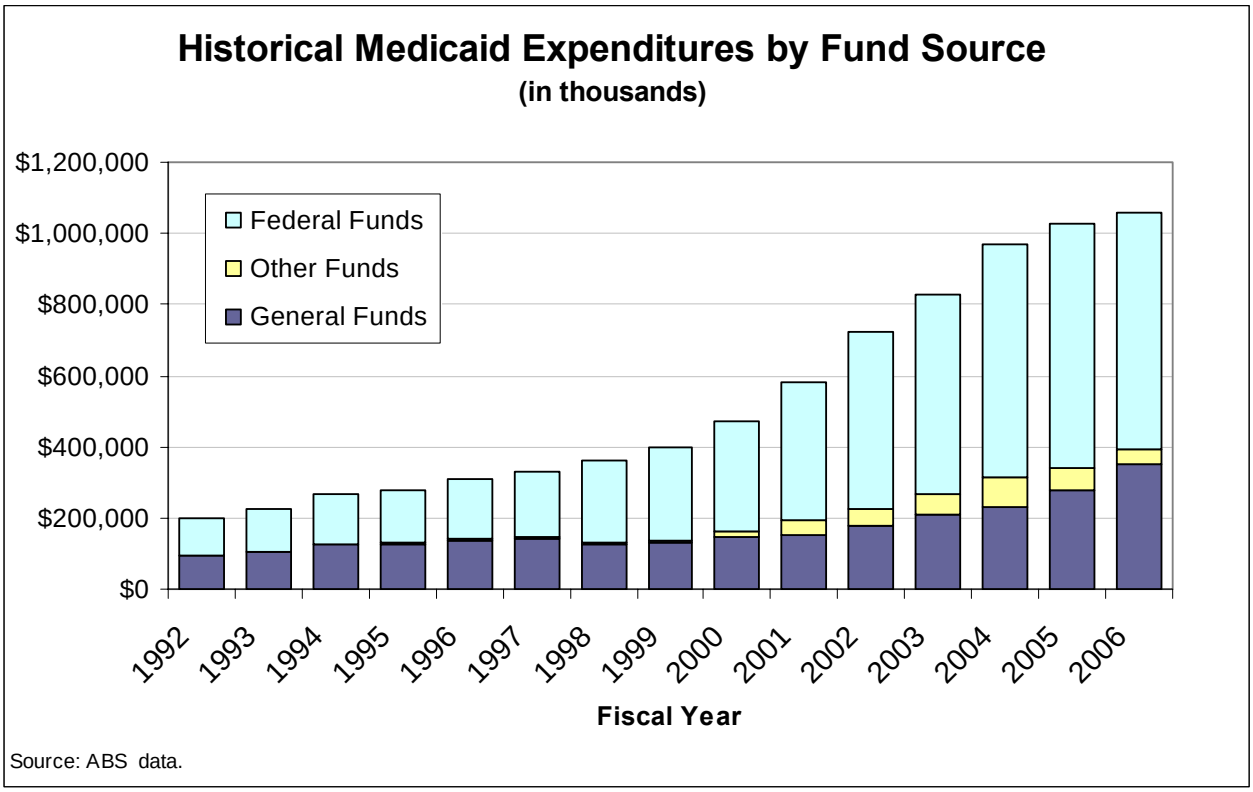
	Federal Fiscal Year Statutory Rate		State Fiscal Year Average Rate	
Year	Regular FMAP	Enhanced FMAP	Regular FMAP	Enhanced FMAP
1998	50.00	71.86	50.00	71.86
1999	59.80	71.86	57.35	71.86
2000	59.80	71.86	59.80	71.86
2001	60.13	72.09	60.05	72.03
2002	57.38	70.17	58.07	70.65
2003	59.75	70.79	58.79	70.64
2004	60.60	70.87	61.31	70.85
2005	57.58	70.31	57.78	70.45
2006	57.58	70.31	57.58	70.31
2007	57.58	70.31	57.58	70.31
2008	52.48	66.74	53.76	67.63

Source: Medicaid Budget Group and Centers for Medicare and Medicaid Services.

Alaska currently benefits from special legislation passed in the Deficit Reduction Act of 2005 that allowed the FMAP to remain at the FFY 2005 level of 57.58% for FFY 2006 and 2007. This special rate will expire October 1, 2007, at which time Alaska's FMAP will drop 5.1 percentage points to 52.48%. The FFY08 change in FMAP will require an estimated $37,125.4 increase in GF to replace the lost federal funds and maintain services at the current level if congress does not act to fix the problem. *This fund change is not included in the Governor's Budget proposal.*



The department has successfully minimized the need for additional state general funds while still meeting its mission. Although costs, including total general funds, have grown yearly, federal dollars have covered the majority of the increases. The department accomplished this by taking full advantage of enhanced match rates and federal refinancing programs. General funds accounted for 45% of Medicaid funding in SFY 1997. In SFY 2006, general funds supported only 37% of the Medicaid program.



One of the refinancing measures the department has implemented is to increase the proportion of Medicaid services eligible for Indian Health Service 100% federal reimbursement. For every dollar shifted to the tribal system from regular FMAP in FFY 2007, the State saves 42 cents in state matching fund. The department continues to work with tribal health corporations to maximize the benefits of this refinancing program. In SFY 2006 16% of all Medicaid expenditures were IHS.

Cost containment is an important method of holding down increases in Medicaid expenditures. Strategies to control costs have been successful as demonstrated by the slowing rate of growth in Alaska's Medicaid costs. Medicaid expenditures for Alaska climbed an average of 20% per year from SFY 2000 to SFY 2003 compared to 9% growth rate from SFY 2006 to SFY 2007.

Medicaid Expenditures by Fund Source

(in thousands)

Fiscal Year	General Funds	Federal Funds	Other Funds	Total Funds
1991	$80,094	$91,990	$1,796	$173,880
1992	$93,582	$105,740	$934	$200,256
1993	$103,447	$119,602	$708	$223,757
1994	$123,553	$142,729	$1,401	$267,684
1995	$127,125	$149,589	$1,792	$278,506
1996	$138,013	$167,280	$3,105	$308,398
1997	$141,517	$183,355	$6,568	$331,440
1998	$125,542	$231,330	$5,476	$362,347
1999	$131,523	$261,316	$2,851	$395,690
2000	$145,515	$307,508	$17,686	$470,709
2001	$152,791	$387,432	$43,671	$583,894
2002	$177,701	$497,428	$46,926	$722,054
2003	$211,077	$558,581	$58,460	$828,117
2004	$230,119	$658,741	$82,631	$971,491
2005	$276,089	$685,474	$63,355	$1,024,918
2006	$348,648	$664,722	$46,507	$1,059,877
2007 *	$387,527	$799,905	$24,440	$1,211,872
2008 **	$430,272	$863,528	$28,290	$1,322,090

Source: Medicaid Budget Group using Alaska Budget System data.

*Management Plan. **Governor's Budget.

The statistics summarized in this section are for the entire Medicaid program. There are additional detailed Medicaid statistics in the division sections for Health Care Services, Behavioral Health Services, and Senior and Disabilities Services.

In SFY 2006, 132,000 or one in five Alaskans were enrolled in the state's Medicaid program. Enrollment has remained relatively stable, growing on average about 2% a year since SFY 2000. Ninety-three percent of the enrollees utilized services in SFY 2006, down three percentage-points from SFY 2005 but still the second highest participation rate since SFY 2000.

Participation in Medicaid

Fiscal Year	Alaska Population	Medicaid Enrollment	Medicaid Beneficiaries	Percent of Population Enrolled in Medicaid	Percent of Enrollees Receiving Benefits
2000	627,500	110,219	96,033	18%	87%
2001	632,249	116,226	104,730	18%	90%
2002	640,699	121,582	109,571	19%	90%
2003	648,510	126,632	116,008	20%	92%
2004	657,755	129,528	118,466	20%	91%
2005 *	663,661	131,136	125,318	20%	96%
2006 **	669,977	131,996	122,978	20%	93%

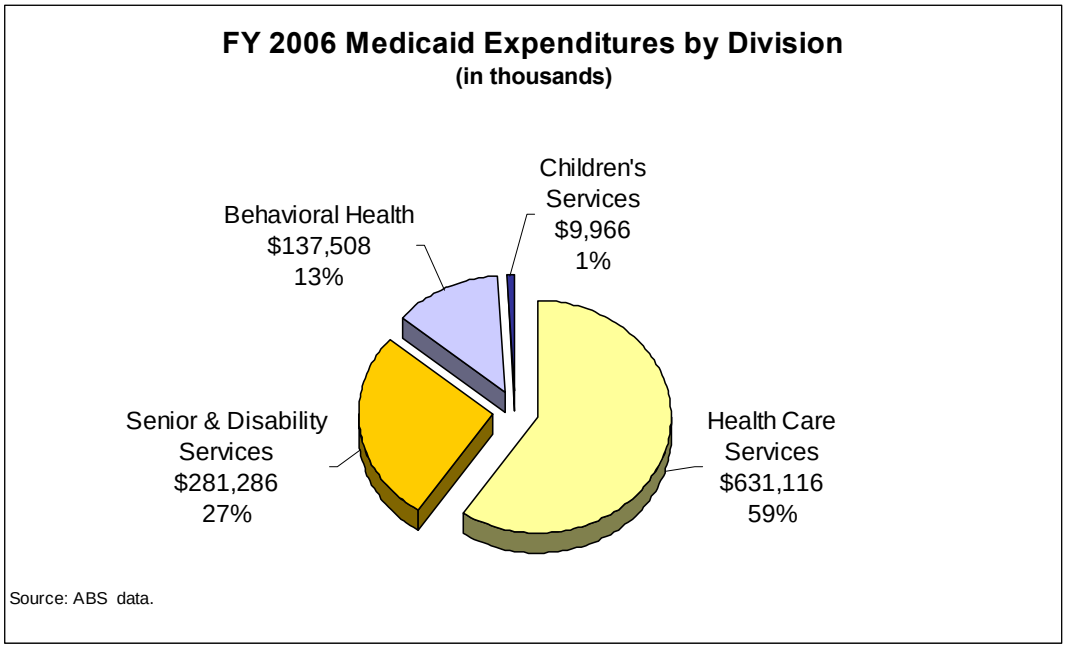
Source: Medicaid Budget Group (MMIS-JUCE) and AK Dept. of Labor and Workforce Development.

* Population for 2005 is provisional. ** Population for 2006 is projected.

Enrollment and beneficiaries are unduplicated counts of individuals in each fiscal year.

Many enrollees receive services through more than one division since clients, once enrolled, can receive any services for which they are eligible. For example, a client receiving mental health counseling through the Division of Behavioral Health can also get a flu shot through the Division of Health Care Services. Ninety-nine percent of enrollees received some benefits through Health Care Services, 11% received benefits through Behavioral Health Services; Senior and Disabilities Services assisted 6%; and Children's Services provided care to 1% of the enrollees.

The majority of expenditures are in Health Care Services, which accounted for 59% of the costs in SFY 2006. Costs for long-term care for seniors and the persons with disabilities comprised 27% of the total. The remaining 14% of expenditures were incurred by Behavioral Health Services (13%) and Children's services (1%).

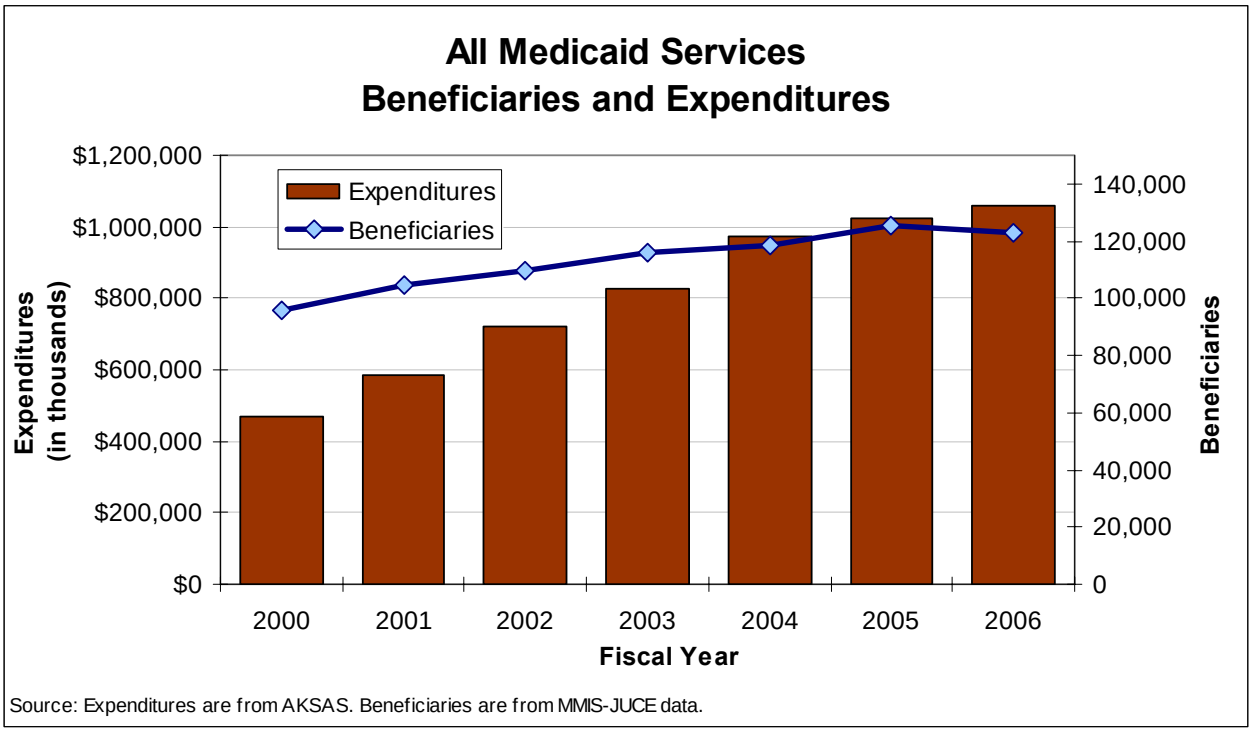


Medicaid Expenditures by Division, SFY 2006

(in thousands)

Total Medicaid Services	$	1,059,876.8
Division of Health Care Services	$	631,116.3
Pharmacy	$	83,539.0
Physician Services	$	117,267.3
Hospital Services	$	207,195.3
Transportation	$	44,574.7
Dental	$	20,983.6
Medicaid (State-only)	$	605.4
Other Medicaid Direct Services	$	55,318.2
Non-MMIS Services	$	42,258.3
Medicaid Refinancing	$	59,374.5
Division of Seniors & Disabilities Svcs	$	281,286.4
Personal Care Services	$	83,542.5
Nursing Homes	$	72,511.2
AD Waiver	$	15,792.3
CCMC Waiver	$	8,914.4
MRDD Waiver	$	69,062.8
OA Waiver	$	30,866.4
Other LTC	$	596.8
Division of Behavioral Health	$	137,508.3
Res. Psych. Treatment Center	$	56,496.4
Inpatient Psychiatric Facilities	$	16,898.0
General Mental Health	$	64,113.9
Office of Children's Services	$	9,965.8
Behavioral Rehabilitation	$	9,965.8

Source: Medicaid Budget Group using AKSAS data.



Medicaid expenditures have been rising due to the increased cost of medical services and increased utilization of services by greater numbers of Alaskans, especially the elderly. The cost of health care is rising faster than the inflation rate. The Anchorage Consumer Price Index for all items increased 10.7% between 2001 and 2005; meanwhile medical care expenses increased 21.7% between 2001 and 2005.

The number of Alaskans enrolled in Medicaid has risen 9% over the last five years. Demand for medical services has also climbed as the proportion of enrollees utilizing services has increased. Growth has been greatest in three categories: personal care services, residential psychiatric treatment centers, and hospitals.

SFY 2006 DEPARTMENT LEVEL SUMMARY	MEDICAID CLAIMS AND ENROLLMENT							
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	ENROLLMENT		PARTICIPATION (Recipients as Percent of Enrollment)
	Percent of Category	Annual Count	Percent of Category	Annual Total		Percent of Category	Annual Count	
Medicaid, Department Annual Totals		**122,975**		**$978,844,191**	**7,960**		**131,996**	**93.2%**
Gender								
Female	56.9%	70,051	56.9%	$556,852,260	$7,949	55.1%	72,807	96.2%
Male	43.1%	52,982	43.1%	$421,991,341	$7,965	44.9%	59,281	89.4%
Unknown	0.0%	2	0.0%	$590	$295	0.0%	3	66.7%
Race								
Alaska Native	37.1%	46,158	37.6%	$368,453,544	$7,982	36.3%	48,600	95.0%
American Indian	1.4%	1,784	1.4%	$13,276,933	$7,442	1.5%	2,001	89.2%
Asian	5.2%	6,483	4.6%	$44,986,639	$6,939	5.6%	7,526	86.1%
Pacific Islander	2.6%	3,232	1.9%	$18,489,666	$5,721	2.9%	3,919	82.5%
Black	5.1%	6,375	4.5%	$44,513,546	$6,983	5.3%	7,052	90.4%
Hispanic	3.5%	4,342	2.3%	$22,278,984	$5,131	3.5%	4,741	91.6%
White	41.5%	51,619	44.7%	$437,955,421	$8,484	41.3%	55,273	93.4%
Unknown	3.4%	4,269	3.0%	$28,889,457	$6,767	3.6%	4,758	89.7%
Native	38.8%	47,905	39.0%	$381,730,478	$7,968	38.1%	50,547	94.8%
Non-Native	61.2%	75,551	61.0%	$597,113,714	$7,903	61.9%	82,124	92.0%
Age								
under 1	9.0%	12,069	8.6%	$84,148,591	$6,972	8.3%	11,690	103.2%
1 through 12	37.1%	49,618	14.8%	$145,338,277	$2,929	39.1%	55,368	89.6%
13 through 18	17.0%	22,756	16.8%	$163,992,495	$7,207	18.1%	25,661	88.7%
19 through 20	3.2%	4,318	2.6%	$25,645,316	$5,939	2.8%	3,995	108.1%
21 through 30	10.1%	13,451	10.3%	$101,249,650	$7,527	9.3%	13,199	101.9%
31 through 54	13.8%	18,459	21.7%	$212,205,134	$11,496	13.3%	18,889	97.7%
55 through 64	3.3%	4,444	8.0%	$78,097,447	$17,574	3.1%	4,345	102.3%
65 through 84	5.4%	7,262	13.2%	$129,594,484	$17,846	5.1%	7,258	100.1%
85 or older	0.9%	1,228	3.9%	$38,572,797	$31,411	0.8%	1,166	105.3%
Benefit Group								
Children	63.2%	79,051	35.8%	$350,281,539	$4,431	65.4%	87,266	90.6%
Adults	18.1%	22,658	11.8%	$115,873,550	$5,114	17.1%	22,819	99.3%
Disabled Children	1.5%	1,923	5.6%	$54,758,642	$28,476	1.4%	1,847	104.1%
Disabled Adults	11.2%	13,985	30.8%	$301,004,761	$21,523	10.5%	14,046	99.6%
Elderly	6.0%	7,493	16.0%	$156,925,700	$20,943	5.6%	7,475	100.2%

Payments: Net amount of paid claims. Amounts do not reflect payments for Medicaid services made outside of the Medicaid management information system such as lump-sum payments, recoveries, or accounting adjustments. Therefore, these amounts will not tie to AKSAS or ABS.

Enrollment: Number of persons eligibile for Medicaid and enrolled at some time during state fiscal year 2006. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,benefit group, and region categories). Some duplications may occur in subgroup counts. For example, a child might be counted in the under 1 subgroup but also in the 1 through 12 subgroup after their first birthday.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2006. Service may have been incurred in a prior year. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,benefit group, and region categories). Some duplications may occur in subgroup counts.

Participation: Recipients as a percent of eligible persons (as a percent of enrollment). The percent of eligible persons having claims paid or adjusted during the fiscal year. The number of persons with claims paid in this fiscal year for services incurred in a prior fiscal cycle may cause the calculated %participation to exceed 100%.

Department-wide recipient counts are unduplicated across divisions.

Source: HSS, Finance and Management Services, Medicaid Budget Group.

		2007 Mgmt Plan	2008 Proposed	07 to 08 Change
Total All Medicaid Services	General Funds	387,526.9	430,272.5	42,745.6
	Federal Funds	799,905.6	863,528.0	63,622.4
	Other Funds	24,439.8	28,289.8	3,850.0
	Total	**1,211,872.3**	**1,322,090.3**	**110,218.0**
Behavioral Health Medicaid Services	General Funds	61,154.3	65,883.9	4,729.6
	Federal Funds	92,417.2	110,937.9	18,520.7
	Other Funds	1,500.0	2,400.0	900.0
	Total	155,071.5	179,221.8	24,150.3
Children's Medicaid Services	General Funds	7,080.6	7,080.6	0.0
	Federal Funds	9,065.1	9,065.1	0.0
	Other Funds	0.0	0.0	0.0
	Total	16,145.7	16,145.7	0.0
Adult Preventative Dental Medicaid Services	General Funds	219.7	1,309.2	1,089.5
	Federal Funds	1,988.3	7,557.8	5,569.5
	Other Funds	425.0	1,425.0	1,000.0
	Total	2,633.0	10,292.0	7,659.0
Health Care Medicaid Services	General Funds	191,080.7	219,082.5	28,001.8
	Federal Funds	513,005.7	538,166.6	25,160.9
	Other Funds	21,139.8	21,889.8	750.0
	Total	725,226.2	779,138.9	53,912.7
Senior and Disabilities Medicaid Services	General Funds	127,991.6	136,916.3	8,924.7
	Federal Funds	183,429.3	197,800.6	14,371.3
	Other Funds	1,375.0	2,575.0	1,200.0
	Total	312,795.9	337,291.9	24,496.0

Source: Medicaid Budget Group using Alaska Budget System data.

For SFY 2008, the department is requesting an increase of $110.2 million from SFY 2007 for Medicaid services, department-wide. In the last ten years, total costs for Medicaid have risen at an average annual rate of 11% from $308.4 million in SFY 1996 to $1,059.9 million in SFY 2006. The SFY 2008 request represents an increase of only 9% from SFY 2007 authorization. Of the $110.2 million requested, $42.7 million, or 39%, is general fund.

SFY 2008 Budget Change Record Summary for All Medicaid Services

For additional information on these change records, please see the division(s) listed in parentheses after the title.

	General Funds	Federal Funds	Other Funds	Total
Total All Change Records for Medicaid Services	**$42,745.6**	**$63,622.4**	**3,850.0**	**$110,218.0**
Year 2 Fiscal Notes (HCS, DBH, APDMS)	**($3,001.0)**	**$1,178.4**	**$1,000.0**	**($822.6)**
There are two Year 2 Fiscal notes: $7,659.0 (1,089.5 GF/5,569.5 Fed/1,000.0 MHTAAR) for the Adult Preventative Dental Medicaid Services established under HB 105; and -$8,481.6 (-4,090.5 GF/-4,391.1 Fed) for cost savings from changes to eligibility under HB 426.				
SFY08 Projected Medicaid Growth (DBH, HCS, SDS)	**$17,784.6**	**$33,796.3**	**$2850.0**	**$54,430.9**
For SFY08, the department projects a 4% increase due to program growth in direct services. This increment request is necessary to maintain the current level of Medicaid services. Medicaid claim payments for direct services grew 12% from FY04 to FY05, but only 4% from FY05 to FY06. The projection for FY08 is to maintain the same 4% growth rate. Growth in Medicaid can be attributed to the rising cost of medical services and increased utilization of services by greater numbers of Alaskans.				
Increase Disproportionate Share Hospital (DSH) (HCS)	**$11,201.9**	**$11,499.7**	**$0.0**	**$22,701.6**
Alaska's allotment of federal DSH funds increases by 16% each federal fiscal year; however, the level of funding in the state's budget for DSH has not increased in many years. The department makes payments to hospitals in the institution for mental disease and designated evaluation and treatment categories using GF to leverage the DSH federal funds. However, there currently is no GF available to make payments to hospitals in other categories. The department estimates DSH funding for SFY08 of approximately $36 million. Institution for mental disease and designated evaluation and treatment payments are expected to be about $13 million, leaving approximately $23 million to distribute to hospital in other categories. GF needed to match the federal dollars would be $11.2 million.				
FFY08 Medicaid SCHIP Allotment Shortfall (DBH, HCS)	**$3,917.1**	**($3,917.1)**	**$0.0**	**$0.0**
Alaska's annual allotment has fluctuated between $7 and $11 million. Since Alaska's annual allotment represents only about 25% of our costs, we have relied heavily on unspent funds from other states to maintain funding levels. As more and more states have increased their SCHIP programs, there are less unspent funds available. Alaska will have only 41% of the federal SCHIP funding needed to cover program expenditures in 2008, exhausting its SCHIP funds in the second quarter. When it reverts to regular Medicaid, the difference in federal reimbursement rates means that an additional $3.9 million GF is needed to maintain children's health coverage.				
Medicaid Rate Increases (DBH, HCS, SDS)	**$8,941.5**	**$25,251.1**	**$0.0**	**$34,192.6**
The department has several increments related to rate increases for providers. Rates for primary care providers are tied to Medicare rates, which underwent a major change this year. Rates for tribal outpatient behavioral health services, which are 100% federal, are expected to increase due to a change in methodology. Rates for in-state residential psychiatric treatment centers were raised in FY07 but are not included in the base budget. Hospitals and nursing facilities must be recalculated every four years per regulation and SFY08 is a re-basing year. Each of these rate increases is discussed in depth in the division sections.				
Upper Payment Limit Decline-ProShare (HCS)	**$4,044.0**	**($4,044.0)**	**$0.0**	**$0.0**
The ProShare program allows the state to make payments to qualifying hospitals for the difference between Medicare and Medicaid rates or the Upper Payment Limit (UPL). The department has made payments to hospitals and community health care providers for several years under ProShare supporting rural health care, mental health care, and children's health care programs. The additional funding is needed because a change in the way the UPL is calculated resulted in an allotment lower than our current ProShare payment level.				

Department of Health and Social Services

Mission

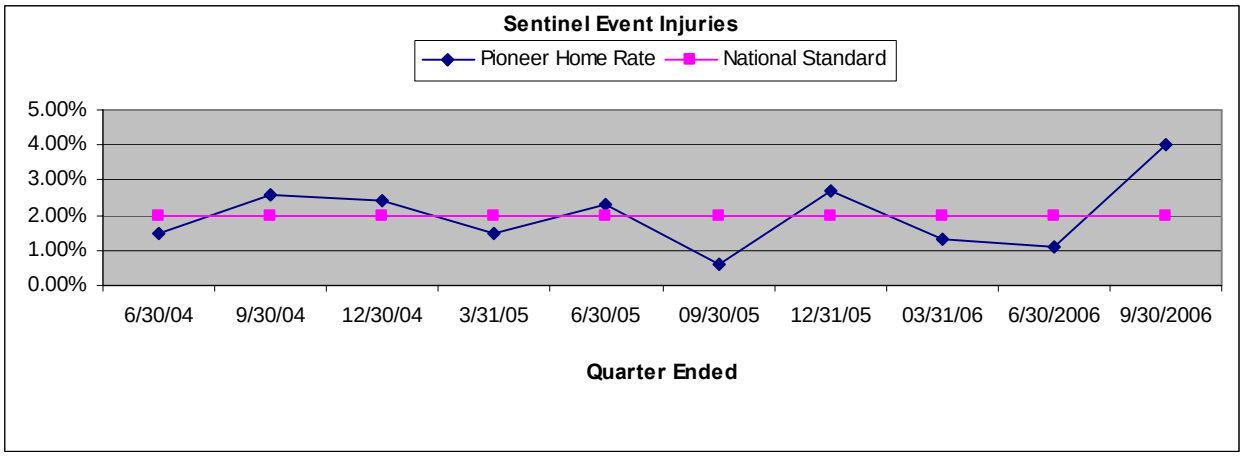
To promote and protect the health and well being of Alaskans.

Core Services

- Provide quality assisted living in a safe home environment.
- Provide an integrated behavioral health system.
- Promote stronger families, safer children.
- Manage health care coverage for Alaskans in need.
- Address juvenile crime by promoting accountability, public safety and skill development.
- Provide self-sufficiency and basic living expenses to Alaskans in need.
- Protect and promote the health of Alaskans.
- Promote independence of Alaska Seniors and people with physical and developmental disabilities.
- Provide quality administrative services in support of the department's mission.

A: Result - Outcome Statement #1: Provide a safe environment for Alaska pioneers and veterans.

Target #1: Injury rate below half the national standard, which is two to six percent.
Measure #1: Pioneers Home sentinel event injury rate.



Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	2.9%	0.7%	0%	0.37%	.99%
2003	1.1%	.04%	1.79%	1.5%	1.1%
2004	1.96%	0.1.26%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	4.0%	0	0	0	0

The Sentinel Event injury rate reports the percentage of falls that resulted in a major injury. The rate is calculated by dividing the number of Sentinel injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: The elderly, who represent 12 percent of the population, account for 75 percent of deaths from falls.

The average age in the Pioneer Homes is 84.9. This puts the residents in the highest risk category, and they are more likely to suffer a serious injury from a fall, and experience significant morbidity thereafter.

The Pioneer Homes will respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problems are even more disturbing. The event is called "sentinel" because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization, than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

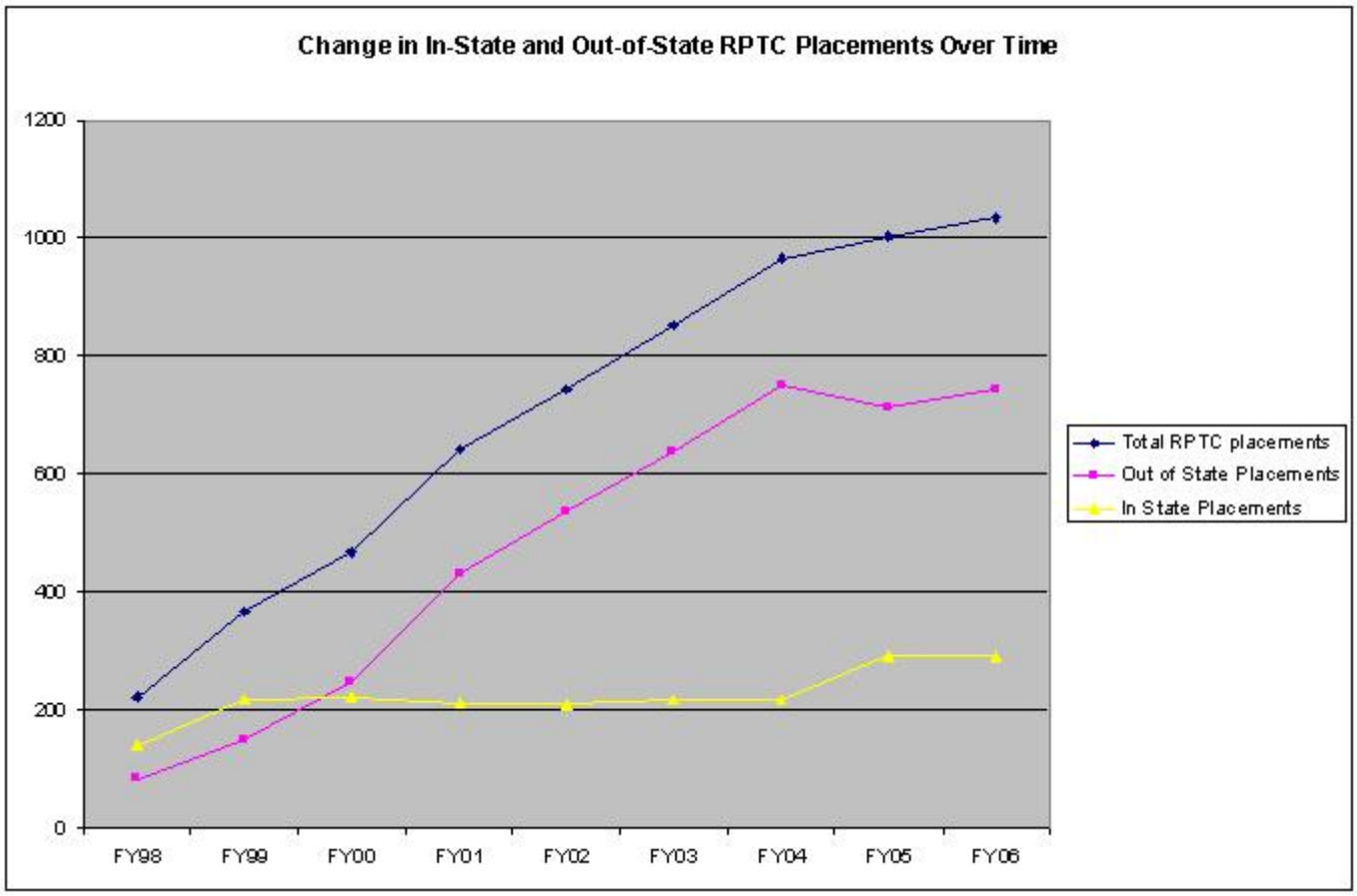
See Alaska Pioneer Homes Division Level Strategy A2: Target 1: Measure 1 for additional explanation.

A1: Strategy - Provide sufficient staffing for safe environment in the homes.

B: Result - Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.

Target #1: To reduce the number/percentage of children in out-of-state placement by 50 children annually over the next seven years.

Measure #1: Change in number/percentage of children reported in out-of-state care from Medicaid MMIS.



Source: DBH Policy and planning using MMIS-JUCE data, unduplicated count of RPTC beneficiaries.

Analysis of results and challenges: For the past eight years there has been a steady increase in the number of children receiving out-of-state Residential Psychiatric Treatment Center (RPTC) services. Between SFY 1998 and 2004, the unduplicated number of youth with Serious Emotional Disorders (SED) receiving out-of-state RPTC care has steadily increased – on average 46.7% per year. The RPTC population as a whole has also showed steady increase from SFY 98-04, an average annual increase of 24.8%.

The Bring the Kids Home Project was initiated during SFY 2004. Positive changes are already apparent. Between SFY 2004 and 2005 there was a 5.1% reduction in the number of children receiving out-of-state RPTC care, from 749 to 711. However, between SFY 2005 and 2006, there was again an increase in out-of-state placement, of 5%, from 711 to 743. In SFY 2006, there has also been a 3% increase in total RPTC placements. The historical average increase of 46.7% for out-of-state placements has been effectively challenged with the efforts to enhance "step-down" activities, that is, programs for children that are less intensive, less restrictive, and closer to home, than out-of-state residential programs.

Alaska Statute 47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the department has developed and implemented "diversion" activities, including aggressive case management services that discharge and return children to less restrictive levels of care; utilization review staff implementing gate-keeping protocols with a "level of care" instrument that insures appropriate placements; and collaboration with community-based providers to augment services at the least restrictive level within a client's home community. There have also been multiple capital projects initiated to increase the number of beds in-state, some of which have become available in SFY 07.

As more new beds and other programs become available, it is anticipated that there will be further impact on the rate of out-of-state placements. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice and Office of Children's Services, in partnership with the Mental Health Trust Authority.

Target #2: To reduce the rate of suicides in Alaska to 10.6 deaths per population of 100,000.
Measure #2: Alaska's suicide death rate compared to National rate.

Age Group	Deaths	Rate
05-14	17	1.9
15-24	275	37.7
25-34	188	26.7
35-44	201	22.7
45-54	182	22.9
55-64	76	18.6
65-74	32	17.0
75-84	21	23.1
85+	6	25.4

***Rates are age-specific rates per 100,000 population.**

Suicides by Region 1998-2005

Region	Deaths	Rate
Anchorage/Mat-Su	412	16.2
Fairbanks/SE Fairbanks	121	18.1
Gulf Coast	108	19.1
Northern/Interior	158	61.2
Southeast	71	12.4
Southwest	128	40.9

***Rates are age-adjusted rates per 100,000 standard population**

Rate of Suicides 1998-2005

Year	Alaska Rate	Lives Lost	US Rate
1998	22.7	131	11.1
1999	17.2	95	10.5
2000	21.1	135	10.4
2001	16.5	103	10.7
2002	20.9	131	10.9
2003	20.6	124	10.8
2004	23.5	155	10.7
2005	18.8	122	N/A

**Rate is number per 100,000 standard population and accounts for differences in population distribution.*
**The US rate for 2005 will not be available until approximately April 2007.*

Analysis of results and challenges: Alaska averages 125 suicides per year and has a suicide rate double the National Suicide rate. The Healthy Alaskan 2010 target is to reduce Alaska's rate to 10.6 deaths per 100,000 populations. The suicide rate for Alaska in 2005 shows a slight decline, however is still at 18.8, still much higher than the target. This measure reflects a system-wide problem that takes coordination between state agencies, community providers, school districts and faith based organizations.

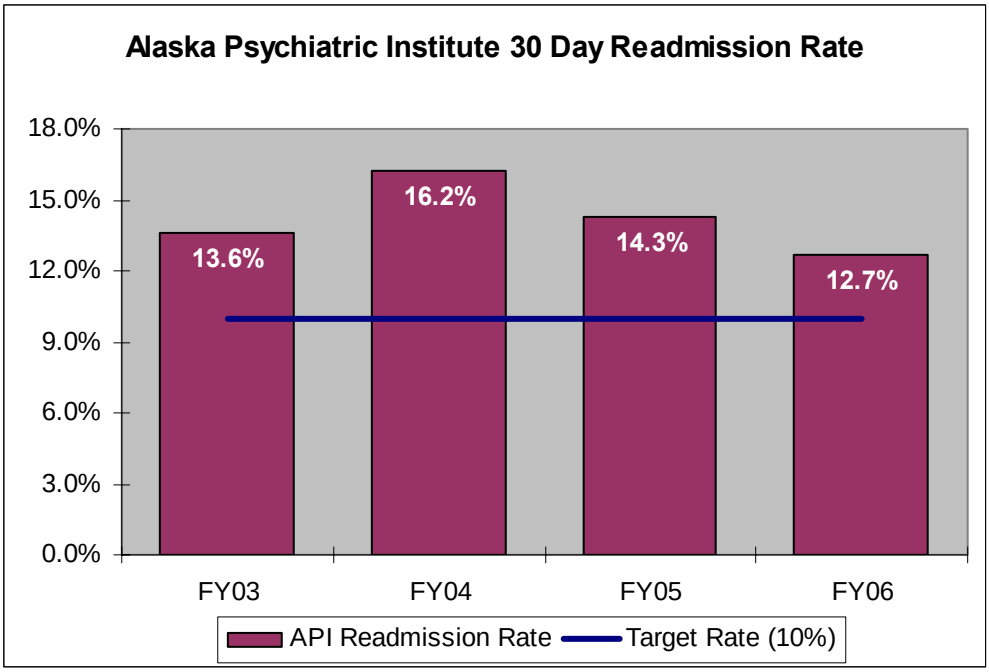
Work continues to better understand the underlying causes of suicide of Alaskans. The Statewide Suicide Prevention Council partners with the Department of Health and Social Services, Division of Behavioral Health to provide training on the Statewide Suicide Prevention Plan and assessing community readiness for decreasing suicide and non-lethal suicidal behaviors. The Division of Behavioral Health has done the following: required all community-based suicide grantees align their suicide prevention efforts with the Suicide Prevention plan; conducted a presentation on community-based planning implementing effective strategies aligned with the statewide plan; and coordinated with Native health corporations, police, chaplains, and other groups to assist in suicide prevention or coping program design.

An interim report of the Suicide Follow-Back Study shows the following system-wide factors, based on a limited number of interviews, of those related to, or close to those who had died by suicide:

54% had quit working during the preceding year;
47% were seeing a therapist at the time of their death;
59% had current prescriptions for mental health problems;
65% experienced an event that caused a great deal of shame (such as sexual abuse, child porn, an arrest, etc.);
61% had problems with law enforcement;
20% were abused as children – 80% by their father;
50% were seen by a doctor in the last six months;
46% had symptoms of post traumatic stress disorder (PTSD);
62% were active smokers;
33% had prior suicide attempts; and
20% had recent exposure to suicide of a loved one.

As the tables above show, the rate of suicides and number of deaths is higher in the Northern/Interior and Southwest regions of Alaska and is more predominant in the 15-24 age groups. The overall age span with highest suicide incidents is 15-24.

Target #3: Reduce 30 day readmission rate for API to 10%.
Measure #3: Rate of API readmissions.



Analysis of results and challenges: This measure tracks the percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions. This measure not only is an indication of successful outcomes for API, but also of the mental health community system. The ultimate goal is to have Alaska's rate fall below 10%.

According to data for FY 06, API and the 'system' continue to demonstrate unsatisfactory outcomes. API relocated to a new hospital in July 2005. The success of a 'downsized' state psychiatric hospital was predicated on increased funding for community providers and establishing 18 designated evaluation and treatment beds in Anchorage. These initiatives did not receive planning or funding. As a result, API comes under increasing pressure to shorten length of stays for acutely ill psychiatric patients who ultimately return to the hospital due to lack of adequate supportive housing and treatment options.

B1: Strategy - Provide enhancements to prevention and early intervention services.

C: Result - Outcome Statement #3: Children who come to the attention of the Office of Children's Services are, first and foremost, protected from abuse or neglect.

Target #1: Decrease the rate of substantiated allegations of child abuse and neglect in Alaska.
Measure #1: The rate of child abuse and neglect per 1,000 children under the age of 18.

Rate of Child Abuse & Neglect Per 1,000 Children Under Age 18 in Alaska

Fiscal Year	Rate Per 1,000	National Rate
FY 2001	32.2	0
FY 2002	27.6	0
FY 2003	23.0	0
FY 2004	22.3	0
FY 2005	N/A	0
FY 2006	16.0****	11.9

***** The Office of Children's Services is now through its second year using the new case management system - Online Resources for the Children of Alaska (ORCA). With the implementation of ORCA, new methods of measurement in compliance with federal standards have been used. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable. As a result, FY 2006 data is not comparable to FY 2001 through FY 2004.*

Due to data instability resulting from the conversion of the old data system to ORCA, the FY05 information is not reliable and not available for analysis.

The FY 2006 measures represent an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. The population equals the number of children under the age of 18 years as of July 1, 2005, as estimated by the Department of Labor. Data reported prior to FY 2006 can be duplicative.

Source: Target of 11.9 - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

Analysis of results and challenges: The Office of Children's Services goal is to protect children from abuse and neglect. Measuring the success of children's services agencies can be done, in part, through the number of substantiated child protective services reports received per 1,000 children under the age of 18 in the state.

The Department of Labor reports 194,595 children under the age of 18 in Alaska as of July 1, 2005. The Office of Children's Services investigated 10,195 child protection reports of abuse and/or neglect and substantiated abuse and/or neglect for 3,118 children in FY 2006, or 16 per 1,000 children in the state.

In FY 2004, national levels of substantiated abuse and neglect per 1,000 children was calculated by Child Trends Databank at 11.9 and averaged 12.2 over five years. This places Alaska's victim rate at 31% higher than the national average.

While the Office of Children's Services met all of its goals as set out in the Federal Performance Improvement Plan by August 2006, outcomes affecting children and their families still need to improve. The division has embarked on several new approaches to address this issue regarding the children in our state, including a new Safety Assessment model.

When the Office of Children's Services determined that its safety assessment model was ineffective at assessing the difference between safety threats and risk factors, a new safety model was introduced and is being implemented. FY 2006 one time only training money was used to train every front line staff, supervisor, manager, key central office staff and several interested tribal partners. The new model and subsequent training focused on requiring workers to take more time to do a throughout assessment each time a new investigation is assigned.

One of the fundamental differences in the new model requires workers to do an assessment of the entire family and their overall functioning and to look beyond whether the abuse or neglect is substantiated or not substantiated. In the past, workers focused just on the maltreatment itself and did not address other issues going on in the home. This resulted in missed opportunities to engage

families in remedial services to avoid subsequent abuse and neglect to the child. Further, the new model helps workers to understand the essential differences in whether the child is unsafe or at risk. Unsafe determinations require OCS intervention, while risk factors may necessitate a referral to community resources. This will result in better identification of families that must be served by the child protective services system versus those that can be served by other resources.

OCS staff, community providers and tribal partners all agree this is a better way to work with families; however, workloads make the new process very difficult to achieve given the time requirement to complete a thorough assessment.

Target #2: To decrease the rate of repeat maltreatment to meet or exceed the national standard of 6.1 percent.

Measure #2: Percentage rate of repeat maltreatment.

Year	YTD Total	Target
2000	23.6%	0
2001	25.4%	0
2002	22.6%	0
2003	17.6%	0
2004	17.3%	0
2005	10.6%****	6.1%

Data Source: National Child Abuse and Neglect Data System and Alaska's Online Resources for the Children of Alaska (ORCA).

*****Introduction of Online Resource for the Children of Alaska (ORCA). With the transition from the old case management system (PROBER) to the new system (ORCA), data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.*

Data for this measure submitted to the federal government in FFY 2005 in compliance with the National Child Abuse and Neglect Data System requirements indicated an 8% repeat maltreatment rate. Further research, data clean-up efforts, and a separate analysis cross-checking and linking different data sources indicated the 8% was under-reported. The division has incorporated new findings into this measure.

OCS is still undergoing the data clean-up process and is unable to provide FY 2006 findings at this time. Resources constructing the FY 2005 measure are no longer available, and OCS does not anticipate updates until late spring 2007.

Analysis of results and challenges: The federal guideline for repeat maltreatment includes all children who are victims of substantiated child abuse and/or neglect twice during a six month period. Because Alaska's rate of repeat maltreatment has been so high, a protocol was developed to more closely examine past investigations resulting in a substantiated finding of abuse or neglect. If there have been past substantiated investigations, the OCS worker will review the previous record to ascertain whether the newly reported allegations are against the same child by the same maltreater. If so, the worker and his/her supervisor will devise a strategy for intervention for the current investigation acknowledging that there may be a pattern of abuse that needs to be recognized. The supervisor will closely monitor the progress of the investigation and ensure the appropriate actions are taken to protect the child from further abuse.

It is expected that OCS will begin to see improvements in the number of repeat maltreatment cases not only due to this new business practice, but a positive effect is expected due to increased efforts in prevention, i.e., increased early intervention/infant learning program screenings for young children with substantiated protective services reports.

The chart above shows an adjusted rate of improvement because of the transition between the old case management system (PROBER) and the new (ORCA). FFY 2005 data has been adjusted after further work was completed. The OCS will now focus on meeting or exceeding national standards.

Target #3: Decrease the percentage of substantiated maltreatment by out-of-home providers.
Measure #3: Percentage of children maltreated by an out-of-home provider.

Percentage of Children Maltreated by an Out-of-Home Care Provider

Fiscal Year	Quarter 1	National Rate
FFY 2000	1.91%*	0
FFY 2001	2.00%*	0
FFY 2002	2.09%*	0
FFY 2003	1.35%	0
FFY 2004	1.20%	0
FFY 2005	1.10%****	0
FFY 2006	1.16%	.57%

** Data is based on a calendar year. Federal mandates changed to the federal fiscal year in 2003.*

*****Introduction of ORCA. With the transition from the old case management system (PROBER) to the new (ORCA) system, data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.*

Source: Online Resources for the Children of Alaska (ORCA) data system for the National Child Abuse and Neglect Data System (NCANDS) and federal Adoption and Foster Care Analysis and Reporting System (AFCARS).

Source: Target of .57% - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

Analysis of results and challenges: Recognition that the rate of abuse of children placed outside of the home by a care provider is unacceptable lead the OCS to launch a new process to assess prospective foster and adoptive parents ("resource families") before licensure and placement of children in the home. The new process was piloted in Anchorage last year and this year expanded to other regions and more rural locations. The Resource Family Assessment is far more comprehensive than the previous licensure process and continued evaluation and changes are being made to the program as determined necessary. One of the primary issues is the amount of time needed to complete the new assessment. While most all agree it is a better way to look at potential foster or adoptive families, it requires much more from already strained resources.

Target #4: Reduce the rate staff turnover and increase the number of workers providing direct services at any given time.
Measure #4: Annual employee turnover rate; number of positions available to provide direct services.

Office of Children's Services Vacancy /Turnover Rates & the Number of Positions Filled

Fiscal Year	Vacancy Rate	Turnover Rate	Avg. # Positions Filled	Target
FY 2001	N/A	24.84%	N/A	0
FY 2002	N/A	24.21%	N/A	0
FY 2003	N/A	23.55%	N/A	0
FY 2004	7.59%	20.27%	275	0
FY 2005	9.48%	20.97%	307	0
FY 2006	9.30%	28.37%	315	20%

Vacancy Rate and number of positions filled methodology is based on a calendar year average. FY 2006 turnover rate is year-to-date as of September, 2006. Turnover rates exclude lateral transfers and promotions within OCS. As of September, 2006 there were 31 (10% of average number of positions filled) lateral transfers and 23 promotions (7% of average number of positions filled).

Includes direct service (front line) workers only.

Analysis of results and challenges: The Office of Children's Services contracted with Hornby Zeller Associates, Inc. last year to complete a workload study to provide OCS leadership with a way to evaluate whether front line staff had sufficient time to meet the basic requirements of their jobs to protect children and serve families. Workload is defined as the amount of time needed to complete the tasks necessary as opposed to caseloads that only count the numbers of families served with no regard to the differences in the amount of time to properly handle assigned cases. The final report with the results and recommendations was received in May 2006. The contractor concluded that a plan needed to be developed to fill existing vacancies and monitor caseloads over time before engaging in wide scale changes to personnel that would include transferring positions from over-staffed offices to under-staffed offices. While staffing patterns over time need to continue to be monitored and assessed, the contractor did conclude in order to meet the workload of the state, OCS needs an additional 19 positions to handle the state's entire caseload appropriately as mandated by state and federal policy guidelines.

In addition, the work load study revealed that front line workers and supervisors spend on average 12.4% of their time on administrative tasks. With the addition of the new front line staff as authorized in FY 2005 and FY 2006 but no administrative staff added, more administrative tasks have fallen to workers. The OCS will request additional administrative support when allowed to do so.

Lastly, a comprehensive plan to address retention and recruitment of front line staff is currently in development. The OCS understands that worker turnover continues to be high and of great concern and previous strategies have not changed that fact; therefore, greater emphasis and planning is necessary.

This measure has been enhanced by adding vacancy rates and the average number of direct service positions filled. Turnover rates, while extremely high and disruptive, do not provide a complete picture. OCS added vacancy rates as a measure of positions vacant at any given time through a year and filled positions to show that while turnover and vacancy rates remain high, progress in the number of available workers at any time has improved.

C1: Strategy - Implementation of new safety assessment model to provide front line workers with a better tool to identify safety issues in the home.

C2: Strategy - Children placed outside of the home are protected from further abuse and neglect.

C3: Strategy - Retain an effective and efficient workforce.

D: Result - Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.

Target #1: Decrease average response time from receiving a claim to paying a claim.
Measure #1: Average number of days per annum from receipt of claims to payment of claims.

Operation Performance Summary-Annual Average Days /Entry Date to Claims Paid Date

Fiscal Year	Claims	Avg Days	Days Changed
FY 2000	3,720,254	10	0
FY 2001	4,409,121	12	2
FY 2002	4,959,864	12	0
FY 2003	5,615,072	10	-2
FY 2004	6,690,344	10	0
FY 2005	7,903,523	13	3
FY 2006	7,721,709	12	-1
FY 2007	1,793,488	22	10

Note: Between FY02 and FY03 reports were based on six months of data. Since SFY04 reports are based on annual data. Source: MARS MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between first quarter State Fiscal Year (SFY) 2006 and first quarter SFY 2007 increased from 16 days in 2006 to 22 days in 2007.

Three new initiatives, two in the second half of SFY 2006 and the other in first quarter 2007 may provide explanations for the increase of average days. The Personal Care Program instituted a prior authorization process during the third quarter 2006. As part of this new initiative, claims became subject to prior authorization editing. Additionally, regulatory changes for certain Durable Medical Equipment (DME) high-volume supplies occurred during the second half of SFY 2006. This resulted in additional claims pending for evaluation and pricing. Lastly, during the first quarter 2007, several new home and community-based waiver program edits were initiated.

Adding to the hindrance, the Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry. As training is completed and staff becomes more proficient, holdups are improving for the second quarter of SFY 2007.

All of the above would have had impact on processing time.

Target #2: Increase the percentage of adjudicated claims paid with no provider errors.
Measure #2: Change in the percentage of adjudicated claims paid with no provider errors.

Error Distribution Analysis-Change in the percentage of adjudicated claims paid with no provider errors

Fiscal Year	Claims Pd	% No Errors	% Change
FY 2000	3,076,978	72%	0
FY 2001	3,670,331	73%	1%
FY 2002	4,202,677	74%	1%
FY 2003	4,776,730	73%	-1%
FY 2004	5,106,692	76%	3%
FY 2005	6,150,027	72%	-4%
FY 2006	6,082,318	74%	2%
FY 2007	1,363,276	72%	-2%

Chart Notes

1 Between FY01 and FY03 reports were based on six months of data. Since FY04 reports are based on annual data.

2. This measure was updated annually through SFY 2005; beginning with SFY 2006, it is being updated quarterly.

3. Source: MARS MR-0-11-T.

4. FY07 numbers are for the first quarter of FY07.

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

During SFY2006, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required HSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

Target #3: Reduce the rate of Medicaid payment errors

Measure #3: Improper payment estimates as provided to Center for Medicare and Medicaid Services

Analysis of results and challenges: The Improper Payments Information Act of 2002 (Public Law 107-300) requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper payments and report those estimates to the Congress, and if necessary, submit a report on actions the agency is taking to reduce erroneous payments. The effect of this rule is that States are now to be required to produce improper payment estimates for their Medicaid and SCHIP programs and to identify existing and emerging vulnerabilities.

The PERM program commenced nationally on July 1, 2005 with Phase I and one-third of the states participated. Alaska is a year 3 state and will be required to participate during calendar year 2007. There will be an impact on the resources in each division managing Medicaid Services to assist the PERM staff with access to policies, procedures and data. Division staff may be called upon to assist in the interpretation of medical records pertaining to claims associated with services that division manages. The PERM process includes expectations for corrective actions. Divisions will need resources to implement corrective actions resulting from PERM findings.

D1: Strategy - Continue to develop new Medicaid Management Information System (MMIS).

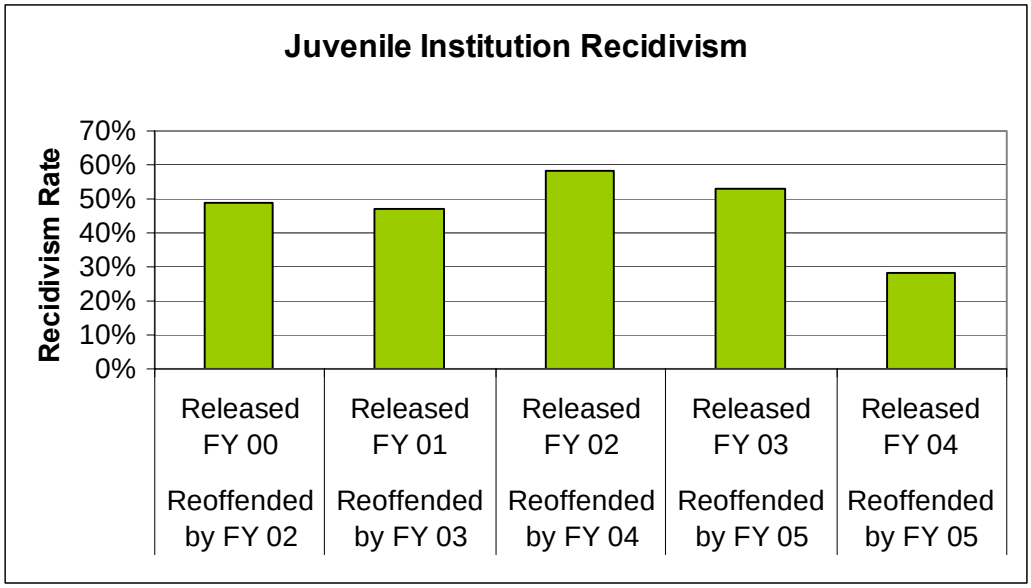
E: Result - Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who re-offend following release from institutional treatment facilities to less than 40% of the total.

Measure #1: Percentage change in re-offense rate following release from institutional treatment.

Facility	Number released in FY 04	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Bethel Youth Facility	10	3	30%
Fairbanks Youth Facility	22	9	41%
Johnson Youth Center	18	8	44%
McLaughlin Youth Center	94	20	21%
Total	**144**	**40**	**28%**

Race	Number released in FY 04	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Caucasian	59	15	25%
African American	9	6	67%
Native Alaskan/American Indian	57	12	21%
Asian	2	2	100%
Pacific Islander	1	1	100%
Multiple Races	15	4	27%
Other	1	0	0%
Total	**144**	**40**	**28%**



Analysis of results and challenges: This measure examines recidivism only for youth who have been committed to and released from one of the division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the State's more chronic and serious juvenile offenders compared with youth who only receive probation supervision. Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

The major reason for the demonstrated drop in recidivism among this group was the change this fiscal year from surveying recidivism among juveniles in a 24-month window to 12 months. This change was made to better align Alaska's reporting of recidivism with the national norm of reporting recidivism on a 12-month basis. (Sixteen of the 32 states that track recidivism do so, on a 12-month basis.) Among those states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 28% rate, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Re-offenses, like the original offenses that brought the juveniles to the division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. Re-offenses are defined as: any offenses resulting in a new juvenile institutional order, a new juvenile adjudication, or an adult conviction. Adjudications and convictions for motor vehicle, Fish & Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their release date, and the offense must have

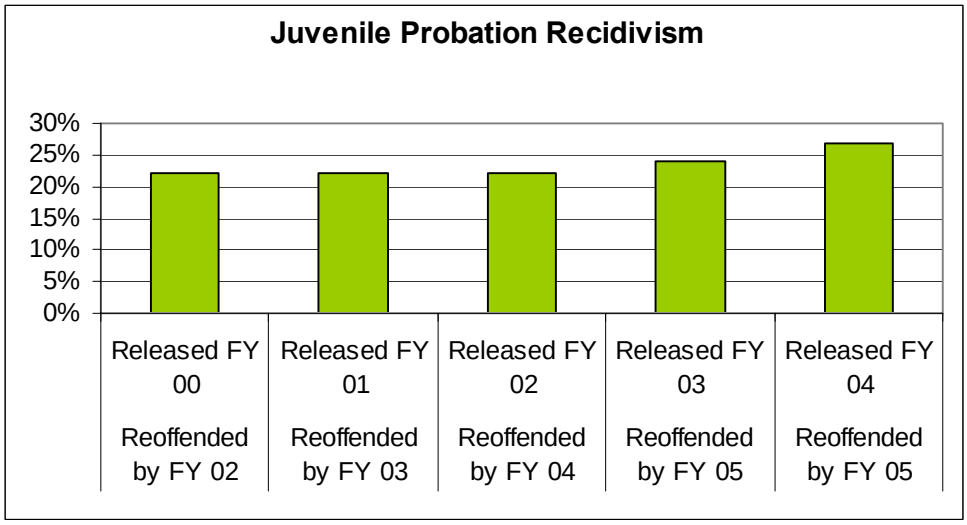
resulted in an adult conviction, a new juvenile adjudication, or a new juvenile institutional order for a probation violation.

Target #2: Reduce percentage of juveniles who re-offend following completion of formal court-ordered probation supervision to less than 20% of the total.

Measure #2: Percentage change in re-offense rate following completion of formal court-ordered probation supervision.

Region	Percentage re-offenders	Number of re-offenders 12 months after release	Percentage of offenders who re-offended
Anchorage	70	22	31%
Northern Region	103	33	32%
Southcentral Region	89	21	24%
Southeast Region	47	10	21%
Total	**309**	**86**	**28%**

Race	Number released from formal probation in FY 05	Number of Re-offenders 12 months after release	Percentage of offenders who re-offended
Asian	11	2	18%
African-American	17	5	29%
Multi-race	30	11	37%
Alaska Native/American Indian	133	41	31%
Pacific Islander	8	2	25%
Other	1	1	100%
Caucasian	109	24	22%
Total	**309**	**86**	**28%**



Analysis of results and challenges: This measure examines re-offense rates for juveniles who received probation supervision while either remaining at home or in a nonsecure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized (and whose recidivism rate is discussed in measure #1). Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

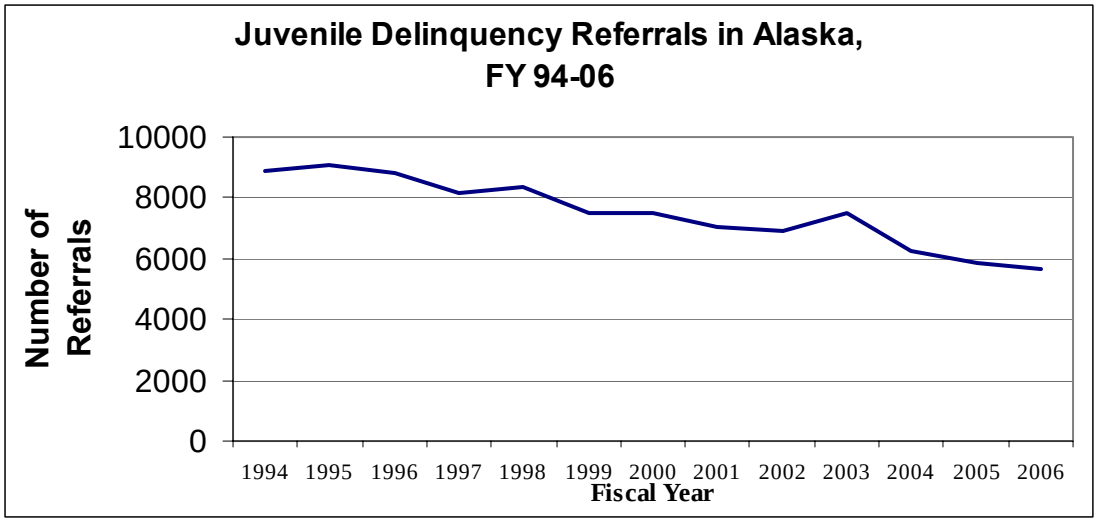
As with the institutional population performance measure, this measure was changed this year such that re-offenses were counted as recidivism if they occurred within 12 months, rather than 24 months, from the time offenders were released from formal probation. This measure also was changed to better correlate with the institutional recidivism measure (as well as national recidivism statistics) in that an offense needed to result in a new adjudication in the juvenile system or a conviction in the adult system to be counted as a re-offense (previously, only referrals to the juvenile system were counted as re-offenses). The increase in recidivism among the population of youth released from formal probation in FY 04 is primarily due to the inclusion of offenses occurring within the adult system. Inclusion of adult offenses is a more accurate measure of the activity of offenders once they are released from juvenile probation.

Sixteen of the 32 states that track recidivism do so, on a 12-month basis. Among those states that measure recidivism based on a 12-month follow-up period and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 28% rate, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Re-offenses, like the original offenses that brought the juveniles to the division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review and incorporate research-based practices as it seeks to improve its outcomes for youth on probation supervision.

Note: Re-offenses for juveniles released from formal probation are determined by checking for entries in the division's Juvenile Offender Management Information System and the Alaska Public Safety Information Network. This table reports the number of youth for whom court-ordered probation episodes closed during the fiscal year for one of the following reasons: Completed Successfully, Order Expired, Non-compliant Closed, Waived to Adult Status, Declared Incompetent, or Deceased. Youth whose formal probation ends because of Court Termination Resulting in a new Supervision, Modified, Revoked, or Supervision Transfer are not included. This analysis also excludes youth who were ordered to an Alaska treatment institution, as these youth are included in the analysis for our institutional recidivism performance measure, above. Re-offenses are defined as offenses resulting in a new juvenile adjudication or an adult conviction. Adjudications and convictions for Motor Vehicle, Fish & Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their release date, and the offense must have resulted in an adult conviction or new juvenile adjudication.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.
Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



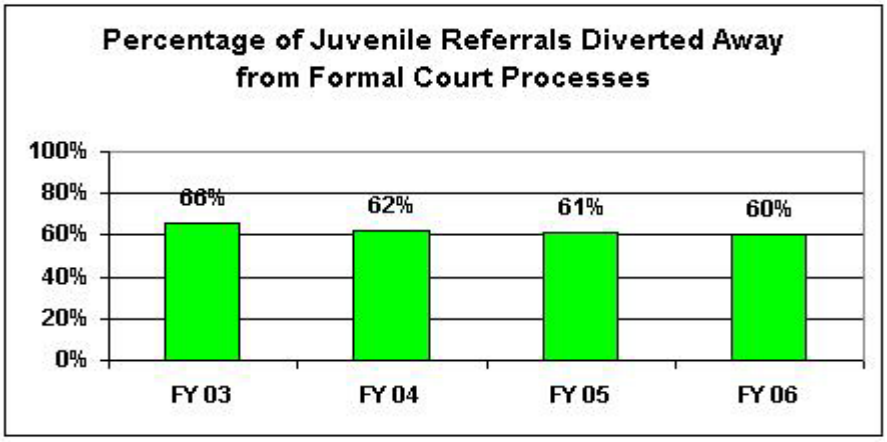
REGION	DISTRICT	Juveniles	Referrals	Charges
ANCHORAGE	ANCHORAGE	1531	2111	3221
ANCHORAGE	***Total***	***1531***	***2111***	***3221***
NORTHERN	BARROW	44	78	141
	BETHEL	227	368	768
	FAIRBANKS	459	662	1170
	KOTZEBUE	103	171	430
	NOME	104	172	301
NORTHERN	***Total***	***937***	***1451***	***2810***
SOUTHCENTRAL	DILLINGHAM	90	129	228
	HOMER	52	70	122
	KENAI	273	394	632
	KODIAK	81	131	267
	MAT-SU	367	477	865
	VALDEZ	44	55	109
SOUTHCENTRAL	***Total***	***907***	***1256***	***2223***
SOUTHEAST	JUNEAU	270	458	713
	KETCHIKAN	154	240	417
	PETERSBURG	18	27	49
	PRINCE OF WALES	30	37	64
	SITKA	54	75	126
SOUTHEAST	***Total***	***526***	***837***	***1369***
Grand Total		**3901**	**5655**	**9623**

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population was very slightly reduced in FY 06 compared with FY 05, representing virtually no statistical difference between the these years. Nevertheless, the target of reducing referrals by 5% from two years prior (FY 04) was surpassed. Definitive reasons for changes in referral levels are unknown, although possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

Note: Population data is based on estimates for the previous fiscal year (FY 05) from the Alaska Department of Labor. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database on August 1, 2006 and

includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 60% of youth referred to the division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.
Measure #4: The percentage of referrals that are managed through informal processes.



Analysis of results and challenges: In FY 06 the proportion of juvenile referrals (reports from law enforcement that allege a juvenile perpetrator) that were diverted from the formal court process remained high, at 60%. This means that approximately 2,360 juveniles out of the total 3,929 that entered the juvenile justice system in FY 06 had their cases managed through non-court adjustments, informal probation, referral to community panels such as youth court, or were dismissed.

Diversion of youth from formal court processing serves a number of important, valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and needless harm that can result from delinquency adjudication. Diversion can provide opportunities for community partners and victims to take more active roles in addressing low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to them. Diversion is a considerably less expensive and faster process than the formal adversarial court process and reduces probation caseloads as well, enabling the division to better allocate resources and staff time to more serious offenders.

Note: For this measure, youth are considered to have been diverted away from the formal court system if the intake decision for their delinquency referral results in the referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Additionally, diverted would include those referrals that are screened and referred elsewhere (1% of total in FY06), such as back to law enforcement for further information, and those that were still in process (4% of the total in FY06) at the time this data was collected.

*Referral: A request for a Division of Juvenile Justice response service following the arrest of a juvenile or submission of a police investigation report alleging the commission of a crime or violation of a court order by a juvenile offender.

E1: Strategy - Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.

Outcome Statement #6: Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10% annually.
Measure #1: Rate of change in self-sufficient families.

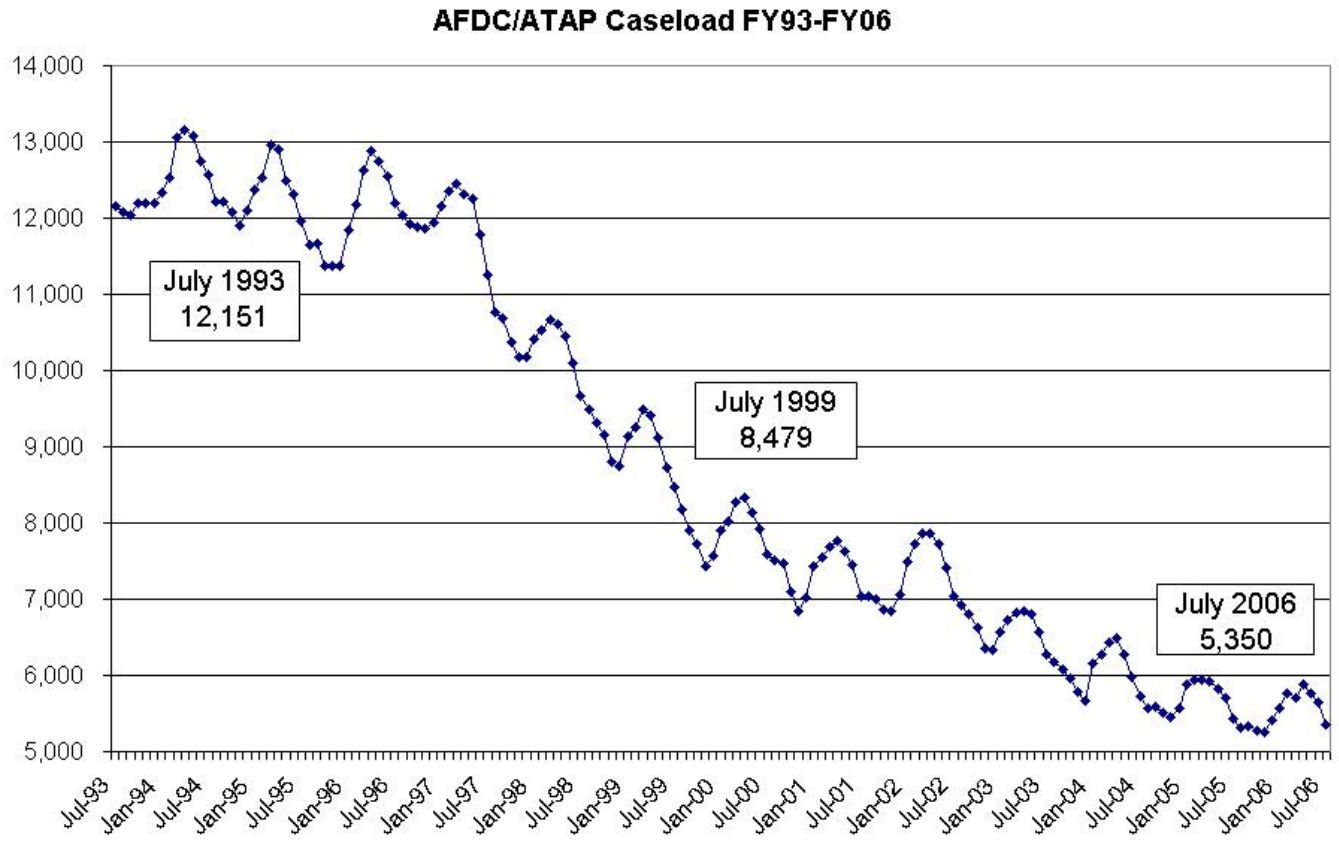


*Table includes ATAP & Native Family Assistance Programs

Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2002	-16%	6%	4%	3%	-2%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2006	-6%	-3%	-4%	-1%	-2%
FY 2007	-5%	0	0	0	-5%

**YTD Total column represents the average annual monthly caseload rate change.*

Analysis of results and challenges: As shown in the YTD Total column, SFY2006 had a 2% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to SFY2005. The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

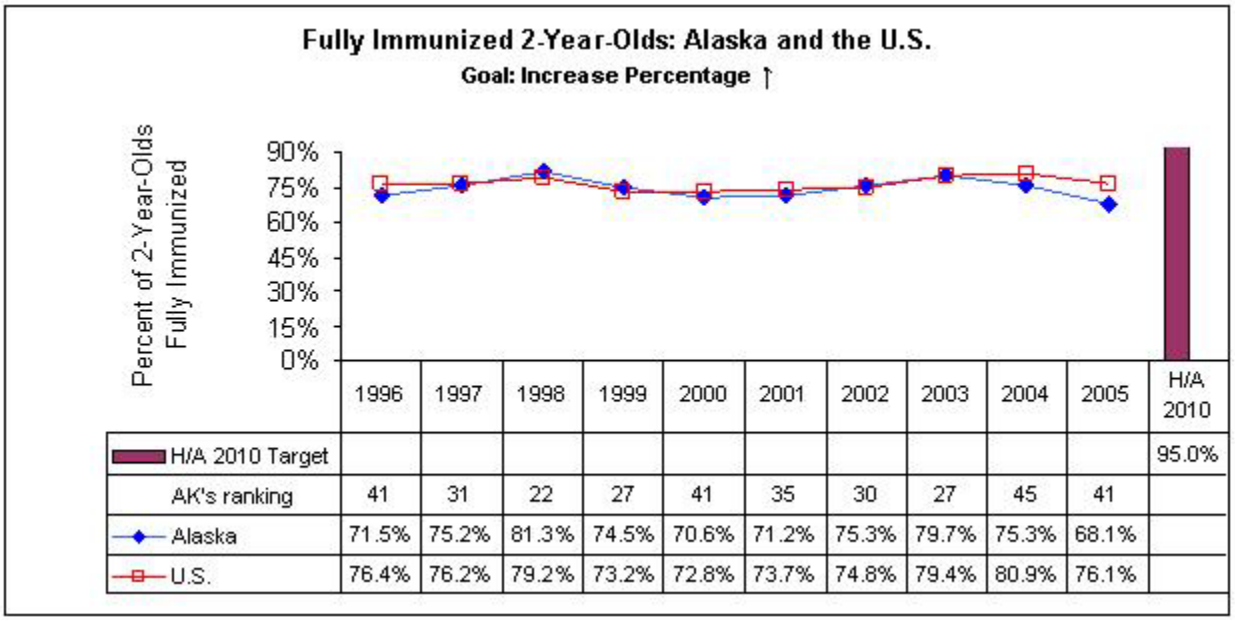
The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the

program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

F1: Strategy - Use TANF high performance bonus funds for families approaching 60-month time limit.

G: Result - Outcome Statement #7: Healthy people in healthy communities

Target #1: 80% of all 2 year olds are fully immunized
Measure #1: % of all Alaskan 2 year olds fully immunized



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	H/A 2010
H/A 2010 Target											95.0%
AK's ranking	41	31	22	27	41	35	30	27	45	41	
Alaska	71.5%	75.2%	81.3%	74.5%	70.6%	71.2%	75.3%	79.7%	75.3%	68.1%	
U.S.	76.4%	76.2%	79.2%	73.2%	72.8%	73.7%	74.8%	79.4%	80.9%	76.1%	

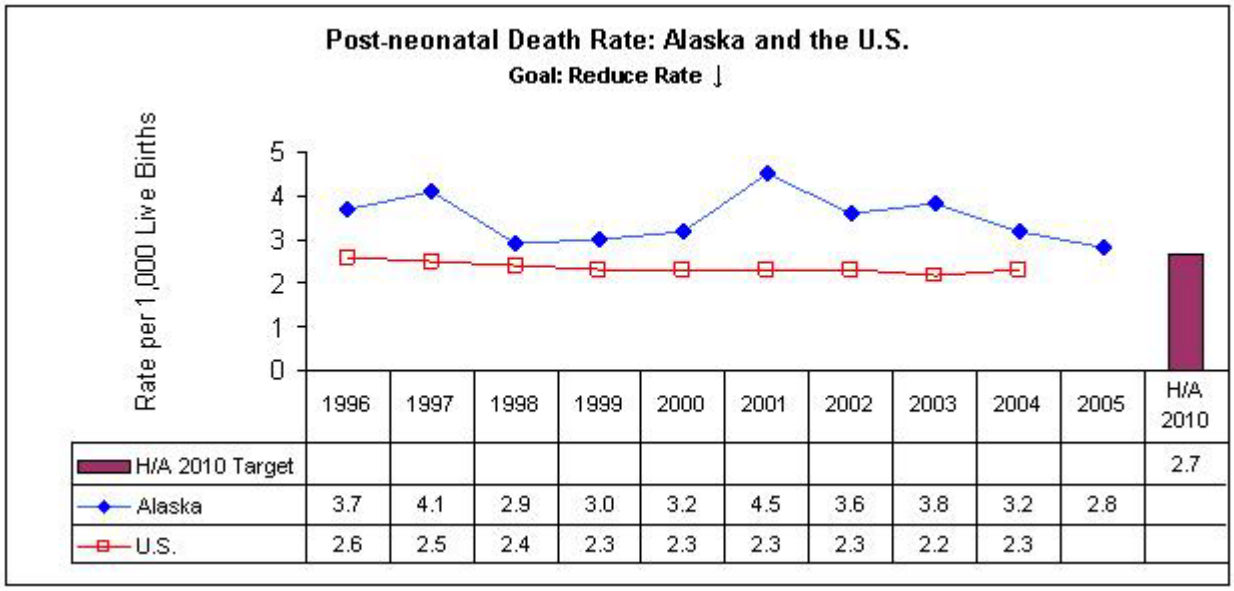
Vaccination Coverage among Children 19-35 Months of Age, Alaska and US

Year	US %	Alaska %	AK US Rank
1999	73.2	74.5	27
2000	72.8	70.6	41
2001	73.7	71.2	35
2002	74.8	75.3	30
2003	79.4	79.7	27
2004	80.9	75.3	45
2005	76.1	68.1*	41

Analysis of results and challenges: Chart Note: Source - National Immunization Survey, Centers for Disease Control and Prevention. Annual percentages are based on CDC recommendations at the time, which have changed over the years as vaccines have been added to the "basic immunization series."

* In 2005, the CDC increased its recommendation to a new, six-dose series of vaccinations. As a result, the national rate of fully immunized two year olds dropped considerably, as did Alaska's rate. However, Alaska's ranking amongst states increased slightly, from 45th in 2004 to 41st in 2005. These results continue to illustrate the need for renewed emphasis on the importance of timely immunizations for young children.

Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010
Measure #2: Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year)



Post-Neonatal Death Rate - AK and US

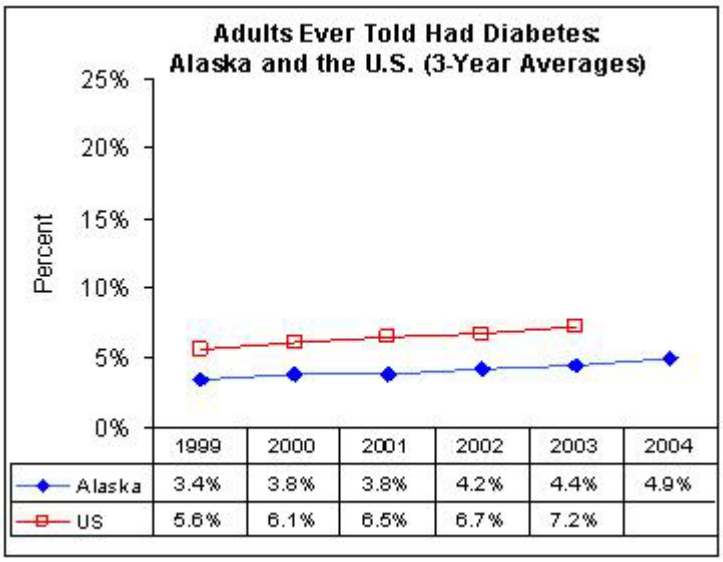
Year	Alaska	US
1999	3.0	2.3
2000	3.2	2.3
2001	4.5	2.3
2002	3.6	2.3
2003	3.8	2.2
2004	3.2	2.3
2005	2.8	N/A

Note: The 2005 US death rate will not be available until late in 2006 or early 2007.

Analysis of results and challenges: Chart Note: Rate per 1,000 Live Births and reflects three year rate, i.e. 2003 represents 2001-2003.
Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the leading causes of death during the post-neonatal period (28 through 364 days) during 2002 were Sudden Infant Death Syndrome (SIDS), birth defects, and unintentional injuries. The post-neonatal mortality rate in Alaska is higher than the national target of 1.5 per 1,000 live births (Healthy People 2010) and has remained relatively static over time. While not shown graphically, over the last decade Alaska Native infants were 2.3 times more likely to die during the post-neonatal period than Caucasian infants.

Work by DHSS is underway with the Indian Health Service on a rural initiative to prevent Sudden Infant Death Syndrome (SIDS). Also, cessation efforts involving tobacco, alcohol and other drugs are being targeted on the pre-conception and prenatal periods. Finally, work has begun with health providers and community partners to establish a model program of early prevention and chronic disease management for prenatal patients.

Target #3: Decrease diabetes in Alaskans
Measure #3: Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages



Est Annual Prevalence of Diabetes among Adults (18+) in Alaska Based upon Midpoints of Three-Year Averages

Year	Alaska	US
1999	3.4%	5.6%
2000	3.8%	6.1%
2001	3.8%	6.5%
2002	4.2%	6.7%
2003	4.4%	7.2%
2004	4.9%	N/A

Note: 2004 Alaska data is based on a 3 year average of 2003-2005.

Analysis of results and challenges: Data Source: BRFSS - Behavioral Risk Factor Surveillance System

Diabetes is a chronic disease characterized by high levels of blood glucose. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases and typically occurs in adults, but is increasingly being diagnosed in children and adolescents. Type 2 diabetes usually begins as insulin resistance, a condition in which the cells do not use insulin properly. Risk factors for Type 2 diabetes include older age (40-plus years), obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

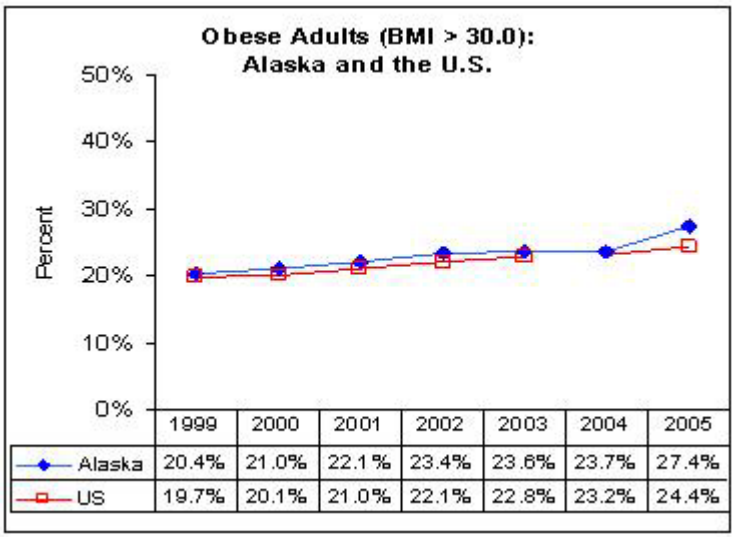
Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence of diabetes in the United States is expected to increase as the population ages.

Over the past decade, an increasing number of Alaskan adults have reported being told by a health professional that they have diabetes. This number, plus the estimated 29% of all diabetes cases that go undiagnosed, yields the best estimate of the true prevalence of diabetes in Alaska. One limitation

of this estimate is that, with improving surveillance and detection, prevalence will continue to increase independent of any real increase in morbidity.

The department works to reduce the health burden and economic costs of diabetes in Alaska through an integrated program of prevention and disease management that supports individuals and communities. To slow or halt the upward trend of diabetes, a comprehensive approach is needed to make healthy behaviors the norm. The major risk factors contributing to chronic diseases are tobacco use, physical inactivity, unhealthy eating habits and resulting obesity. The department will address all of these factors by giving individuals the knowledge and tools they need to make healthier choices, while also assuring that healthy behaviors are reinforced in schools, worksites and other community settings.

Target #4: Decrease Alaska's adult obesity rate to less than 18%
Measure #4: Obesity rate of Alaskans



Prevalence of Obesity: Alaska & US

Year	Alaska	US
1999	20.4%	19.7%
2000	21.0%	20.1%
2001	22.1%	21%
2002	23.4%	22.1%
2003	23.6%	22.8%
2004	23.7%	23.2%
2005	27.4%	24.4%

Analysis of results and challenges: The trends in Alaska continue to show growing numbers of overweight and obese adults, with a significant increase in obesity in 2005, to 27.4%. By comparison, the Healthy Alaskans 2010 target for obesity is 18%.

Premature death and disability, increased health care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with sedentary behavior are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States.

National studies show an association of overweight and obesity with certain types of cancers (endometrial, colon, post menopausal breast, and prostate), as well as heart disease, stroke, diabetes and arthritis. Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

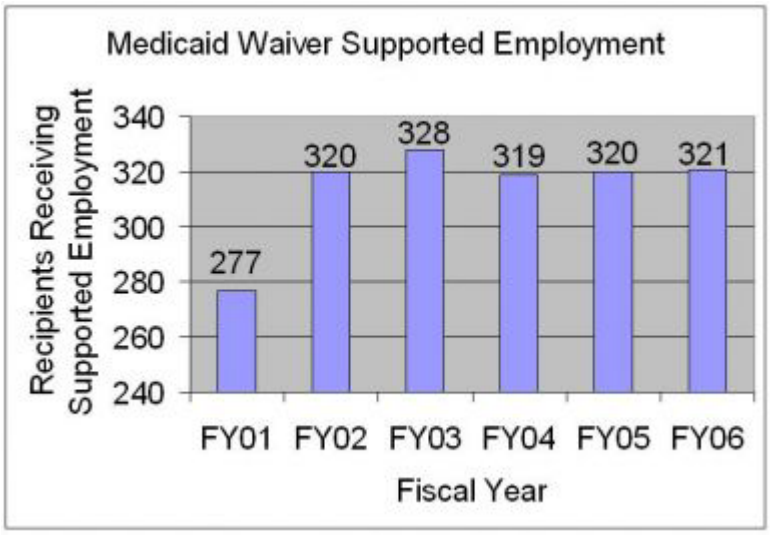
Through educational, programmatic, policy and environmental strategies, the department works to reduce the percentage of Alaskans classified as overweight, obese or at-risk for being overweight, and to promote healthy food choices and exercise. A comprehensive approach is needed to reduce the trend of increasing obesity in Alaska. Along with tobacco use, physical inactivity and unhealthy eating habits, obesity contributes greatly to the prevalence of chronic disease. The department is working to address all of these factors by giving individuals the knowledge and tools they need to make healthier choices. Strategies also are targeted to promote healthy behaviors in communities - the workplace, schools and other settings.

G1: Strategy - Strengthen public health in strategic areas.

H: Result - Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live independently as long as possible.

Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services.

Measure #1: % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.



% Change in Recipients Receiving Supported Employment

Fiscal Year	% Change
FY 2002	15.5%
FY 2003	2.5%
FY 2004	-2.7%
FY 2005	0.3%
FY 2006	0.3%

Analysis of results and challenges: Supported Employment Services is one of the best resources available to developmentally disabled beneficiaries to help them live independently by providing them with the opportunity to work. The Division of Senior and Disabilities Services has determined that the reason the number of DD waiver beneficiaries receiving supported employment has reached a plateau in recent years is because only the highest-functioning clients without behavioral issues can be easily employed. In FY07 and beyond, the division will be working with the Governor's Council on Disabilities and Special Education to increase participation in supported employment as outlined in the Alaska Works Initiative 2006-2010 Strategic Plan.

H1: Strategy - Promote independent living and provide preadmission screening to nursing homes.

I: Result - Outcome Statement #9: The efficient and effective delivery of administrative services.

Target #1: Increase by 5% the percentage of customers that report Finance and Management Services (FMS) is meeting their needs.

Measure #1: Percentage of customer service internal survey respondents that report FMS is meeting their needs.

% of Survey Respondents rating that FMS met their needs

Year	FMS Overall %	% Change	Avg % of All Services	% Change
2003	58.7%	0.0%	70.6%	0.0%
2004	64.7%	6.0%	70.6%	0.0%
2005	64.0%	-0.7%	71.5%	0.9%

Analysis of results and challenges: An internal customer survey on Finance and Management Services (FMS) performance is conducted annually. A 2006 survey was not done..

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed; however, only the overall results are shown in the above table. You can reference the specific program areas reported at the division level Result B, Target 1, Measure 1. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the percentage of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall percentage did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in the next survey.

Target #2: Reduce the average response time for complaints/inquiries to 14 days.

Measure #2: Department Inquiry/Complaint "HSS Track" log response times.

# of Inquiries/Complaints

Fiscal Year	Opened	Closed	Avg Days to Close
FY 2005	552	503	15.18
FY 2006	1590	1408	25.78
FY 2007	323	282	10.39

FY2007-represents the first quarter of FY2007.

Analysis of results and challenges: The response log "HSS Track" includes all inquiries or complaints that are received by the DHSS Commissioner's Office (i.e., public or legislative complaints, legislative questions, press inquires, etc.).

The increase in the inquiries/complaints opened in FY06 is attributed to the fact that in FY05 only a limited number of sections in the department were utilizing the log. In FY06, the Office of Children's Services was added to the HSS Track. This greatly increased the number and complexity involved to close out inquiries.

The response log "HSS Track" will be monitored by the Commissioner's Office.

Target #3: Reduce by 5% per year processing time for key indicators.
Measure #3: Track number of days it takes to process: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.

Timeliness and Accuracy

Fiscal Year 2006	# Processed	Days to Process
Purchase Requisitions	507	7.00
Operating Grant Awards	610	19.12
Processing Time for Payments	158,281	9.33
Capital Grant Awards	93	3.36
Legislative Inquiries	172	3.52

Analysis of results and challenges: This is a new indicator with new data for FY2006. The data will develop a baseline for future comparisons.

I1: Strategy - Implement results of Business

Alaska Pioneer Homes

Mission

Provide the highest quality of life in a safe home environment
for older Alaskans and veterans.

Introduction

The Division of Alaska Pioneer Homes provides residential and pharmaceutical services in Sitka, Fairbanks, Anchorage, Ketchikan, Palmer and Juneau to qualified Alaska seniors. The services are designed to maximize independence and quality of life by addressing the physical, emotional and spiritual needs of Pioneer Home residents. The Pioneer Home system served 562 Alaska seniors during FY06. As of November 30th, 2006, 199 Alaska seniors were on the active wait list and 2,521 were on the inactive wait list.

Core Services

To provide residential assisted living and pharmaceutical services to Alaska seniors residing in the six statewide Pioneer Homes that includes the Alaska Pioneers and Veterans Home.

Services Provided

The following table describes the three levels of service provided by the Pioneer Homes system.

Level I	Provision of housing, meals, emergency assistance and opportunities for recreation; Level I services do not include staff assistance with activities of daily living, medication administration, or health-related services, although the pioneer home pharmacy may supply prescribed medications.
Level II	Provision of housing, meals, emergency assistance, and, as stated in the resident's assisted living plan, staff assistance, including assistance with activities of daily living, medication administration, recreation and health-related services; assistance provided by a staff member includes supervision, reminders, and hands-on assistance, with the resident performing the majority of the effort; during the night shift, the resident is independent in performing activities of daily living and capable of self-supervision.
Level III	Provision of housing, meals, emergency assistance, and, as stated in the resident's assisted living plan, staff assistance, including assistance with activities of daily living, medication administration, recreation and health-related services; assistance provided by a staff member includes hands-on assistance, with the staff member performing the majority of the effort; the resident may receive assistance throughout a 24-hour day, including the provision of care in a transitional setting.

The state maintains and operates five Pioneer Homes and the Alaska Pioneers and Veterans Home. The services provided over time ranged from room and board to skilled nursing care, however, the focus today is residential assisted living under "The Eden Alternative™" care concept. All six facilities are licensed as assisted living homes. Any Alaskan age 65 or over that has been an Alaska resident for more than one year immediately preceding application for admission and is in need of aid is eligible for admission.

The Eden Alternative™ is a well-developed concept and approach to elder care that emphasizes enlivening the environment to eliminate loneliness, helplessness, and boredom. Important facets of the approach include opportunities for interaction with others, plant life, animals, and children and assuring the maximum possible decision-making authority remains in the hands of the residents or in the hands of those closest to them.

The Pioneer Homes are primarily funded by the general fund and resident payments (receipt supported services). A change in federal law and in department policy in FY 2005 allowed for Pioneer Home residents to receive Medicaid benefits. With this change, federal funds (reflected in the budget as inter-agency receipts) also support the operating costs of the Pioneer Homes. The Homes received just under $3.0 million in Medicaid Waiver receipts in FY 2006 and expects to collect about the same amount in FY 2007.

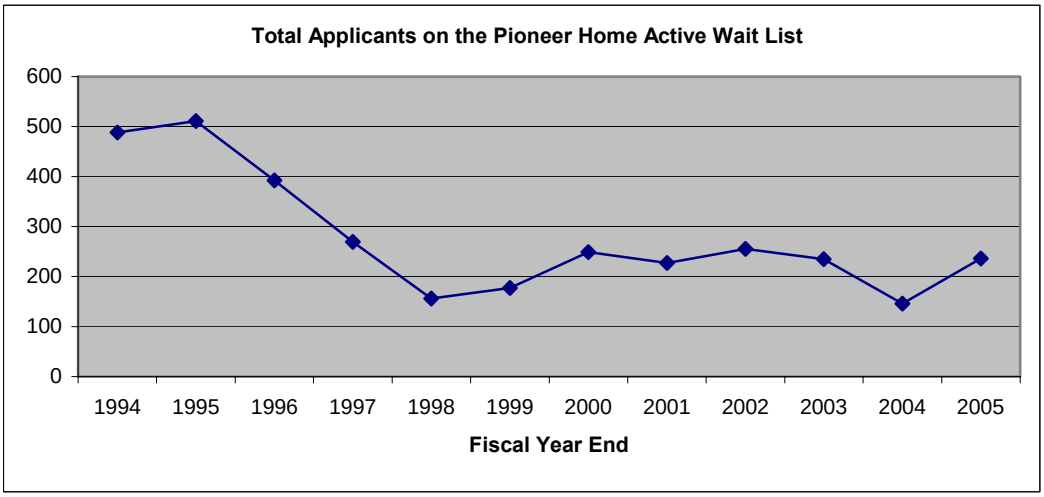
Pioneer Home residents pay the State a monthly rate based on their assessed level of care. If an individual's income and assets are insufficient to pay the monthly rate, they may apply for and receive payment assistance through the division's Payment Assistance Program. Effective December 31, 2005 all residents receiving state assistance, must also apply for other public benefit programs for which they may be eligible. The amount of payment assistance received by a resident is that portion of the monthly rate they are unable to pay.

Pioneer Homes Wait List

Individuals apply for admission to an Alaska Pioneer Home or the Alaska Pioneers and Veterans Home by completing and submitting an application. An individual who is a resident of the state and has attained 65 years of age may submit an application. The date and time of the application's submission determines the order of admission into the Pioneer Home system. An applicant chooses to move onto the "active branch" of the wait list when they are willing and ready to move into a Pioneer Home within 30 days of an offer. Invitations to enter a Pioneer Home are only offered to those on the active branch of the wait list.

When a bed becomes vacant in a particular level of service, the applicant offered admission is the person whose name is listed on the active branch of the wait list as having the earliest date of application. The applicant is admitted if the level of service the applicant requires matches the level of service of the available bed. At present, most people on the active branch of the wait list require Level II or Level III services and there are few vacancies in those levels. The number of applicants on the active wait list for each home increased over the past year, due in part to outreach by both management at the division level and the individual Pioneer Home administrators. The inactive wait list decreased by just under 150 applicants over the past year, with some applicants moving to the active wait list. The number of seniors on the Pioneer Homes active wait list over the years is shown in the table and chart below.

Pioneer Home Applicants on the Active Wait List							
Fiscal Year End	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
1994	37	67	103	190	39	52	488
1995	50	84	111	153	55	58	511
1996	39	75	79	111	30	58	392
1997	34	39	55	58	24	59	269
1998	16	24	27	15	25	49	156
1999	14	24	26	44	18	51	177
2000	11	44	52	64	28	50	249
2001	6	44	44	46	34	53	227
2002	8	90	31	68	29	29	255
2003	15	89	12	56	27	36	235
2004	4	78	16	21	7	20	146
2005	15	84	24	76	16	21	236
2006	13	93	67	100	24	44	341
Nov 2006	14	67	64	91	31	50	317



The following provides the composition of the Pioneer Homes wait list by facility as of November 2006.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Active Branch	14	67	64	91	31	50	317
Inactive Branch	682	878	889	1,249	482	841	5,021
Total	696	945	953	1,340	513	891	5,338
Number of Applicants Choosing More than One Home (Duplicates)							2,618
Number of Actual Applicants on Active Wait List (Not Duplicated)							199
Number of Actual Applicants on Inactive Wait List							2,521

Pioneer Home Rate History

The next chart shows the history of monthly rates within the Pioneer Home system. The July 1996 rate increase was the first increase in the Pioneer Homes Advisory Board's seven year plan to move towards charging Pioneer Home residents the full cost of care. The final increase of the seven year plan occurred in FY03 and there was no increase in FY04.

In FY05 the rate structure and service levels were changed to reflect actual utilization. This rate change resulted in a rate decrease for those residents formerly receiving Comprehensive Care Services and an increase for the other levels of service. There was no increase in the rates in FY 2006 or FY 2007 and the division has not proposed a rate adjustment for FY 2008.

However, the division is addressing the following FY 2007 legislative intent language:

It is the intent of the Legislature that the Pioneers Home program administration review the actual full cost of care for services provided at the Pioneers Homes and develop a proposal to increase rates to reflect the system wide average of full cost of care at the three different levels. In order to maximize Medicaid recovery, a proposed rate increase should be considered for implementation July 1, 2007.

The division developed a cost of care study based on actual FY 2006 costs that is being reviewed by the Commissioner's Office. Any proposed rate increase requires consultation with a variety of constituent groups and a regulation revision. At this time, the earliest implementation date for increasing the rates is July 1, 2008.

Assistance from Medicaid and the division's Payment Assistance Program are available for residents whose income and resources are insufficient to pay the full monthly rate.

Effective Date	Coordinated Services	Basic Assisted Living	Enhanced Assisted Living	Alzheimer's & Dementia Related Disorders	Comprehensive Care
July 1996	$934	$1,289	$1,553	$1,579	$1,864
July 1997	$1,140	$1,720	$2,140	$2,200	$2,630
July 1998	$1,340	$2,150	$2,730	$2,815	$3,395
July 1999	$1,540	$2,580	$3,315	$3,430	$4,160
July 2000	$1,735	$3,005	$3,905	$4,040	$4,920
July 2001	$1,935	$3,435	$4,490	$4,655	$5,685
July 2002	$2,135	$3,865	$5,080	$5,270	$6,450
July 2003	$2,135	$3,865	$5,080	$5,270	$6,450

Effective Date	Level I	Level II	Level III
July 2004	$2,240	$4,060	$5,880
July 2005	$2,240	$4,060	$5,880
July 2006	$2,240	$4,060	$5,880

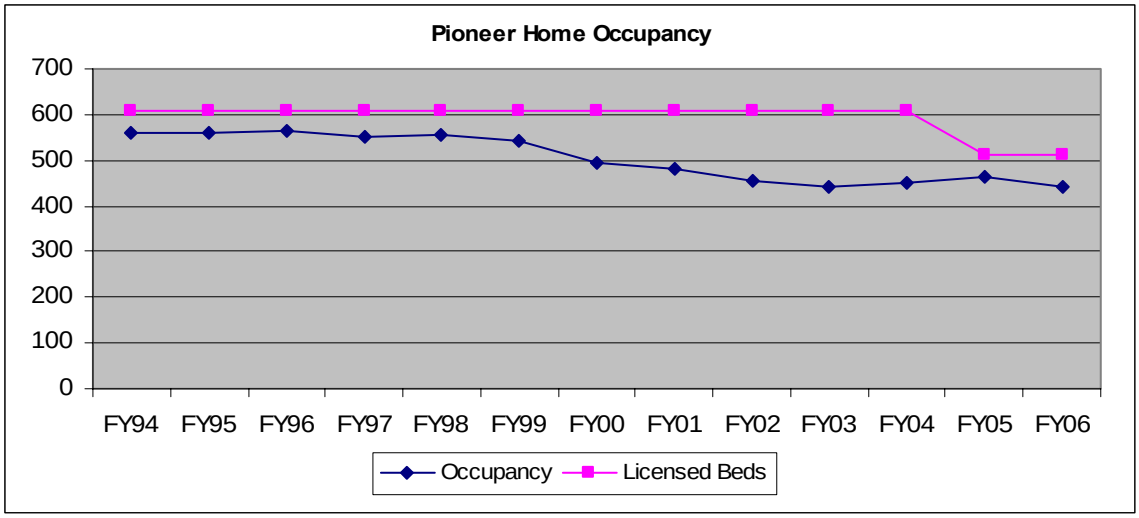
Historical Pioneer Home Occupancy

In FY 2005 the division reduced the number of its licensed beds by 91 to more accurately reflect the number of beds that meet current licensure requirements and are available for occupancy. In FY 2006 the licensed beds in the Fairbanks decreased by three and in FY 2007 number of beds in the Juneau Home will decrease slightly to reflect a safe resident to staff ratio.

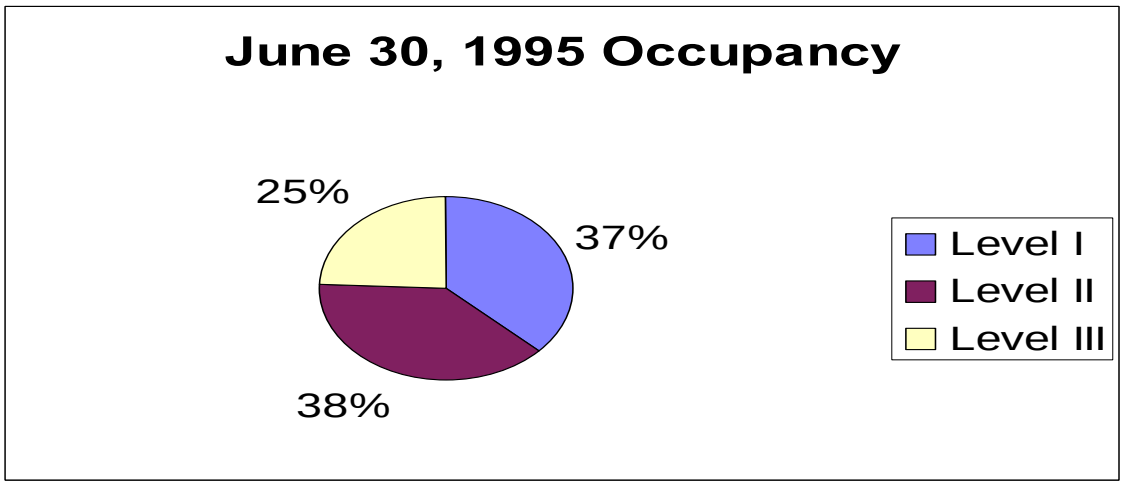
The majority of vacancies are in the Level I care units and there is not a demand for these beds. With the family and community support services available to seniors, many remain in their own homes until their need for assistance is acute. Those on the Pioneer Home active wait list require Level II and Level III services and those level beds are occupied. Use of Level I beds for Level II or Level III residents requires additional staffing and significant remodeling of these areas for this occupancy.

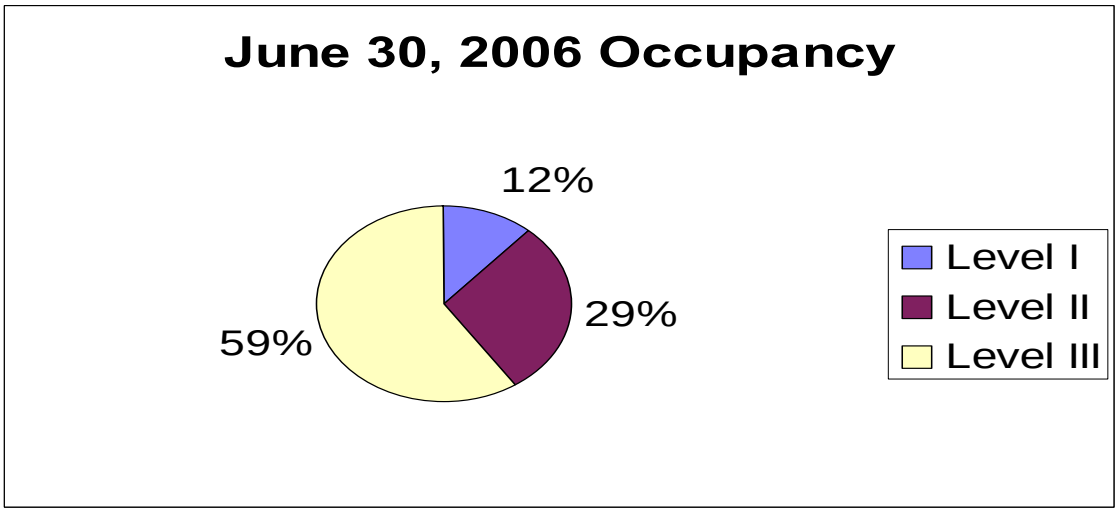
In FY07 the Legislature authorized additional staff to fill 10 and 12 vacant beds in the Sitka and Palmer Homes, respectively. With the positions now filled, these Homes are working their active wait lists to admit residents as quickly as possible.

The following two graphs display 1) actual occupancy to the total number of licensed Pioneer Home system beds and 2) the residents and the percentage of residents in each of the three care levels in 1995 and 2006. As mentioned above, the gap between licensed and occupied beds was significantly decreased in FY 2005 when the division decreased the number of licensed beds to more accurately reflect those that are available to fill.



The change in the level of service provided to Pioneer Home residents over the past eleven years is significant and is shown in the following two pie charts. Those residents requiring the highest level of service, Level III, increased from 25 to 59 percent, while those requiring Level I care decreased from 37 to 12 percent.





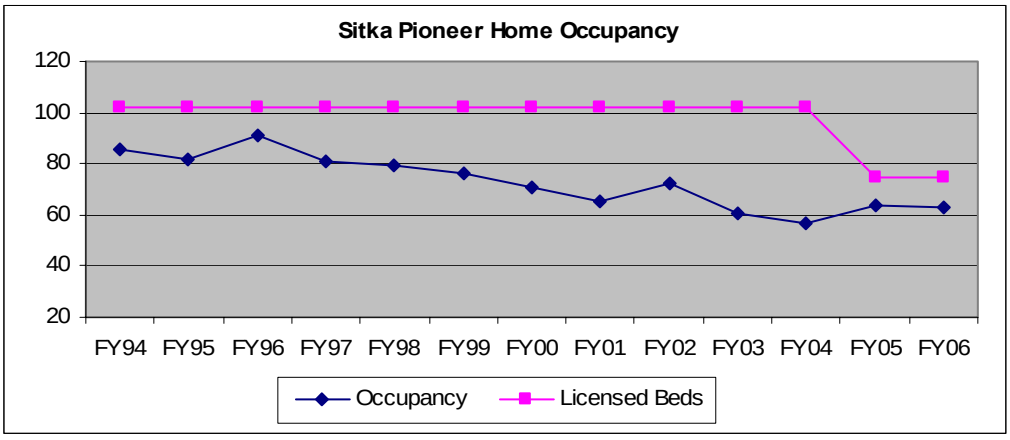
Current Pioneer Homes Occupancy

The table below shows the November 2006 occupancy figures for each of the five Pioneer Homes and the Alaska Pioneers and Veterans Home in Palmer by level of service. Totals towards the bottom of the chart compare occupied beds and available beds to the licensed beds.

Service Level Occupied/Assigned	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Level I	6	8	3	31	3	2	53
Level II	22	16	13	47	17	15	130
Level III	34	58	39	73	26	23	253
Total	**62**	**82**	**55**	**151**	**46**	**40**	**436**
Licensed Beds	75	93	79	165	48	48	508
Occupied/Assigned	62	84	59	151	46	40	442
Non-Occupied	13	9	20	14	2	8	66
% Licensed Beds Filled/Assigned	82.7%	88.2%	69.6%	91.5%	95.8%	83.3%	85.8%

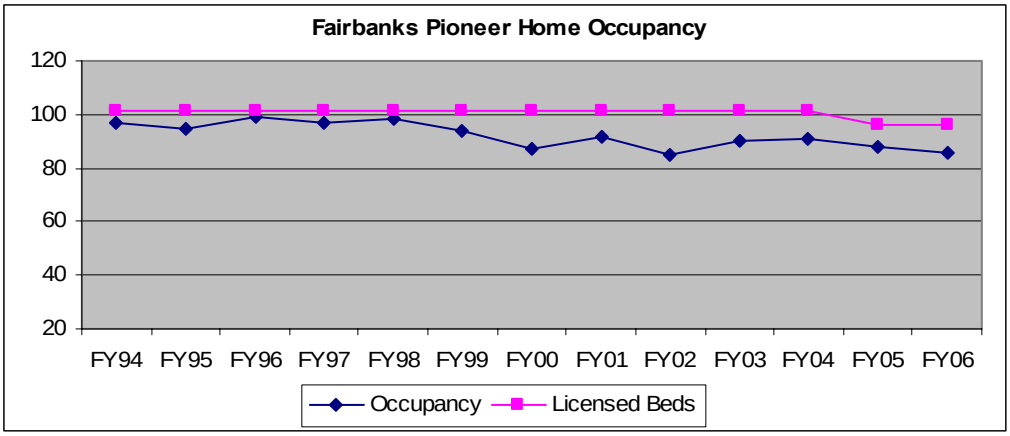
Sitka Pioneer Home

The Sitka Pioneer Home opened in 1913 when Alaska had been a Territory for just one year. The Home was established in the abandoned Sitka Marine Barracks building which was built in 1892. In 1934 a new main building, manager's house and nurses quarters were constructed. An addition was built on the north side of the building in 1954. The Sitka Pioneer Home is on the National Historic Register, which requires all renovations to adhere to stringent federal guidelines. Of the 75 licensed beds in the Sitka Pioneer Home, 62 were occupied as of November 2006. With the increase in staff authorized for nine months of FY 2007, the Social Worker is actively working to fill the additional ten beds.



Fairbanks Pioneer Home

The Fairbanks Home was the second Pioneer Home built and began serving the community in 1967. The Fairbanks Home consistently maintains a high occupancy level. As of November 2006, 82 of the 93 licensed beds were occupied. In November 2006, the Fairbanks Home decreased the number of its licensed beds from 96 to 93.

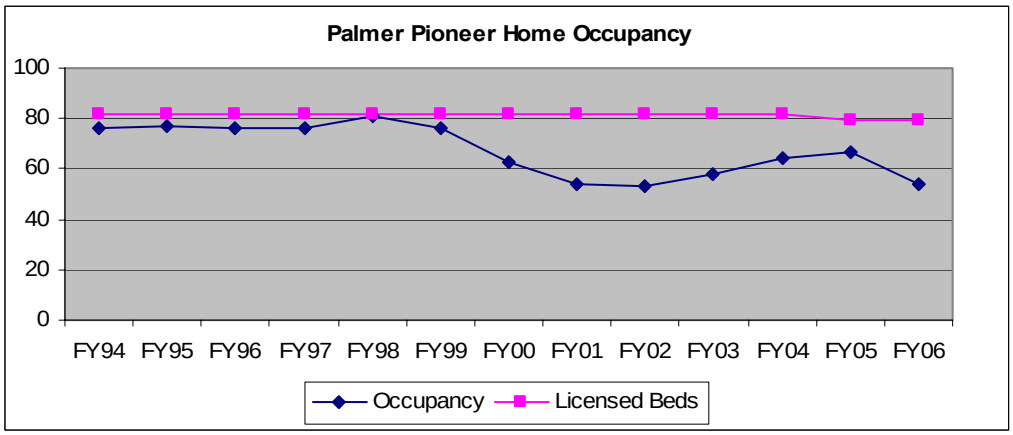


Palmer Pioneer Home

The Palmer Home, located in the Matanuska Valley, was built in 1971. It is a single level, ranch-style building and encompasses 11 acres of lawn and gardens. Within six years of opening, it became apparent more space was needed and an addition was built. As of November 2006, 55 of the 79 licensed beds were occupied.

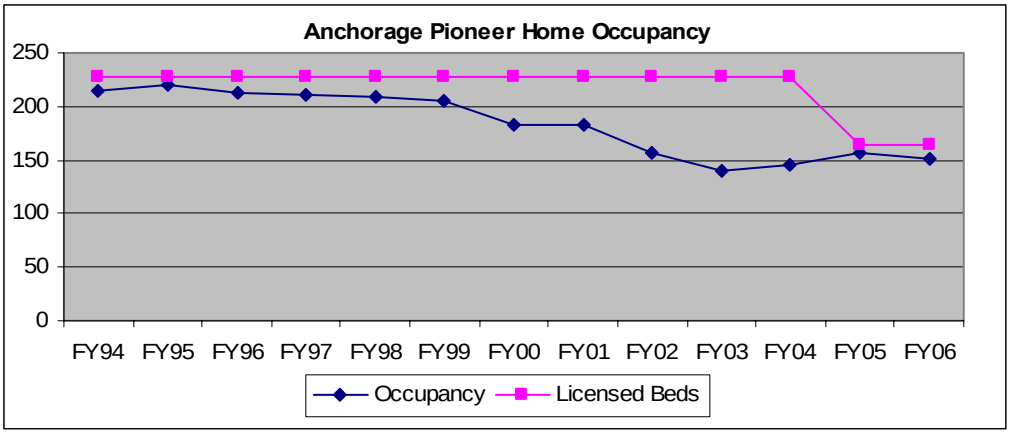
The Palmer Home is currently awaiting final certification from the US Department of Veterans Affairs to become Alaska's first state Veterans Home. Once certified and over a period of years, the Home will transition to fill 60 of its 79 licensed beds with veterans. Nineteen of the beds are reserved for spouses of veterans, children of veterans, and all non-veteran related pioneers. The state Pioneers and Veterans Home in Palmer will operate under the same guidelines as the other five Pioneer Homes, requiring one year residency and residents who are 65 years of age or older.

The Legislature authorized ten new positions in FY07 to serve the needs of 12 additional residents in the Palmer Home. The staff of the Palmer Home is actively working the wait list to fill these beds.



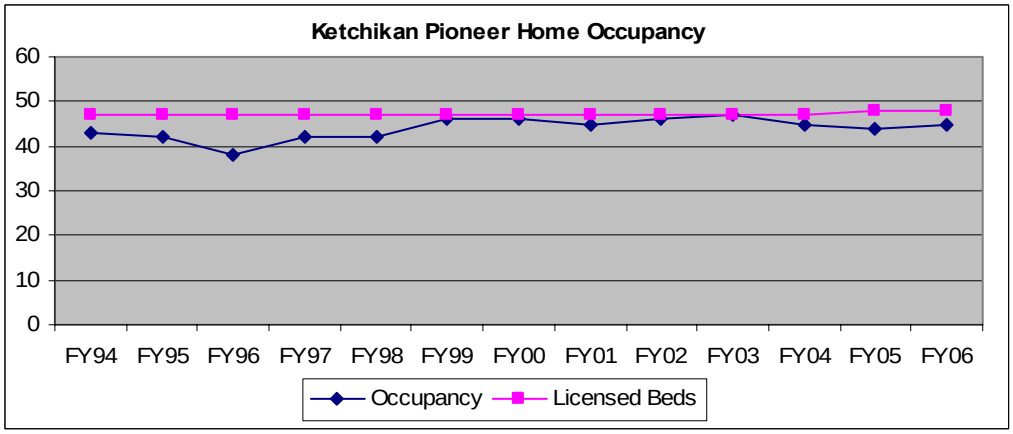
Anchorage Pioneer Home

The Anchorage Home is the largest Pioneer Home with 165 licensed beds. The Home was built in two stages. The five story south side was built in 1977 and the two-story north wing opened in 1982. As of November 2006, 151 beds were occupied.



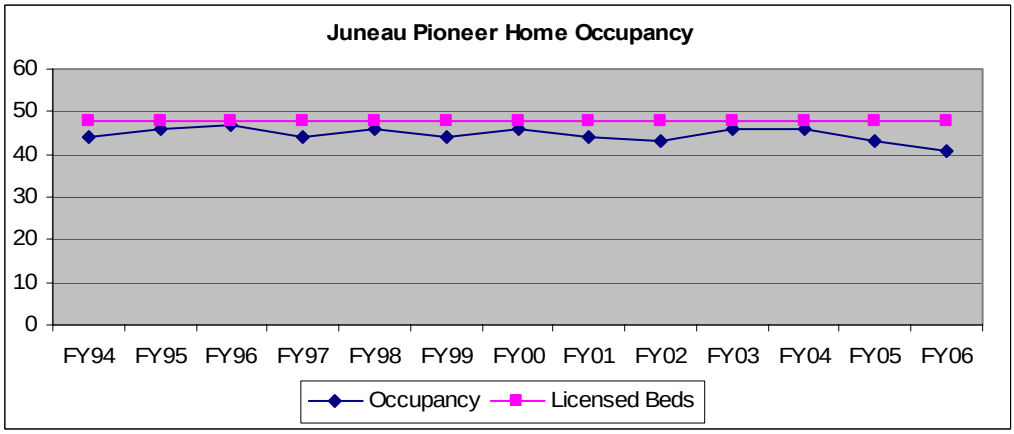
Ketchikan Pioneer Home

The doors of the Ketchikan Home opened to accept residents in November 1981. The resident rooms are located on the two upper floors of the three-story building. Ketchikan maintains a high census. In November 2006, 46 of the 48 licensed beds were occupied.



Juneau Pioneer Home

The newest Pioneer Home opened in Juneau in 1988 as a skilled nursing facility. Today, it is home to 40 Alaska seniors as an Assisted Living Home and is licensed for 48 beds.



Ch 59, SLA04	Pioneers' Homes/Veterans' Homes: SB 301
AS 44.29.020(1)(16)	Duties of H&SS Department-Amd by Ex Order 108, Sec 4; Ch 59, SLA 2004
AS 44.29.400	State Veterans' Home Facilities – Amd by Ex Order 108, Sec. 4; Ch 59, SLA04
AS 47.55	Pioneers' Homes – Amd by Exec Order 108, Sec 4; Ch 59, SLA04
7AAC 74	Pioneers' Homes – Revised August 2004

AK Pioneer Homes	2007	2008 Proposed	07 to 08 Change
General Funds	28,902.7	34,288.0	5,385.3
Federal Funds	413.8	314.7	-99.1
Other Funds	19,641.6	20,349.1	707.5
Total	**48,958.1**	**54,951.8**	**5,993.7**

Pioneer Homes

Additional Positions to Meet Veteran Home Requirements $162.5 General Fund; $162.5 Receipt Supported Services

The division requests three additional positions for the Alaska Pioneers and Veterans Home in Palmer ($325.0). An Assistant Administrator, Health Practitioner I and Nurse III are necessary to meet the requirements to become a certified Veterans Home and to run the additional programs required by the US Department of Veterans Affairs. The specific requirements were unknown until the Veterans Affairs team developed a checklist to evaluate the Pioneer Home. This checklist includes 13 functional areas and forty sub-parts which the Pioneer Home must meet before it can be certified as a state Veterans Home. These three positions are vital in meeting and maintaining certification from the US Department of Veterans Affairs, collecting veterans' per diem payments and providing a safe living environment for Alaska's veterans and seniors. This funding request is split between general funds and receipt supported services.

Annualize Funding for FY 2007 New Positions $390.0 General Funds

The Legislature approved 24 new positions for the Pioneer Homes in FY 2007 and funded them for nine months. The FY 2008 budget includes a request for $390.0 to annualize the funding for these positions. These additional positions are providing the level of resident care and safety required with the increased acute care levels of our residents and allows the Sitka Home to fill ten additional beds.

Funding for Meals for New Sitka and Palmer Residents $66.0 Receipt Supported Services

The additional staff approved in FY 2007 for the Sitka and Palmer Pioneer Homes supports filling 10 and 12 vacant beds, respectively. The division requests $66.0 in contractual and receipt supported services funding to pay for food service costs related to these additional residents. Food service for all Pioneer Home residents is provided via a professional services contract with Nana Management.

Other Budget Changes:

- Funding for the Nurse Salary Market Based Pay Increase the Legislature authorized in the FY07 Budget: $862.3 ($700.0 general funds; $162.3 other funds)
- Fuel/Utility Cost Increase Funding Distribution: $131.0 general funds authorized by the Legislature in FY07.

Pioneer Home Advisory Board Concerns
After touring the three Southeast Pioneer Homes, holding public meetings and conferring with staff, the Pioneer Homes Advisory Board (PHAB) sent a letter to the Governor outlining their concerns and making several recommendations. The following are issues brought to the Governor's attention by the Board:

The 2006 Lewin Group report projects the 65 and older population will triple from 43,000 in 2005 to 124,000 by 2025. Today, Alaska's Pioneer Homes can only meet the needs of a small segment of the senior population. If we are to meet the needs of seniors throughout the state in the long term, we must support and expand facilities and services.

Operating
Certified Nurse Aides (CNA'S): In many communities our nurse aide salaries are substantially below what their counterparts in the private sector earn and our CNA wages do not reflect the enormity of their work.

Nurses: The salary increase for nurses implemented in July of this year made a remarkable difference in the Homes' ability to recruit and retain valuable registered and licensed practical nurses. However, we must remain vigilant in tracking national trends in compensation packages if we are to remain competitive in a difficult nursing market**.**

Capital
The Sitka Pioneer Home continues to use 17 five-gallon buckets in their attic to address the numerous ongoing leaks in the tile roof. The Sitka Home is on the National Historic Register so special consideration must be given to repairs as there are restrictions on materials that can be used to correct deficiencies.

There continues to be identified deferred maintenance needs in the all the Pioneer Home facilities that are still of great concern to the Advisory Board. Systemic problems include peeling and warped flooring, unacceptable handicap accessible bathrooms, bathing areas and hallways, and a lack of storage space for stockpiling goods necessary for mandatory pandemic and emergency planning.

In addition to the concerns raised by the Advisory Board, the division continues to be challenged by the following:

Increased Documentation
As regulations change and requirements for documentation and programmatic responses multiply, the time it takes to fully assess and properly "document" a resident according to all the various regulations is increasing.

The application materials for Medicaid and the Medicaid Waiver are labor intensive for our social workers and often have time constraints out of their control, such as eligibility determination.

The Pioneer Homes' two page residential services contract has expanded to six pages in order to comply with new assisted living regulations.

The application packet is now 37 pages long and it does not include the four additional booklets of information that must be discussed with family members.

A comprehensive resident assessment, mandated by assisted living licensing, requires completing 13 pages that address everything from spiritual preference to bowel control. It is very labor intensive to discuss such personal matters with family members and get a true picture of a resident's care needs.

Legislative Intent Results

Regulations, effective December 31, 2005 require Pioneer Home residents to apply for Medicaid, Medicare or any program the department identifies that may reduce the amount of state payment assistance needed under AS 47.55. The division notified current residents of the need to apply for other benefit programs and included supplemental funding paperwork in the Pioneer Home admission packets. Social workers assist residents and/or responsible parties with the forms and initial application for benefits as well as with follow up paperwork.

As of December 2006, 56 percent of Pioneer Home residents were subsidized by the state through the division's Payment Assistance Program and 72.6 percent of those had applied for Medicaid.

The following table shows the number of residents receiving state assistance through the Pioneer Home Payment Assistance Program as of December 2006. The Medicaid and Older Alaskans Waiver figures are as of January 2007.

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Residents Receiving State Assistance	37	42	37	79	24	22	241
Medicaid Approved	14	15	18	34	12	8	101
Older Alaskans Medicaid Waiver Approved	8	10	12	13	7	7	57

Over twenty-three percent of residents receiving state assistance qualify for the Older Alaskans Medicaid Waiver.

The Pioneer Home system billed and collected nearly $3.0 million in Medicaid Waiver receipts in FY 2006 and is expected to collect the same amount in FY 2007. Beginning in FY 2006, all receipts for pharmaceuticals are posted as statutory designated program receipts (SDPR).

As of December 31, 2005, Medicaid payments for medications ceased as part of the federal Medicare Part D program. Seniors who relied on Medicaid to cover the cost of their medications transitioned to the new program, Medicare Part D, as the source of payment for most of their drugs. To date, the Pioneer Home Pharmacy negotiated agreements with eighteen of the forty-five Prescription Drug Plans (PDPs) that the federal Medicare agency approved for Alaska. PDP's have become more competitive in 2007 by adding more covered drugs to their formularies, offering lower costs for generic medications, and offering additional coverage in the coverage gap. In addition, the Low Income Subsidy Program offered through the Social Security Administration provides "extra help" with premiums, deductibles, and coverage in the coverage gap to qualifying recipients.

In August 2006, the division identified and contacted forty-one residents without prescription drug coverage. Of those contacted, thirty or 75 percent have obtained or are in the process of obtaining prescription drug coverage. The division will continue to contact residents on the state's Payment Assistance Program who do not have coverage and request they obtain it.

Contribution to Department's Mission

Provide the highest quality of life in a safe home environment for older Alaskans and Veterans.

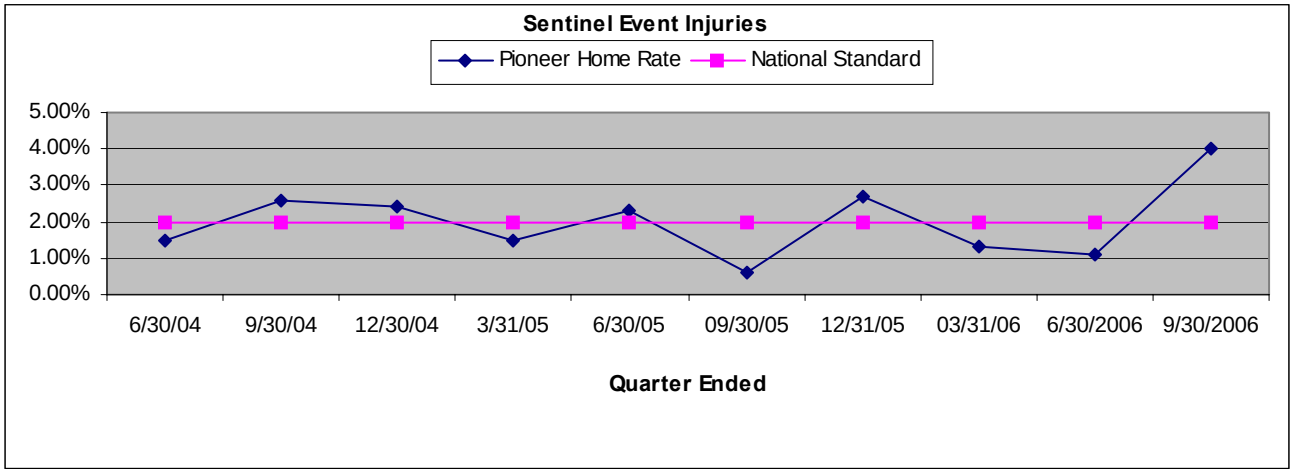
Core Services

- Provide residential assisted living services.

Department Level Measures

A: Result - Outcome Statement #1: Provide a safe environment for Alaska pioneers and veterans.

Target #1: Injury rate below half the national standard, which is two to six percent.
Measure #1: Pioneers Home sentinel event injury rate.



Alaska Pioneer Home Sentinel Event Injury Rate

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	2.9%	0.7%	0%	0.37%	.99%
2003	1.1%	.04%	1.79%	1.5%	1.1%
2004	1.96%	0.1.26%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	4.0%	0	0	0	0

The Sentinel Event injury rate reports the percentage of falls that resulted in a major injury. The rate is calculated by dividing number of Sentinel injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: The elderly, who represent 12 percent of the population, account for 75 percent of deaths from falls.

The average age in the Pioneer Homes is 84.9. This puts the residents in the highest risk category, and they are more likely to suffer a serious injury from a fall, and experience significant morbidity thereafter.

The Pioneer Homes will respond to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problems are even more disturbing. The event is called "sentinel" because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization, than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

See Alaska Pioneer Homes Division Level Strategy A2: Target 1: Measure 1 for additional explanation.

A1: Strategy - Provide sufficient staffing for safe environment in the homes.

Division Level Measures

A: Result - Outcome statement - Eligible Alaskans and Veterans will live in a safe environment.

Target #1: Reduce resident serious injury rate.
Measure #1: Hold constant, below the national level, the number of medication errors and falls that result in serious injury.

Analysis of results and challenges: Increasing age and acuity levels of Pioneer Home residents creates a challenge in reducing adverse events that result in serious injury. By properly utilizing the strength of trending and tracking information available in the division's risk analysis program, the Homes are able to identify times, places, staff and conditions that hold inherent risk. Action plans to address risk help the Homes prevent errors, reduce the number of serious injury events, and reduce the severity of injury.

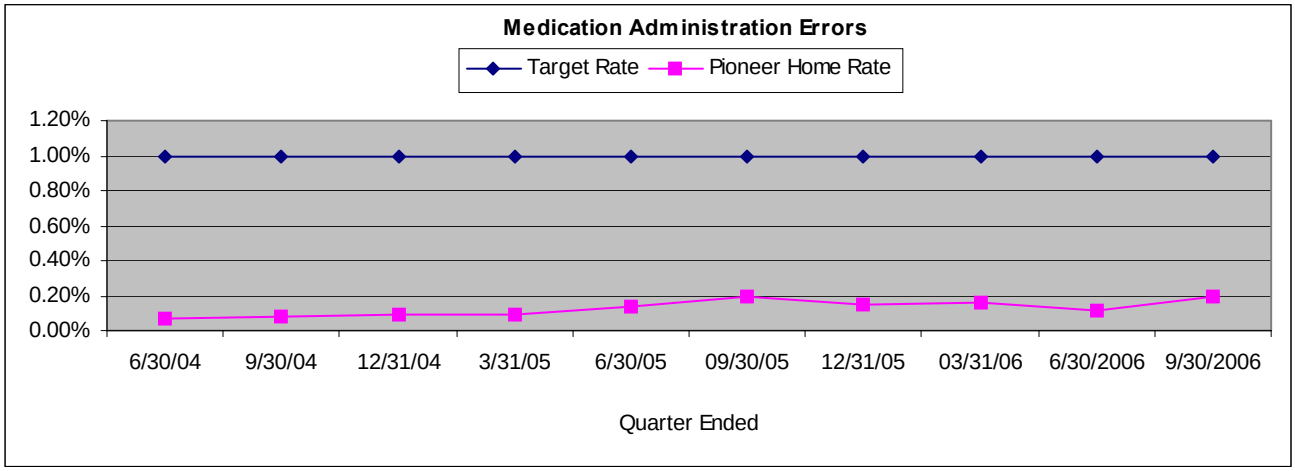
See Alaska Pioneer Homes Division Level Strategy A1 and A2: Target 1: Measure 1 for additional explanation.

- See Division Level Strategy A1 (medication errors): Target 1: Measure 1
- See Division Level Strategy A2 (fall rates): Target 1: Measure 1

A1: Strategy - 1) Improve the medication dispensing and administration system.

Target #1: Less than one percent medication error rate, which is one-half the low end of the national standard range.

Measure #1: Percent of medication administration errors.



Medication Error Rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2002	0.07%	0.08%	0.04%	0.05%	0.06%
2003	0.10%	0.11%	0.09%	0.15%	0.11%
2004	0.07%	0.11%	0.06%	0.07%	0.08%
2005	0.08%	0.09%	0.09%	0.14%	0.10%
2006	0.19%	0.15%	0.16%	0.12%	0.17%
2007	0.19%	0	0	0	0

The medication error rate is calculated by taking the number of medication errors per quarter divided by the total number of medications taken by all Pioneer Home residents in the same quarter.

Analysis of results and challenges: The Centers for Medicare and Medicaid Services, which licenses nursing facilities throughout the United States, considers a five percent medication error rate acceptable.

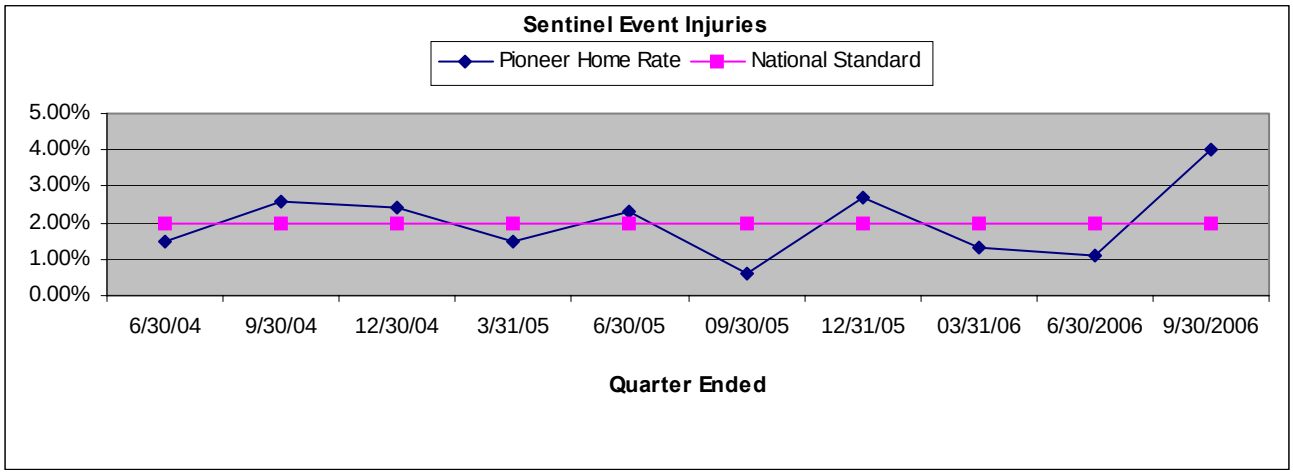
The Pioneer Home system collects medication information at the individual Pioneer Home level and aggregates the numbers for reporting at the division level. In 2006, Pioneer Home staff administered an average of 434,464 individual medications each quarter.

All care processes are vulnerable to error, yet several studies have found that medication-related activities are the most frequent type of adverse event. Medication administration errors are the traditional focus of incident reporting programs because they are often the types of events that identify a failure in other processes in the system. A wrong medication may be administered because it was prescribed, transcribed, or dispensed incorrectly. The division uses a system wide risk reporting program that tracks medication errors, and allows the collected data to be reported and trended for use in identifying error prone steps (risks). Trending the cause of the error tends to provide the most useful information in designing strategies for future error prevention.

A2: Strategy - 2) Reduce the number of residents' serious injuries from falls.

Target #1: Less than two percent injury rate, which is the low end of the National Safety Council's range of two to six percent.

Measure #1: Percent of Pioneer Homes serious injuries from falls.



Sentinel Event injury rate

Year	Qtr 1	Qtr 2	Qtr 3	Qtr 4	YTD Total
2002	2.9%	0.7%	0.0%	0.37%	0.99%
2003	1.1%	0.04%	1.79%	1.5%	1.1%
2004	1.96%	1.26%	0.97%	1.47%	1.45%
2005	2.6%	2.4%	1.5%	2.3%	2.2%
2006	0.6%	2.7%	1.3%	1.1%	1.43%
2007	4.0%	0	0	0	0

The Sentinel Event Injury rate reports the percentage of falls that result in a major injury. The rate is calculated by dividing the number of Sentinel Event injuries to Pioneer Homes residents by the total number of falls reported for the same quarter.

Analysis of results and challenges: Seventy-five percent of elderly deaths result from falls.

Despite remarkable advances in almost every field of medicine, the age-old problem of health-care errors continues to haunt health care professionals. When such errors lead to "sentinel events," those with serious and undesirable occurrences, the problems are even more disturbing. The event is called sentinel because it sends a signal or warning that requires immediate attention. One in three people age 65 and older, and 50 percent of those 80 and older fall each year. The National Safety Council lists falls in older adults as five times more likely to lead to hospitalization, than other injuries. One estimate suggests that direct medical costs for fall-related injuries will rise to $32.4 billion by 2020. Falls can have devastating outcomes, including decreased mobility, function, independence, and in some cases, death.

The average age of Pioneer Homes residents is 84.9 putting them in the highest risk category where they are more likely to suffer a serious injury from a fall and experience significant morbidity thereafter.

The Pioneer Homes responds to serious injuries with root cause analysis investigations and corrective action plans to address underlying causes.

The analysis of the spike in sentinel event injuries between FY04 and FY05 does not indicate one root cause. There were, however, seven deaths associated with falls in FY05*. Of the total, six of the seven falls occurred when the resident was alone so they are categorized as unwitnessed. It is difficult to recreate the events leading up to an unwitnessed fall, especially if the fall involves a resident who suffers from dementia and is unable to articulate what occurred. Most of these of falls are reported as “found on floor,” and the sequence of events leading up to the fall reconstructed by staff depending on the time of day with some supposition on the activity the resident was attempting.

Because such a significant number of the witnessed falls are less severe than unwitnessed falls, the division built a case for increased staffing with the intention of reducing the number of falls that are unwitnessed. Three new positions were funded in FY06 and the table below shows a 2 percent decrease in the overall percentage of unwitnessed falls.

Unwitnessed Fall Rate
FY05 81%
FY06 79%

Twenty-four new positions were funded for nine months in FY07, beginning October 1, 2006, so there are no correlating statistics for the first quarter.

*Any death within 45 days of a sentinel event is associated with that event.

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Behavioral Health

Mission

Provide an integrated behavioral health system.

Introduction

Alaska's behavioral health system includes both the public and the private sectors. The public sector is responsible for serving those who do not have access to private services because of cost and/or location. Every location in the state, no matter how remote, falls into a service delivery area. The Division of Behavioral Health (DBH) is responsible for the state's public behavioral health system which includes the community mental health and substance disorder programs. DBH administers the statewide system of community behavioral health programs for delivery of residential and community-based treatment and recovery services; manages Alaska Psychiatric Institute (API), the state's only public psychiatric hospital; administers grants to the state's network of local community mental health and substance abuse programs; and coordinates with other government, tribal and private providers of behavioral health services to ensure the provision of comprehensive behavioral health services to Alaska residents. DBH works closely with the Alaska Mental Health Board (AMHB) and the Alaska Board for Substance and Drug Abuse which serve as the state's mental health and substance abuse planning councils, and the provider organizations (Alaska Behavioral Health Association and Alaska's Substance Abuse Directors) on system planning and evaluation. DBH also works in close coordination with the Alaska Mental Health Trust Authority to achieve these goals.

Core Services

- Grant and monitor the use of funds to provide treatment and prevention services for Alaskans with substance use disorders, mental illness, or a combination of both, including behavioral health problems caused by traumatic brain injury and fetal alcohol spectrum disorders;
- Regulation and policy development governing the planning and implementation of services and supports for people who experience mental illness, substance abuse disorders, or both; and
- Operate the Alaska Psychiatric Institute, the state's only seven-day-a-week, 24-hour-a-day psychiatric hospital providing services to clients admitted either voluntarily or involuntarily.

Services Provided

Alaska Fetal Alcohol Syndrome (FAS) Services
This project seeks to prevent alcohol-related birth defects, increase diagnostic services in Alaska, improve the delivery of services to those individuals already affected by Fetal Alcohol Spectrum Disorders (FASD), and to evaluate the outcomes of statewide efforts. Services include training, public education, development of statewide diagnostic services, community support through grants and contracts, and the on-going development of partnerships with other divisions, departments, community agencies, Native health corporations and parents/caregivers to decrease the prevalence of FAS and the secondary disabilities that occur when appropriate services are not provided.

Alcohol Safety Action Program (ASAP) Services
The ASAP program screens, refers and monitors both adult and juvenile offenders to ensure that they complete their substance abuse education or treatment program that is prescribed by the courts, Division of Motor Vehicles, and/or Division of Juvenile Justice. ASAP is both a direct service provider in the Anchorage area and the oversight office for the divisions statewide ASAP grant programs. The program facilitates entry of all misdemeanor defendants ordered by the court into substance abuse education and/or treatment, monitors court requirements, and provides data regarding those defendants.

Behavioral Health Medicaid Services
A combination of federal and matching state Medicaid funds support behavioral health services to Medicaid eligible individuals with a mental disorder or illness and/or a substance abuse disorder. These funds are managed by the division to maximize financial support for mental health treatment and substance abuse intervention and treatment services for Medicaid eligible youth and adults, in both inpatient and outpatient settings.

Behavioral Health Grant Services
The grants to local agencies to support alcoholism, substance abuse and mental illness by funding intervention and treatment services to provide the comprehensive, statewide substance abuse identification and treatment system required by state law. The grants also provide funds for personal skill development and general support services to assist individuals who suffer from a traumatic brain injury to attain their highest possible functioning level. The publicly funded programs primarily serve those Alaskans without insurance or the ability to pay for services.

Behavioral Health Administration
The component supports the administrative operation of the division and the programmatic oversight of all programs and services funded by the division, with the exception of services delivered at Alaska Psychiatric Institute (API). The more than 175 million dollars granted or contracted by the division to provide services to individuals and their families are managed, awarded, disbursed, and monitored by this component. All division staff positions, except those employed by the API and Alcohol Safety Action Program are budgeted in this component.

Community Action Prevention & Intervention Grants Services
The goal of this component is to ensure that effective community-based prevention and early intervention services are available statewide. These services strive to incorporate research-based strategies that demonstrate positive outcomes for individuals and communities. The intent is to provide the foundation funding for Alaska's effort to prevent substance abuse within the state, with a focus on preventing youth from experimenting with and becoming addicted to alcohol and other

drugs. Prevention services include information, general education, alternative activities, problem identification and referral, community-based processes, and environmental strategies.

Rural Services and Suicide Prevention Services
Programs funded through this component include the Community-Based Suicide Prevention Program (CBSPP), which provides small grants directly to communities; and the Rural Human Services System Project (RHSSP) which provides funds to regional agencies to hire, train and supervise village-based counselors. These counselors provide integrated substance abuse and mental health outpatient, aftercare and support services as well as prevention and education activities.

Psychiatric Emergency Services
The funding supports competitive grants to community mental health agencies for services intended to aid people in psychiatric crisis. The service array may include crisis intervention, brief therapeutic interventions for stabilization, and follow-up services. Specialized services such as outreach teams and residential crisis/respite services are also included. The component also will respond to disasters and seek federal aid for events that qualify as declared disasters.

Services for the Seriously Mentally Ill
Competitive grant funding is made available to community mental health agencies for an array of support services for adults with severe mental illnesses. This is the population that impacts the census limits at Alaska Psychiatric Institute (API) and services delivered in the community are critical to keeping this population out of the hospital. Core services are assessment, psychotherapy, case management, and rehabilitative services. Specialized services include residential services, vocational services and drop-in centers.

Designated Evaluation and Treatment
The state, as a payer-of-last resort, makes these funds available to designated local community and specialty hospitals for evaluation and treatment services for people under court-ordered commitment and to people who meet those criteria, but have agreed to accept services voluntarily in lieu of commitment.

Using this funding, a local facility may provide up to 72-hour inpatient psychiatric evaluations, up to 7 days of crisis stabilization, or up to 40 days of inpatient hospital services close to the consumers home, family, and support system. Component funding also supports consumer and escort travel to designated hospitals and back to their home community.

Services for Severely Emotionally Disturbed Youth (SEDY)
The SEDY component provides competitive grant funding to community mental health agencies for a range of services for severely emotionally disturbed youth and their families. Core services provided are assessment, psychotherapy, chemotherapy, case management and rehabilitation. Specialized services include individual skill building, day treatment, home-based therapy, residential services and individualized services.

SEDY grants prioritize services in the least restrictive environment and as close to home and family as possible. Changes have been made to enhance the in-state service continuum for severely emotionally disturbed children and decrease the number of children moving into out-of-state placements and restrictive in-state environments.

Alaska Psychiatric Institute

Alaska Psychiatric Institute (API) provides twenty-four hour inpatient psychiatric care to individuals from all regions of the state. API serves Alaskans with severe and persistent psychiatric disorders or serious maladaptive behaviors including adults and adolescents whose need for psychiatric services exceeds the capacity of local service providers. API also provides longer-term care for organic or highly complex and difficult to place patients and provides court-ordered competency evaluations of persons accused of crimes, and treatment for patients found incompetent to stand trial or not guilty by reason of insanity. The division's staff makes special efforts to transition patients with serious, persistent mental illness into community settings. API provides outreach, consultation, and training to mental health service providers, community mental health centers, and nursing, social work, psychology, rehabilitation, and medical student interns.

Services provided at API include:

- screening and referral
- medication stabilization
- psychosocial rehabilitation services
- multidisciplinary assessments
- individualized and group therapy and counseling
- patient and family education
- inpatient psychiatric treatment with an increasing focus on the role recovery approach
- tele-psychiatry services to reach remote areas of the state

Behavioral Health Treatment and Recovery Statistics

Behavioral Health Services Data	
Mental Health Services	
Adults	11,761*
Children	8,392 *
Psychiatric Emergency	45,145**
Psychotropic Medications Caseload	4,000 per month of a total Alaska Medicaid eligible population of 96,000 ***
Substance Abuse Services	
Adults	4,118*
Youth	1,282*
Pregnant Women	156*
Number Successfully Completing Treatment	2,204**
Diagnosed with Co-occurring Disorder	2,950**

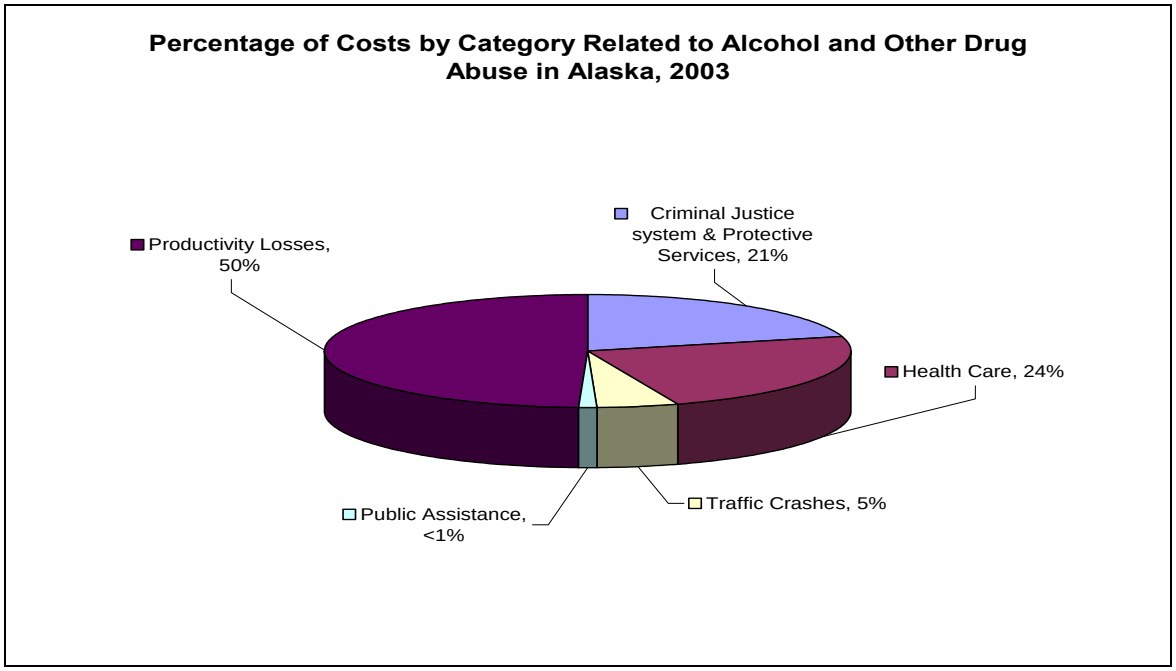
* 2006 Community Mental Health Services or Substance Abuse Block Grants
** FY 06 Quarterly Reports
*** MMIS Data 2006 -- The vast majority of prescribers were not among our grantees.

Societal Costs of Alcohol and Other Drug Abuse to Alaska

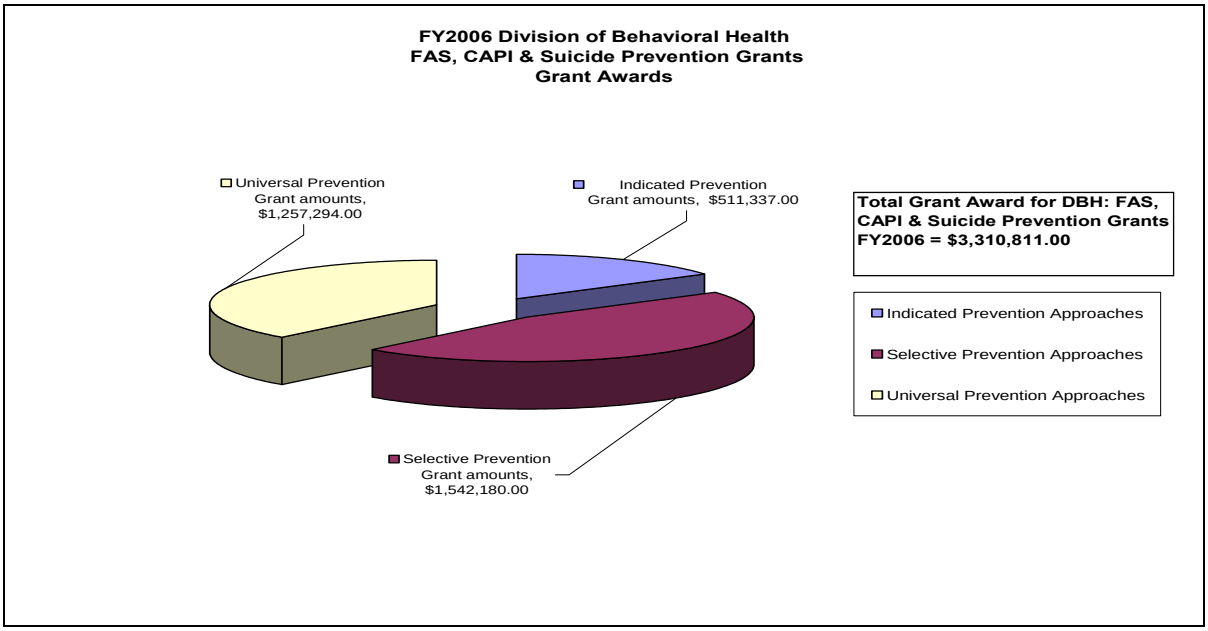
- Public programs (States spent $77.9 billion on criminal justice, Medicaid, child welfare, mental health, highways, state payrolls, schools, and juvenile justice working with substance abuse.)
- Employment (500 million lost work days per year are attributable to alcoholism.)
- Cost Analysis (96 cents of every dollar spent on substance abuse goes to shoveling up the wreckage of impairment; 4 cents are spent on prevention and treatment.)
- Cost per tax payer (Every American paid $277 per year in taxes to deal with consequential burdens of substance abuse; $10 per year for prevention and treatment.)
- Cost (States spent $81.3 billion to deal with substance abuse, which is 13.1 % of state budgets.)

In January of 2004, at the Treatment of Alcohol and Other Substance Use Disorders: What Legislators Need to Know, National Conference of State Legislators, the following information was dispensed:
In 2003, alcohol and other drug abuse cost Alaska $738 million:

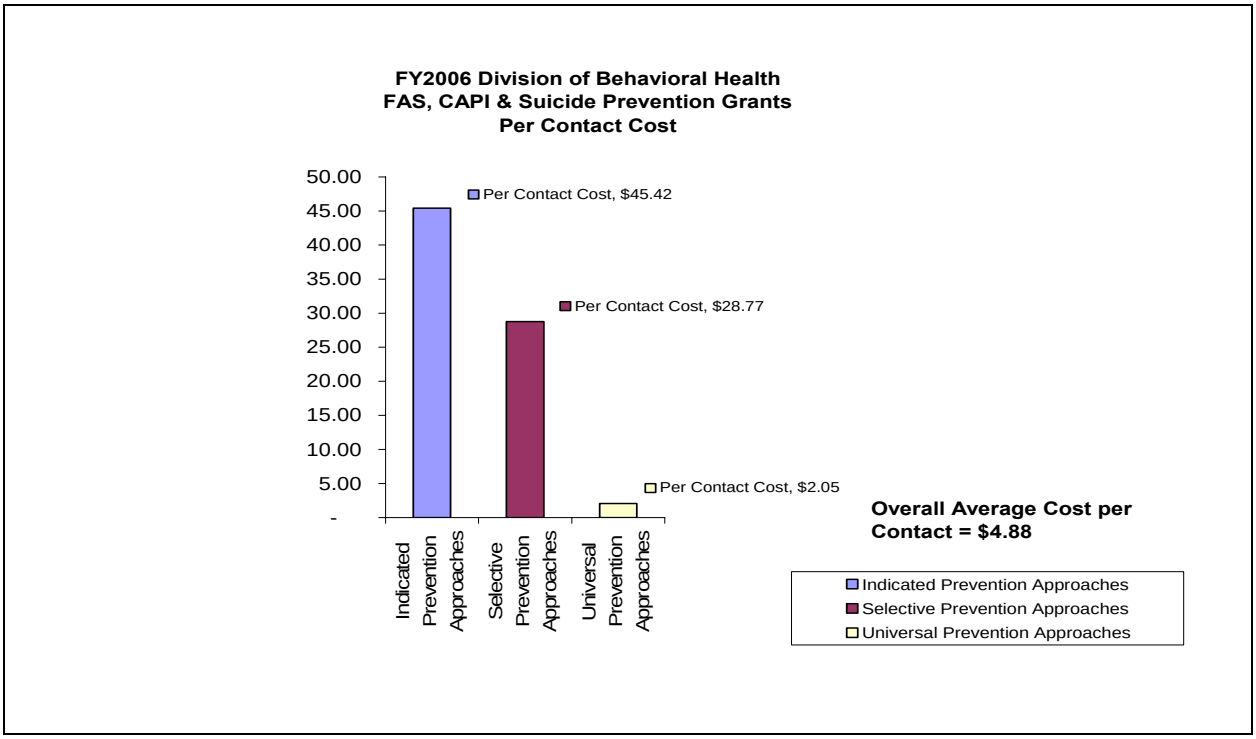
- $367 million from productivity losses
- $154 million from criminal justice and protective services
- $178 million from health care
- $35 million from traffic crashes
- $4 million from public assistance



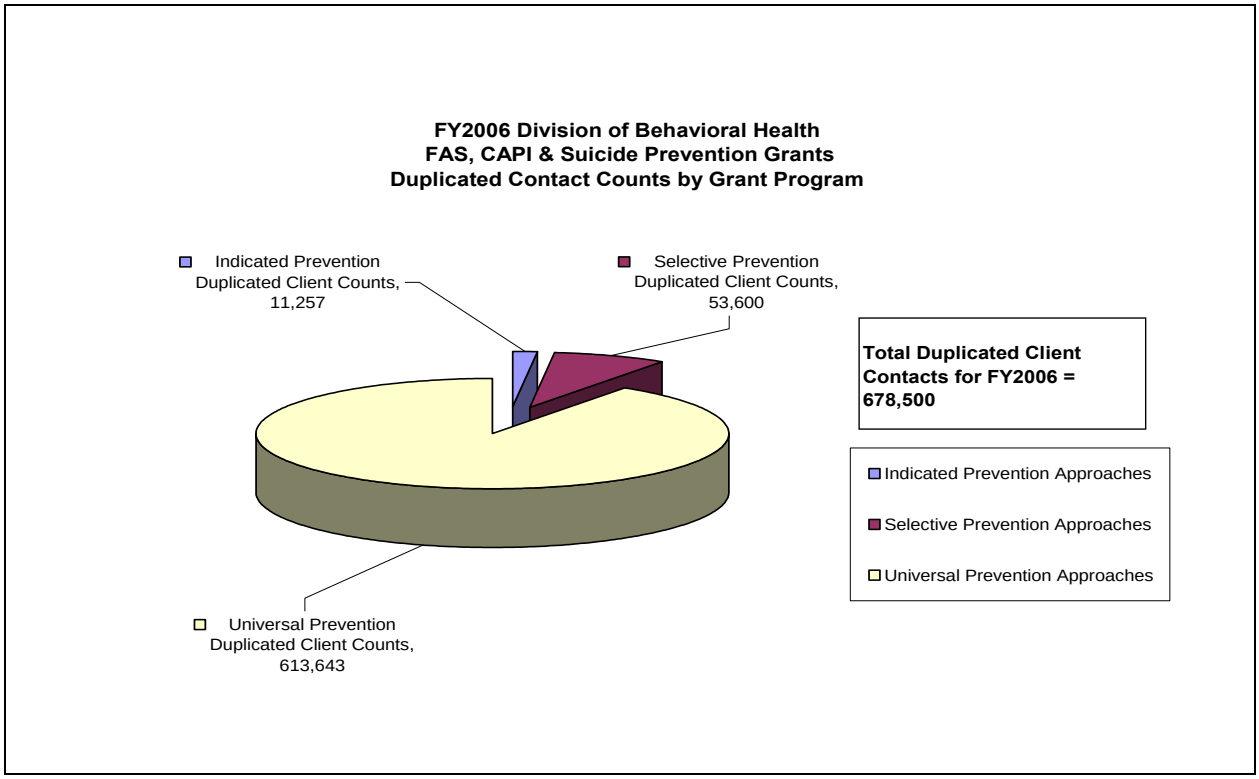
Prevention and Early Intervention Statistics



Costs per Institute of Medicine (IOM) Prevention category are calculated by identifying which grants use each category and how grants funds were distributed.

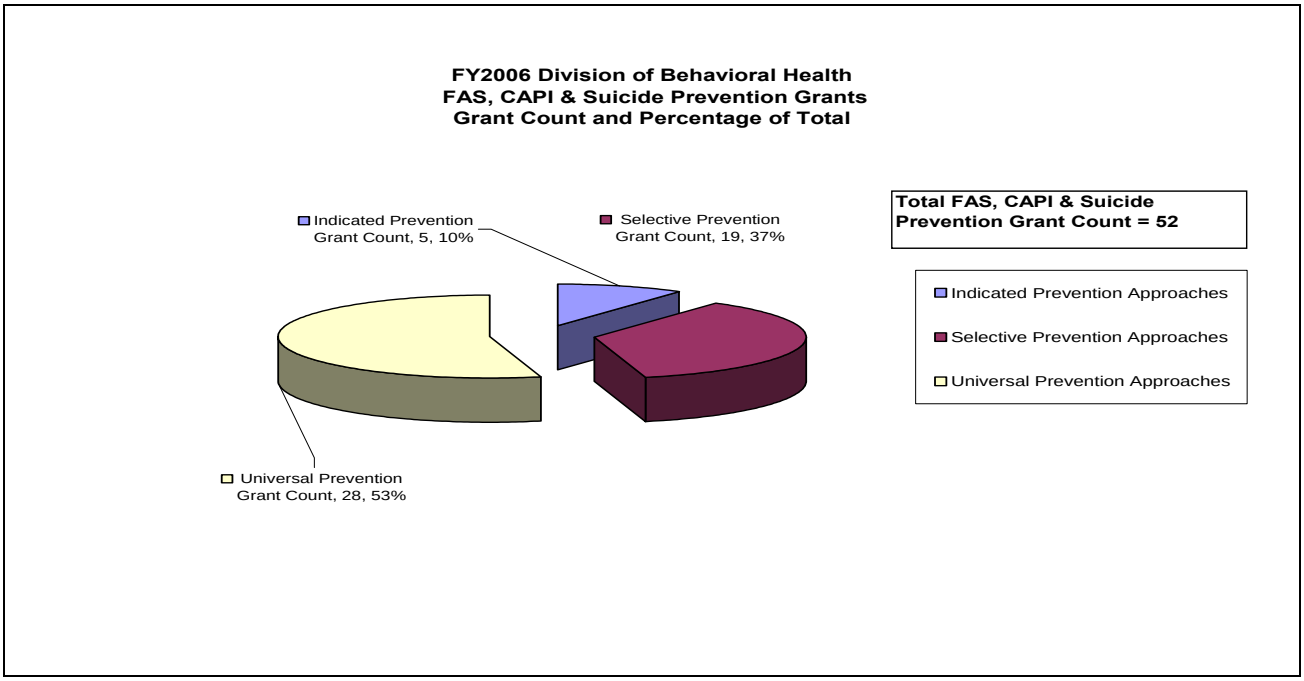


Per client contact was determined by dividing the total costs per category by the number of client contacts per category. All data is aggregated by Institute of Medicine (IOM) Prevention category.



DBH Comprehensive Prevention Grantees report quarterly on the total number of individuals that received or were exposed to a specific service. A portion of the counts will be duplicated; for instance, a teen attending a monthly support group may be counted 3 times per quarter. Some services reach a large audience that may need to be estimated such as media projects. Universal

approaches will reach a larger audience than those programs using Selective or Indicated approaches where their population is more narrowly defined.



Division of Behavioral Health Comprehensive Prevention Grants integrate programs focusing on substance abuse prevention, suicide prevention, fetal alcohol spectrum disorders and youth resiliency and development programs. Each program selects one of the Institute of Medicine (IOM) prevention audience categories for their approach:

- Indicated programs are designed to serve individuals already experimenting with high-risk behaviors such as alcohol abuse, drug use, suicidal ideations, etc.
- Selective programs target groups at risk for high-risk behaviors or subsets of the general population, such as poor school achievers or children of alcoholics.
- Universal programs are designed for the general populations, all individuals in a community, a neighborhood, a school, or other settings.

Fetal Alcohol Spectrum Disorder Data

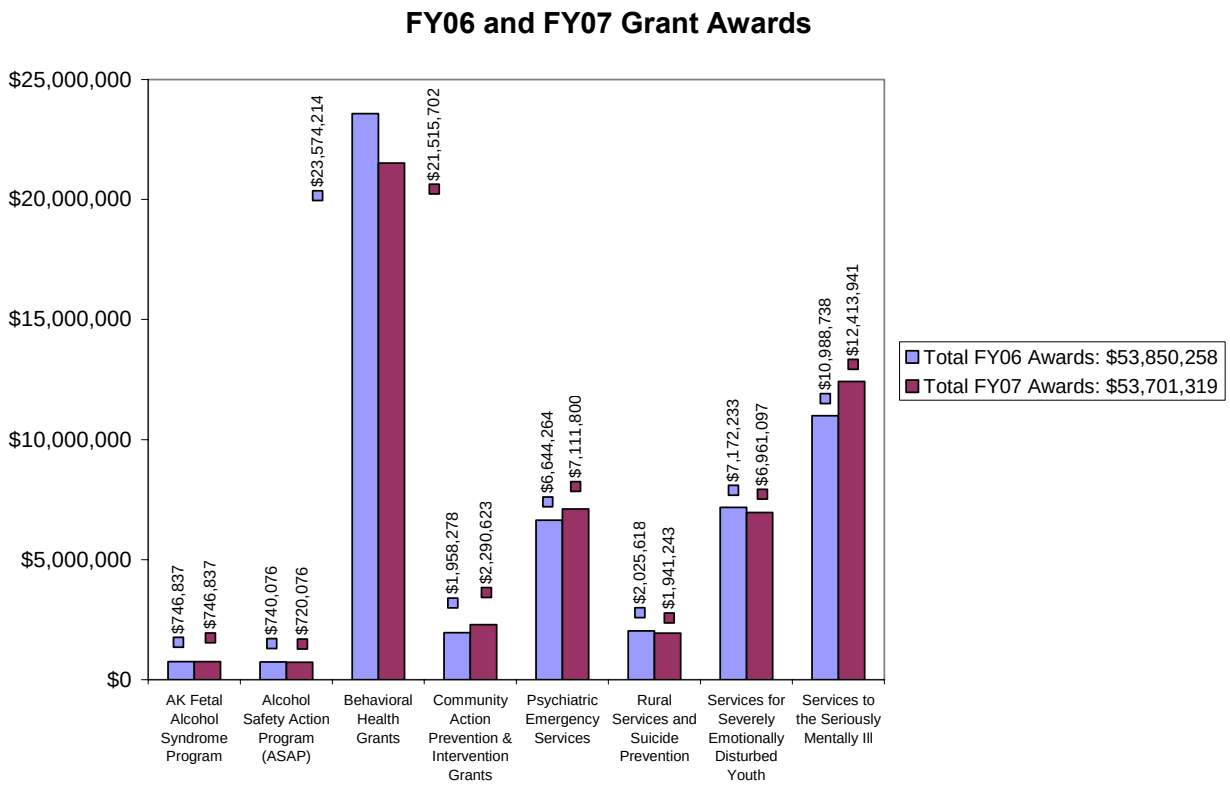
We are currently finalizing the evaluations for Alaska's 5-year Fetal Alcohol Spectrum Disorder (FASD) Project. The results of our second Knowledge, Attitudes, Beliefs and Behaviors (KABB) survey are being finalized this month. Our first KABB survey to assess Alaska's understanding of this disability was in 2002; the follow-up survey was completed in 2006. Final data showing changes in knowledge and understanding about FASD will be available in February 2007. Data from the FAS surveillance project has provided a more complete picture of the prevalence of FAS and other alcohol related birth defects resulting from increased reporting to the Alaska Birth Defects Registry and improved diagnostic capacity across the state. The project is just starting to abstract data from birth records after the FASD Project began its work in 2000 and future abstractions will indicate what kind of change Alaska will see in actual FAS prevalence rates. The federally funded FASD Project has just ended and the compilation and analysis of data will continue over the next 6-months as we finalize our full report of outcomes and results.

Designated Evaluation and Treatment Statistics

Total FY06 reimbursement to providers for this program:

- 1,535 bed days
- 563 transports
- 594 consumers

Behavioral Health Prevention and Treatment Grant Award Statistics



AS 08.64.010 - 380	State Medical Board
AS 08.68.010 - 410	Nursing
AS 08.84.010 - 190	Physical Therapists and Occupational Therapists
AS 08.86.010 - 230	Psychologists and Psychological Associates
AS 08.95.010 - 990	Clinical Social Workers
AS 12.47.010 - 130	Insanity and Competency to Stand Trial
AS 18.20.010 - 390	Hospital (Regulations)
AS 18.70.010 - 900	Fire Protection
AS 28.35.030	Miscellaneous Provisions
AS 44.29.020	Department of Health and Social Services (Duties of department)
AS 44.29.210-230	Alcoholism and Drug Abuse Revolving Loan Fund
AS 47.07	Medical Assistance for Needy Persons
AS 47.25	Public Assistance
AS 47.30.011 - 061	Mental Health Trust Authority AS 47.30.470-500 Mental Health
AS 47.30.520 - 620	Community Mental Health Services Act
AS 47.30.655 - 915	State Mental Health Policy
AS 47.37	Uniform Alcoholism & Intoxication Treatment Act

7 AAC 43	Medicaid
7 AAC 78	Grant Programs
7 AAC 29	Uniform Alcoholism & Intoxication Treatment
7 AAC 72	Civil Commitment
7 AAC 71	Community Mental Health Services
7 AAC 29	Uniform Alcoholism & Intoxication Treatment Act
7 AAC 32	Depressant, Hallucinogenic, and Stimulant Drugs
7 AAC 33	Methadone Programs

Social Security Act:	Title XIX Medicaid
	Title XVII Medicare
	Title XXI Children's Health Insurance Program

Code of Federal Regulations: 42 CFR Part 400 to End

PL 102-321	Community Mental Health Services

Behavioral Health	2007	2008 Proposed	07 to 08 Change
General Funds	94,512.5	107,307.0	12,794.5
Federal Funds	104,121.9	121,953.5	17,831.6
Other Funds	43,281.6	42,642.5	-639.1
Total	**241,916.0**	**271,903.0**	**29,987.0**

Alaska Fetal Alcohol Syndrome Program

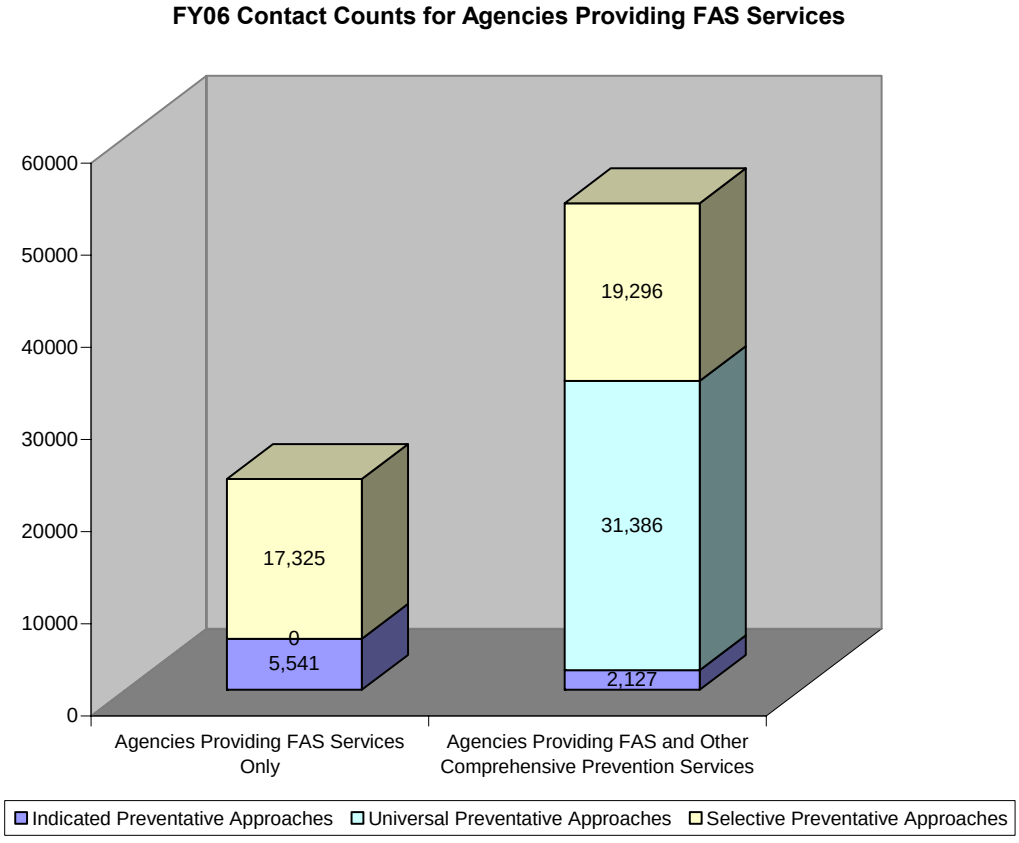
Restore Grants to Continuation Levels $696.8 GF/MH

The Division of Behavioral Health is requesting an increment of $696.8 General Fund to maintain funding for the Fetal Alcohol Syndrome Disorder (FASD) grants. The funding will continue the progress gained over the past five years with federal funding and provide a foundation for a sustainable, statewide, comprehensive FASD project. The funding will allow the continuation of:

- Statewide diagnostic services for youth and adults;
- Job training and job coaching for youth and adults with an FASD; and
- Statewide prevention messaging - educating Alaska about the dangers of drinking alcohol during pregnancy.

Reduction of Excess Federal Funds -$696.8 Federal

Alaska's 5 -Year Fetal Alcohol Spectrum Program Federal Grant ended 9/30/06. Although a time extension has been requested which will allow existing federal funding amounts through 9/30/07, federal authorization is still in excess of anticipated revenue for FY08.



Alcohol Safety Action Program (ASAP)

Additional MHTAAR for ASAP Therapeutic Case Management $15.0 MHTAAR
The Division of Behavioral Health proposes a 15.0 MHTAAR increment to support the Barrow Therapeutic Court Project.

The project is a partnership between the Alaska Mental Health Trust and the Alaska Court System. This increment provides the full amount of $120.0 MHTAAR for this project. The funds will be used to keep the current Barrow Therapeutic court project operational.

The Barrow project model is unique, as it provides therapeutic court support and intensively monitors treatment recommendations ordered by the court without the full structure of a therapeutic court setting. It is a very promising practice in the development, implementation and sustainability of therapeutic courts utilizing limited resources to deliver positive outcomes. The project target population is misdemeanant offenders diagnosed with Fetal Alcohol spectrum disorder. The goal is to reduce involvement with the criminal justice system caused by bail/probation violations that result from an individual's inability to follow or adhere to traditional conditions because of a diminished cognitive capacity, not volitional intent. The position requires the expertise of both substance abuse and mental health disorders and their associated treatments.

Behavioral Health Grants

Increased MHTAAR Funding for Housing, Workforce and Justice Initiatives $155.0 MHTAAR

- **Transition to Full Time Work Project $85.0 MHTAAR**
  The project would assist clients in developing work skills and habits to aide in the transition from temporary to more permanent employment. Positions would be hired to mentor clients in gaining life skills to assist in long-term job retention. The project will partner with other state and local entities to serve up to 100 beneficiaries a year from a variety of community referrals.
- **Convene a biennial Summit on beneficiary issues and the justice system $70.0 MHTAAR**
  The funding will support the Alaska Mental Health Trust Authority's Disability Justice Workgroup recommendation to convene a FY08 follow-up Summit The follow-up summit was one of the two key recommendations from the 2002 Summit. The Trust's Disability Justice Workgroup agreed that it was time to convene a follow-up summit to address the following issues:

  1) Assess the State's implementation progress of effective cross-system (justice, corrections, treatment) collaborative de-criminalization efforts,
  2) Highlight relevant national policy and program trends in the decriminalization of persons with mental disorders to incorporate into Alaska's planning efforts, and
  3) Identify and recommend action steps for new or enhanced solutions.

Decrease in MHTAAR Funding -$1,309.6 MHTAAR
The following one time projects have been deleted from the funding of the Mental Health Trust in FY08.

($50.0) Mental Health Consumer & Family Conference
($200.0) Family Wellness Camps
($320.7) Mini-Grants for Chronic Alcoholic Beneficiaries
($388.9) Mini-Grants for Beneficiaries Experiencing Mental Illness

($150.0) Traumatic Brain Injury Project
($75.0) Improve Capacity to Employ Involuntary Commitment to Treatment
($50.0) AK AIMS Provider Electronic Data Interface
($50.0) AK AIMS Provider Computers/internet
($25.0) Pre-Trial Diversion Project Implementation

Behavioral Health Administration

Bring the Kids Home (BTKH) Residential Aide Training $105.0 GF/MH
The Division of Behavioral Health will fund an on-going effort of BTKH Residential Aides Training via an agreement with the University of Alaska that was originally funded from an MHTAAR project. This is a top priority of the BTKH project. A continuing need for trained residential aides exists in Alaska to provide client services.

The GF/MH funding would transition the BTKH portion of the BTKH Residential Aides Training into the BTKH focus area. It would also establish on-going GF/MH support managed via the Division of Behavioral Health (DBH) with the funding transferred to the University of Alaska for implementation. The fund change will free up MHTAAR to allow the new Work Force focus area to better meet service needs.

Bring the Kids Home (BTKH) Training Academy $200.0 GF/MH
The Division of Behavioral Health proposes funding to provide on-going support for the BTKH Training Academy via an agreement with the University of Alaska to provide on-going training in the BTKH focus area.

This funding will transition the BTKH portion of the BTKH Training Academy into the BTKH focus area and establish on-going GF/MH support managed via the Division of Behavioral Health (DBH) with the funding transferred to the University of Alaska for implementation. This will free up MHTAAR funding for other new Work Force focus areas to better meet service needs.

Bring the Kids Home (BTKH) Level of Care Licensing $100.0 GF/MH
The Division of Behavioral Health (DBH) requires program licensing funds for a statewide level of care assessment tool to ensure accurate assessment of youth placements and appropriate instate service capacity to place youth in the lowest appropriate level of care to meet their needs. The tool is to be used at all residential levels of care from group homes to acute care. Priority would be to license Division of Behavioral Health (DBH) Utilization Review staff to use the tool for the gate keeping function planned. The balance of funds will be used to continue piloting the tool with a few key providers who have large BTKH youth caseloads.

The goals of the assessment tool are to provide an objective and standardized clinical guide to inform placement decisions, ensure a higher level of consistency statewide on placement decisions and better manage resources and avoid unnecessarily restrictive placements.

Transfer PCN 06-?128 to Office of Program Review -$98.4 GF/MH
The position established to coordinate and manage Bring the Kids Home program will be transferred to the Office of the Commissioner.

Increased MHTAAR Funding for Bring the Kids Home, Justice and Housing Initiatives $207.1 MHTAAR

- **On-going policy level planning and implementation workgroup $75.0 MHTAAR**

The funding will support the Alaska Mental Health Trust Authority's Disability Justice Workgroup recommendation to provide funding resources for follow-up planning and implementation workgroup sessions derived from the FY08 Criminal Justice/Mental Health Summit.

- **Office of Integrated Housing $32.1 MHTAAR**
  The request represents an increase in MHTAAR funding support for the Office of Integrated Housing in their efforts to develop safe, decent, and affordable housing and housing opportunities for consumers struggling with mental illness and/or substance abuse.
- **Tool kit development and expansion of school-based services capacity via contract related to the Bring the Kids Home (BTKH) initiative $100.0 MHTAAR**
  As part of enhancing outpatient and school based services to intervene with Seriously Emotionally Disturbed Youth and those at risk, this project will encourage school-based services through contractual assistance to develop a "tool kit" of effective school-based programs that is shared statewide.

Psychiatric Emergency Services

Decrease in MHTAAR Funding for Rural Behavioral Health Conference -$50.0 MHTAAR
The Rural Behavioral Health Conference was part of MHTAAR funding in FY06 and FY07. There is no conference planned in FY08.

Services to the Seriously Mentally Ill

Decrease in MHTAAR Funding -$638.6 MHTAAR
The following project were reduced or eliminated:

($207.8) Independent Case Management - not funded
($301.1) Housing Retention Support Services - not funded
($129.7) Bridge Home Pilot Project – reduced

Seriously and Emotionally Disturbed Youth

Bring the Kids Home-Net Change $3,574.0-$3,584.0 General Funds; $-10.0 MHTAAR
Bring The Kids Home (BTKH) is an initiative to return children with severe emotional disturbances from behavioral health care in out-of-state residential facilities to in-state or community-based care. The following increments will reinvest funding that currently provides expensive distant care to in-state services and capacity development to serve children closer to home, keep families more involved and intact, and more effectively carry out transitions and discharges.

- ***Bring The Kids Home (BTKH) Community Behavioral Health Centers Outpatient Grants & Training for Special Populations $1,000.0 GF; $500.0 MHTAAR***
- ***Bring The Kids Home (BTKH) Youth Intensive Outpatient, Residential & Continuing Care Services $1,000.0 GF***
- ***Bring The Kids Home (BTKH) Individualized Services/Home and Community-Based Start-up Grants $950.0 GF/MH;- $910.0 MHTAAR***

    - **$700.0 GF/MH increase and -$200.0 MHTAAR reduction. - BTKH Individualized Services**
    - **$250.0 GF/MH increase and -$710.0 MHTAAR reduction - BTKH Home and Community-Based Start-up Grants**

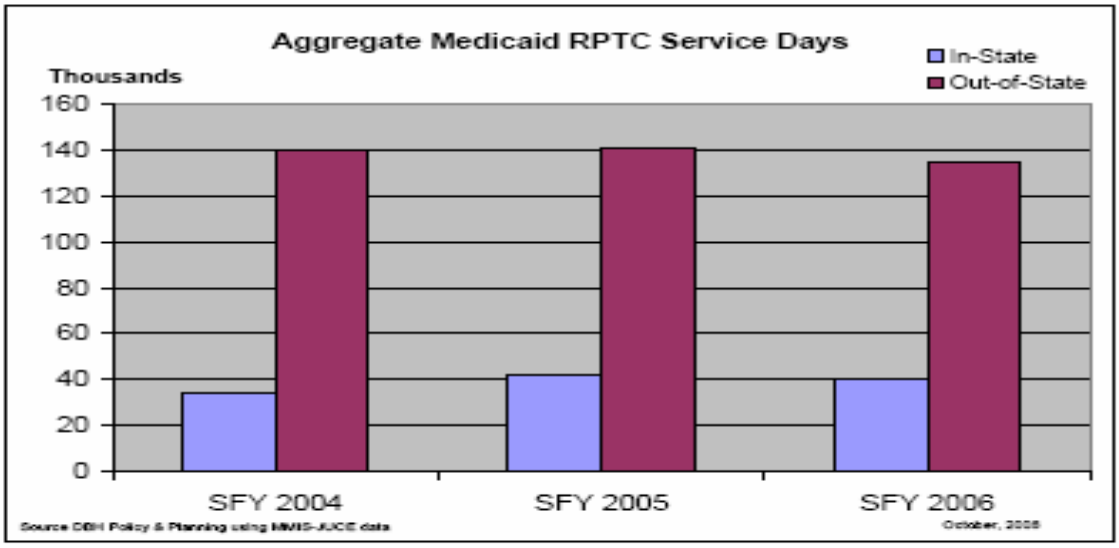
- ***BTKH Anchorage Crisis Stabilization $284.0 GF/MH; $100.0 MHTAAR***
- ***BTKH Expansion of School-Based Services $250.0 GF/MH; $200.0 MHTAAR***
- ***BTKH Peer Navigators Funding to Non-Profits/Parent and Youth Navigators $200.0 GF/MH; $150.0 MHTAAR***

    - **BTKH Peer Navigators Funding to Non-Profits (Parent & Youth) $50.0 GF/MH; $150.0 MHTAAR**
    - **BTKH Parent and Youth Navigators $150.0 GF/MH**

- ***Decrease in MHTAAR Funding for Bring The Kids Home (BTKH) data collection -$50.0 MHTAAR***

Total Medicaid RPTC Bed Days

	SFY 2004	SFY 2005	SFY 2006
In-State	34,449	42,197	40,198
Out-of-State	140,087	140,536	134,407
Total	**174,536**	**182,733**	**174,605**



"Total Bed Days" represents the aggregate number of days children received RPTC care during a state fiscal year.

Alaska Psychiatric Institute

Transfer in Nursing Salary Market Based Pay $422.2 GF
The FY07 budget authorization is transferred to the correct component for the Nursing Salary Market Based pay increased authorized in FY07 budget by the legislature.

Grant Services
The Division of Behavioral Health (DBH) will complete the process of reducing grants to non-profit agencies to reflect the reduction in available funding from a FY06 continuation level. A reduction will result in direct service cuts to grants serving vulnerable children and adults. Determination and redistribution of funding allocations will be based on the following qualitative and quantitative criteria.

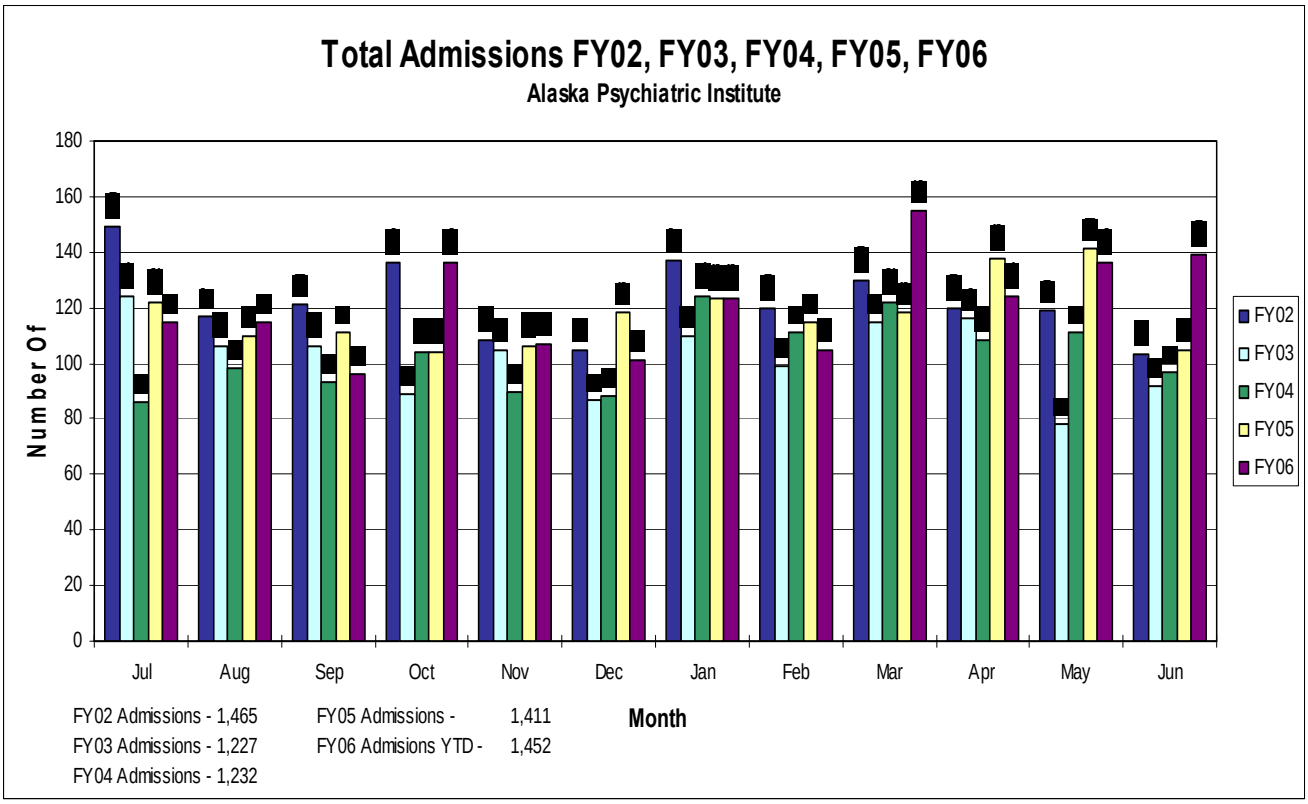
Prevention and Early Intervention Grants: Funding category, documented project outcomes, agency performance, priority population and regional distribution or other resource availability.

Treatment & Recovery Grants: Service categories to be held harmless, number of people treated within priority populations, types of services being provided, audit performance, customer satisfaction, treatment outcomes, grant allocation spending history and history of compliance with grant reporting requirements.

Staffing
DBH was forced to drastically reduce administrative costs in FY 06 to live within available funding. An infusion of General Fund (GF) in DBH would be required to provide staff, travel and other support costs to provide grant oversight, monitoring, quality assurance and technical assistance to the grantees we have to provide direct services to Alaskans with substance disorders, mental illness, or both. Continuing at the current level will increase staff turnover, an increased Medicaid error rate and a loss of ability to detect Medicaid fraud.

Alaska Psychiatric Institute Capacity
Alaska Psychiatric Institute (API) is presently budgeted, staffed and configured for 72 beds; however, as API may not turn away involuntary patients, the facility is often at risk of exceeding bed capacity. Much of this summer, API has been at or over the 72 bed limit; the placement needs have intensified as winter continues.

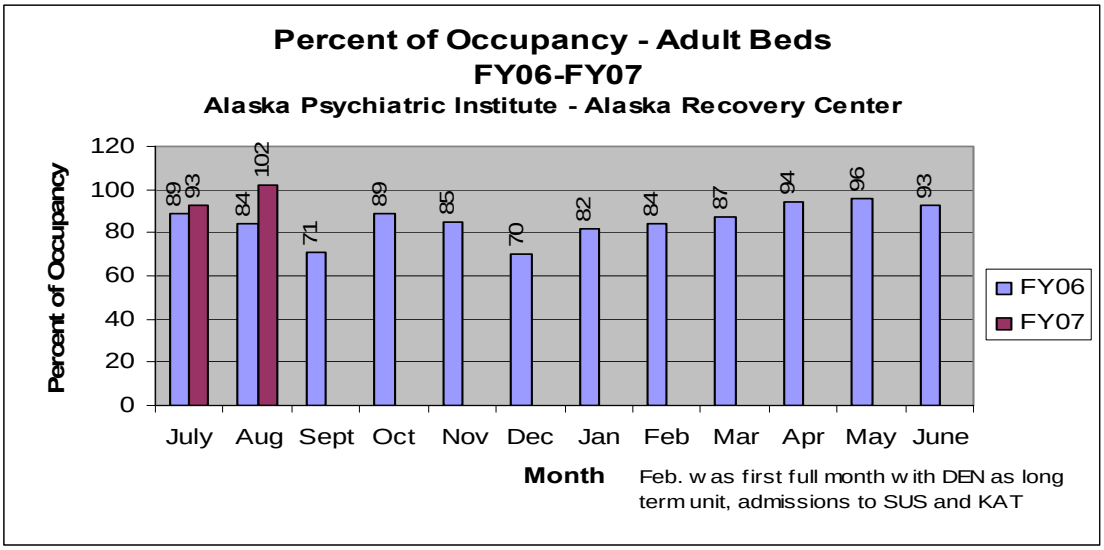
Moreover, API is seeing an increase in acuity in admitted patients. Less severe clients are served through the Designated Evaluation & Treatment (DET) Program statewide. What that leaves API with are more severely disabled patients that require intensive treatment and services with a longer stay and who tend to remain in the Anchorage area. However, API does not have the capacity to meet the lengthier stay. Therefore, targeted community service enhancements are required to mitigate the impact of this smaller state hospital. The need for Designative Evaluation and Treatment, and Designated Evaluation and Stabilization services continues to grow throughout the state; while funding for it has not increased. We have approached the Legislature for supplemental and increment funding in the past. In each of the last two years, we ran at a $500,000 deficit. This does not take into consideration new hospitals that are providing services or the remaining unmet need in Mat-Su and Anchorage.



Total Admissions

	FY02	FY03	FY04	FY05	FY06	By Quarter
Jul	149	124	86	122	115	
Aug	117	106	98	110	115	
Sep	121	106	93	111	96	326
Oct	136	89	104	104	136	
Nov	108	105	90	106	107	
Dec	105	87	88	118	101	344
Jan	137	110	124	123	123	
Feb	120	99	111	115	105	
Mar	130	115	122	118	155	383
Apr	120	116	108	138	124	
May	119	78	111	141	136	
Jun	103	92	97	105	139	399
Total	1465	1227	1232	1411	1452	1452

As of Oct. 5, 2006 API Census Report



Alaska Automated Information Management System (AKAIMS)
The AKAIMS electronic clinical record and data management system are close to being fully operational, and we are working to develop reporting capabilities that will lessen the administrative burden on our providers. This is moving ahead, but more slowly that we would prefer.

Integrated Medicaid Regulations
The Bring the Kids Home Initiative is a complicated project with multiple moving parts. Keeping it moving forward takes considerable energy and consistent inter-departmental coordination. We are now entering into a phase where the in-state providers will need to act on their commitment to keep kids in Alaska. This is proving more difficult with the lack of integrated Medicaid regulations and no rate increase for these services.

The department's new Waiver Demonstration project to provide expanded services to FASD adolescents will require further system transformation to meet the needs of this complicated population.

The division will need to focus significant energy on completion of our Integrated Medicaid Regulations as an important "next step" in the Integration of Mental Health and Substance Abuse Treatment services As well as work to determine if we can expand the eligible populations in substance abuse to cover a large portion of the population (males between the ages of 21-65) that is currently without access to care.

The Division of Behavioral Health strives to accomplish its mission of providing Alaska's integrated and comprehensive behavioral health system through partnerships with our grantees and stakeholders. Our ability to meet this challenge is affected by limitations in funding, pressure on local community resources and the on-going battle to eradicate stigma toward the mental ill and substance abusers. It is our firm conviction that getting the right treatment, to the right person, at the right time will help us to grow resilient children, to rebuild our families and to strengthen our communities.

Designated Evaluation and Treatment (DET)

The DET program funding has always been insufficient to cover the yearly costs of the service. In previous years, the funding was used to purchase additional DET (30 day) beds in our Fairbanks and Juneau facilities. In FY 06, we discovered that the additional costs in the program arise from our Designated Evaluation and Stabilization (7 day) beds with our service partners throughout the state. These services keep individuals within their home community and resolve the crisis with minimal disturbance to the individual's family system and other natural supports.

Contribution to the Department's Mission

To provide an integrated behavioral health system.

Core Services

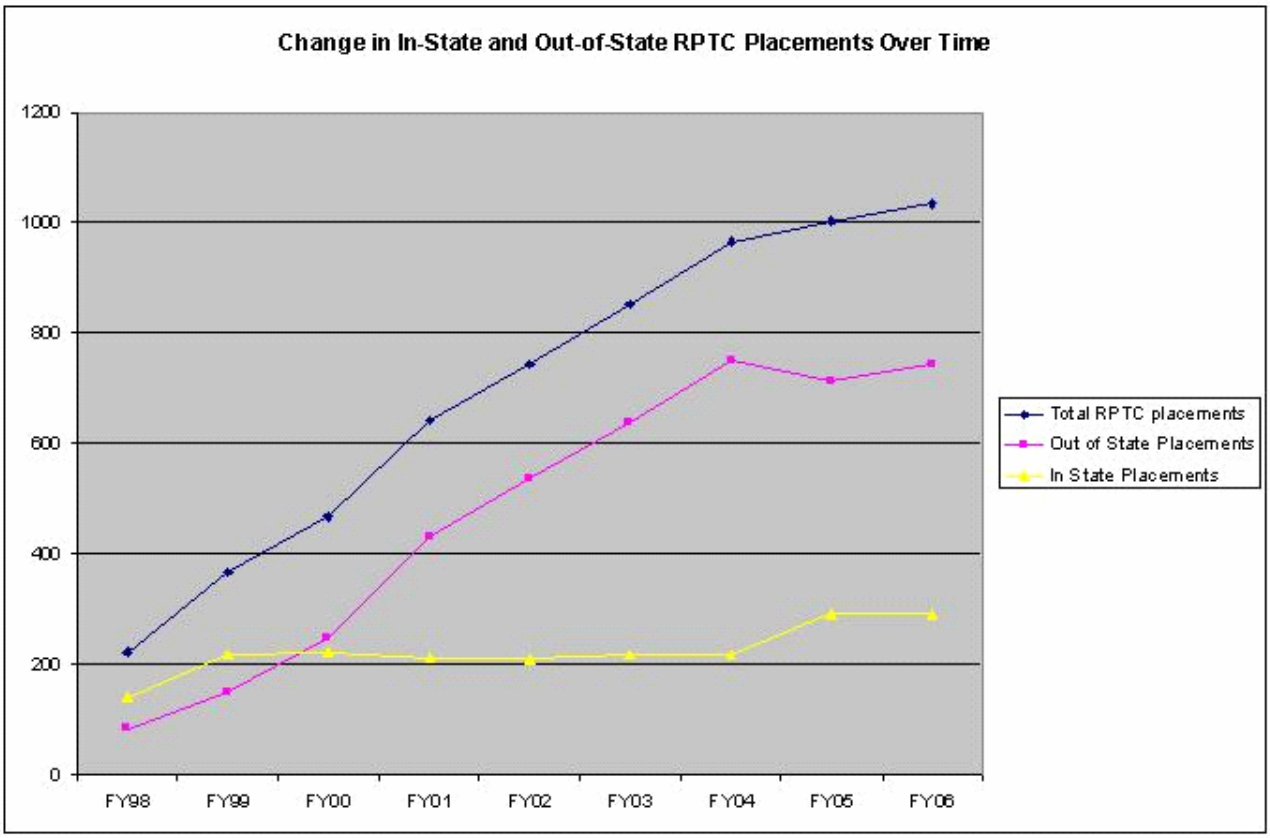
- This division works closely with the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust Authority to determine policy governing the planning and implementation of services and supports for people who experience mental illness, substance abuse disorders, or both, to provide an integrated behavioral health system.

Department Level Measures

B: Result - Outcome Statement #2: Improve and enhance the quality of life for Alaskans with serious behavioral health problems.

Target #1: To reduce the number/percentage of children in out-of-state placement by 50 children annually over the next seven years.

Measure #1: Change in number/percentage of children reported in out-of-state care from Medicaid MMIS.



Source: DBH Policy and planning using MMIS-JUCE data, unduplicated count of RPTC beneficiaries.

Analysis of results and challenges: For the past eight years there has been a steady increase in the number of children receiving out-of-state Residential Psychiatric Treatment Center (RPTC) services. Between SFY 1998 and 2004, the unduplicated number of youth with Serious Emotional Disorders (SED) receiving out-of-state RPTC care has steadily increased – on average 46.7% per year. The RPTC population as a whole has also showed steady increase from SFY 98-04, an average annual increase of 24.8%.

The Bring the Kids Home Project was initiated during SFY 2004. Positive changes are already apparent. Between SFY 2004 and 2005 there was a 5.1% reduction in the number of children receiving out-of-state RPTC care, from 749 to 711. However, between SFY 2005 and 2006, there was again an increase in out-of-state placement, of 5%, from 711 to 743. In SFY 2006, there has also been a 3% increase in total RPTC placements. The historical average increase of 46.7% for out-of-state placements has been effectively challenged with the efforts to enhance "step-down" activities, that is, programs for children that are less intensive, less restrictive, and closer to home, than out-of-state residential programs.

Alaska Statute 47.07.032 requires that the department may not grant assistance for out-of-state inpatient psychiatric care if the services are available in the state. To that end, the department has developed and implemented "diversion" activities, including aggressive case management services that discharge and return children to less restrictive levels of care; utilization review staff implementing gate-keeping protocols with a "level of care" instrument that insures appropriate placements; and collaboration with community-based providers to augment services at the least restrictive level within a client's home community. There have also been multiple capital projects initiated to increase the number of beds in-state, some of which have become available in SFY 07. As more new beds and other programs become available, it is anticipated that there will be further impact on the rate of out-of-state placements. This project is a collaboration of the Division of Behavioral Health, Division of Juvenile Justice and Office of Children's Services, in partnership with the Mental Health Trust Authority.

Target #2: To reduce the rate of suicides in Alaska to 10.6 deaths per 100,000 population.
Measure #2: Alaska's suicide death rate compared to National rate.

Age Group	Deaths	Rate
05-14	17	1.9
15-24	275	37.7
25-34	188	26.7
35-44	201	22.7
45-54	182	22.9
55-64	76	18.6
65-74	32	17.0
75-84	21	23.1
85+	6	25.4

***Rates are age-specific rates per 100,000 population.**

Suicides by Region 1998-2005

Region	Deaths	Rate
Anchorage/Mat-Su	412	16.2
Fairbanks/SE Fairbanks	121	18.1
Gulf Coast	108	19.1
Northern/Interior	158	61.2
Southeast	71	12.4
Southwest	128	40.9

***Rates are age-adjusted rates per 100,000 standard population**

Rate of Suicides 1998-2005

Year	Alaska Rate	Lives Lost	US Rate
1998	22.7	131	11.1
1999	17.2	95	10.5
2000	21.1	135	10.4
2001	16.5	103	10.7
2002	20.9	131	10.9
2003	20.6	124	10.8
2004	23.5	155	10.7
2005	18.8	122	N/A

**Rate is number per 100,000 standard population and accounts for differences in population distribution.*
**The US rate for 2005 will not be available until approximately April 2007.*

Analysis of results and challenges: Alaska averages 125 suicides per year and has a suicide rate double the National Suicide rate. The Healthy Alaskan 2010 target is to reduce Alaska's rate to 10.6 deaths per 100,000 populations. The suicide rate for Alaska in 2005 shows a slight decline, however is still at 18.8, still much higher than the target. This measure reflects a system-wide problem that takes coordination between state agencies, community providers, school districts and faith based organizations.

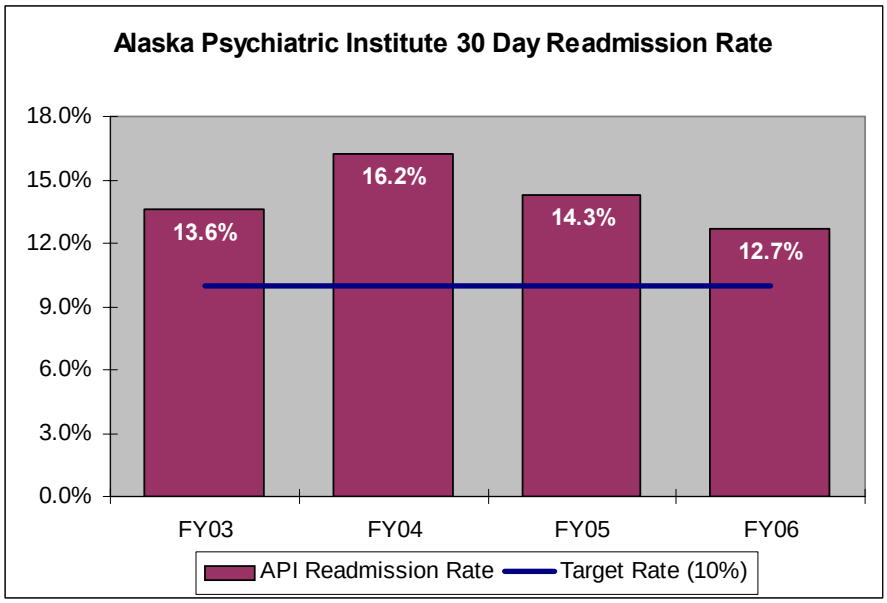
Work continues to better understand the underlying causes of suicide of Alaskans. The Statewide Suicide Prevention Council partners with the Department of Health and Social Services, Division of Behavioral Health to provide training on the Statewide Suicide Prevention Plan and assessing community readiness for decreasing suicide and non-lethal suicidal behaviors. The Division of Behavioral Health has done the following: required all community-based suicide grantees align their suicide prevention efforts with the Suicide Prevention plan; conducted a presentation on community-based planning implementing effective strategies aligned with the statewide plan; and coordinated with Native health corporations, police, chaplains, and other groups to assist in suicide prevention or coping program design.

An interim report of the Suicide Follow-Back Study shows the following system-wide factors, based on a limited number of interviews, of those related to, or close to those who had died by suicide:

54% had quit working during the preceding year;
47% were seeing a therapist at the time of their death;
59% had current prescriptions for mental health problems;
65% experienced an event that caused a great deal of shame (such as sexual abuse, child porn, an arrest, etc.);
61% had problems with law enforcement;
20% were abused as children – 80% by their father;
50% were seen by a doctor in the last six months;
46% had symptoms of post traumatic stress disorder (PTSD);
62% were active smokers;
33% had prior suicide attempts; and
20% had recent exposure to suicide of a loved one.

As the tables above show, the rate of suicides and number of deaths is higher in the Northern/Interior and Southwest regions of Alaska and is more predominant in the 15-24 age group. The overall age span with highest suicide incidents is 15-24.

Target #3: Reduce 30 day readmission rate for API to 10%.
Measure #3: Rate of API readmissions.



Analysis of results and challenges: This measure tracks the percent of admissions to the facility that occurred within 30 days of a previous discharge of the same client from the same facility. For example, a rate of 8.0 means that 8% of all admissions were readmissions. This measure not only is an indication of successful outcomes for API, but also of the mental health community system. The ultimate goal is to have Alaska's rate fall below 10%.

According to data for FY 06, API and the 'system' continue to demonstrate unsatisfactory outcomes. API relocated to a new hospital in July 2005. The success of a 'downsized' state psychiatric hospital was predicated on increased funding for community providers and establishing 18 designated evaluation and treatment beds in Anchorage. These initiatives did not receive planning or funding. As a result, API comes under increasing pressure to shorten length of stays for acutely ill psychiatric patients who ultimately return to the hospital due to lack of adequate supportive housing and treatment options.

B1: Strategy - Provide enhancements to prevention and early intervention services.

Division Level Measures

A: Result - Outcome #1: Improve and enhance the quality of life for Alaskans with a serious emotional disturbance (SED), a serious mental illness (SMI) and/or a substance abuse disorder.

Target #1: 75% of individuals will report improvement in one or more of the following life domains: productive activity/employment, housing situation, health status, economic security, education attained.

Measure #1: Outcomes data as reported through the use of the Client Status Review Form as part of the Federal Government Performance and Results Act.

Analysis of results and challenges: The ability to determine treatment outcomes for clients of our mental health and substance abuse services is a relatively new and exceptionally useful tool. Not long ago, "is he still sober?" or "is she taking her meds?" were the only measures of success that behavioral health programs used: crude measures at best, and misleading at worst. Just as mental illness and substance abuse affects all areas of a person's life, so does recovery affect more than just a single variable. Therefore, clients of our programs are asked questions at entry, discharge, and at various points post-discharge, concerning a variety of "life domains." By comparing these responses, we are offered a picture of change in a person's life, regarding productivity (jobs, homemaking, student activity, subsistence activity, etc.), physical health, mental/emotional health, suicidality, social and family supports, safety, spirituality, finances, and housing.

A1: Strategy - Strategy #1A: Improve and enhance the quality of life of children with a SED by implementing the Bring the Kids Home Program.

Target #1: Reduce the number of kids in out-of-state placement by 25% annually over the next four years.

Measure #1: Change in percent of children reported in out-of-state care from Medicaid MMIS.

Analysis of results and challenges: This measure is reported at the department level.

A2: Strategy - Strategy #1B: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder by implementing the DH&SS Tribal Agenda.

Target #1: Increase the number of Tribal entities providing behavioral health services to Alaska Natives by 10% annually for each of the next four years.

Measure #1: Number of Tribal entities providing behavioral health services directly or contracting with non-Tribal providers for those services

# of Tribal Entities

Fiscal Year	# Providing Service
FY 2004	4
FY 2005	8
FY 2006	14

Analysis of results and challenges: During SFY 2004, there were four Tribal entities providing and billing for behavioral health services. During SFY 2005 the number of Tribal entities providing and billing for behavioral health services increased to 8. These include Bristol Bay Area Health Corp., Copper River Native Assoc., Kenaitze Indian Tribe, Maniilaq Assoc., Norton Sound Health Corp., Southcentral Foundation, Tanana Chiefs Conference, Yukon Kuskokwim Health Corp.

In 2006, fourteen tribal behavioral health grantees were enrolled as either a Community Mental Health Clinic and/or a substance abuse agency, and were enrolled to bill for Medicaid services. These were: Bristol Bay Area Health Corporation, Cook Inlet Tribal, Copper River Native Association, Eastern Aleutian Tribes, Fairbanks Native Association, Hoonah Indian Association, Kenaitze Indian Tribe, Ketchikan Indian Corporation, Maniilaq Association, Norton Sound Health Corporation, Southcentral Foundation, Southeast Regional Health Consortium, Tanana Chiefs Conference, and Yukon/Kuskokwim Health Corporation. Two other tribal entities, Aleutian Pribilof Island Association and Illiuliuk Family and Health, are enrolled, but have not yet billed.

A3: Strategy - Strategy #1C: Improve and enhance the quality of life of Alaskans with a SED, SMI and/or a substance abuse disorder through the development of a comprehensive, integrated Behavioral Health Service System.

Target #1: A fully integrated Behavioral Health Service system will occur over the next four years as evidenced by a 25% improvement in service outcomes and consumer satisfaction.

Measure #1: Treatment satisfaction data from Mental Health Statistics Improvement Program (MHSIP) Consumer Survey.

Percentage of MHSIP Respondents Satisfied with Services

Table (1)

Adult

DOMAIN	FY2004	FY2005	FY2006	Percent increase between FY2004 and FY2006
Participation in Treatment Planning	67%	71%	70%	3%
Quality and Appropriateness	69%	77%	82%	18%
Outcomes	55%	61%	73%	33%
Access	68%	70%	74%	10%
General Satisfaction	77%	82%	82%	6%

FY2006-both Substance abuse and mental health consumers submitted surveys.

Percentage increase column is calculated as follows: (FY2006-FY2004)/FY2004.

Table (2)

Family and Youth MHSIP

DOMAIN	FY2005	FY2006	Percent increase (decrease) between FY2005 and FY2006
Access to Service	71%	72%	3%
Satisfaction with Services	68%	74%	9%
Participation in Treatment	84%	81%	-4%
Cultural Sensitivity	87%	86%	-2%
Positive Outcomes of Services	58%	64%	11%

FY2006-both Substance abuse and mental health consumers submitted surveys.

Percentage increase column is calculated as follows: (FY2006-FY2005)/FY2005.

Family and Youth surveys do not have sufficient response rates for FY2004 to use FY2004 as the base year.

Table (3)

Youth MHSIP

DOMAIN	FY2005	FY2006	Percent increase (decrease) between FY2005 and FY2006
Access to Service	70%	65%	-7%
Satisfaction with Services	77%	74%	-4%
Participation in Treatment	68%	67%	-1%
Cultural Sensitivity	84%	86%	2%
Positive Outcomes of Services	73%	64%	-12%

FY2006-both Substance abuse and mental health consumers submitted surveys.

Percentage increase column is calculated as follows: (FY2006-FY2005)/FY2005.

Youth surveys do not have sufficient response rates for FY2004 to use FY2004 as the base year.

Analysis of results and challenges: The Mental Health Statistics Improvement Project (MHSIP) Survey is one of several instruments used by the Division to measure clients' level of satisfaction with behavioral health services. The survey is mailed or given to consumers and returned by them directly to the Division of Behavioral Health for processing.

This Performance Improvement Process improves validity each year. Early in the implementation of the MHSIP, several factors greatly impacted the project: implementation was disrupted during the integration of the two divisions (Mental Health and Alcoholism and Drug Abuse); and there was inconsistent incorporation into business practices of behavioral health service providers. As a result the validity of measures in FY2004 and FY2005 is questionable due to the poor response rates.

For FY2006, specific improvements instituted by the division resulted in an increase of consumers participating in the survey, as well as an increase in the validity of findings. These included changes in the methodology of distribution and the expectation that behavioral health service providers participate in the survey. The division also expanded the MHSIP survey to include substance abuse consumers.

For FY2007, the following changes have been implemented as part of the improvement process: the Division has (a) improved oversight of the implementation of the consumer survey; (b) developed a formal procedure to establish consistent implementation (timelines and methods) of the survey. It is anticipated that these changes in the consumer survey process will result in a continued improvement in the sampling size and validity of findings.

Clearly, adult clients of our programs are becoming more satisfied over the last several years, while children and their families are less satisfied with certain aspects of treatment. These are important pieces of information, which the division is exploring in depth with the help of our providers and the consumers, in order to increase their levels of satisfaction and the positive outcomes of treatment. These MHSIP surveys are invaluable aids in knowing where to start asking these questions.

Children's Services

Mission

Promote stronger families, safer children.

Introduction

The Office of Children's Services (OCS) works in partnership with families and communities to support the well being of Alaska's children and youth to provide a wide range of services and support systems. These services include child abuse and neglect prevention services, child protective services, foster care, residential care, family support and family preservation services, adoption and guardianship, permanency planning, and health and nutrition services. Services focus on enhancing families' capacities to give their children a healthy start, to provide their children with safe and permanent homes, to maintain their cultural connections, and to help them realize their potential.

The Office of Children's Services builds on the strengths of the past while exploring opportunities and goals for the future. Since the department's reorganization in FY 2004, OCS continues to work to bring together the four programs that support children, youth, and families:

1. Child Protection and Permanency
2. Early Childhood Comprehensive Systems Planning
3. Family Nutrition Services
4. Infant Learning Program

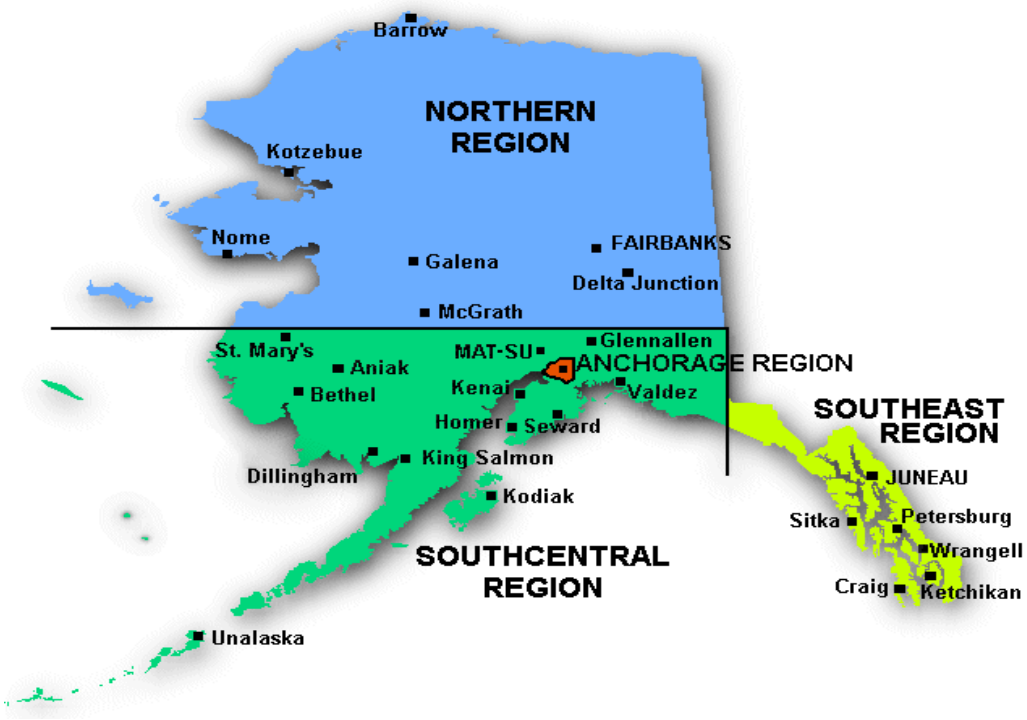
Core Services

- Investigate Child Protective Services Reports and ensure in-home services to children at risk;
- Child Protective Services to prevent and remedy child abuse and neglect through safety assessment and facilitation of treatment services and early intervention when appropriate;
- Family Preservation and Family Support to allow, when appropriate, a child to remain safely with their families;
- Develop permanency plans for children in out-of-home care;
- Recruitment, training, and licensing of foster and adoptive families;
- Placement options to preserve a child's connection to family, culture, and community that will also meet physical and mental health needs;
- Family Nutrition Services to promote optimal health habits through education, breastfeeding
- Support, obesity prevention, and supplemental food packages (Women, Infants, and Children (WIC));
- Behavioral rehabilitation services for youth who need mental health care; and
- Transitional living services that prepare adolescents in foster care to independent living so that they have the ability to achieve success at the age of independence.

The OCS supports 27 local offices in Alaska that deliver child welfare services. These local offices are managed and supported regionally:

- Northern Regional Office (NRO) in Fairbanks: Nome, Kotzebue, Barrow, and surrounding towns and villages;

- Southcentral Regional Office (SCRO) in Wasilla: Mat-Su Valley, Kenai Peninsula, Bethel, Valdez, Kodiak, Dillingham, Aleutian Islands, and surrounding areas;
- Anchorage Regional Office (ARO) is responsible for Anchorage; and
- Southeastern Regional Office (SERO) in Juneau: Sitka, Petersburg, Ketchikan, Craig and surrounding communities.



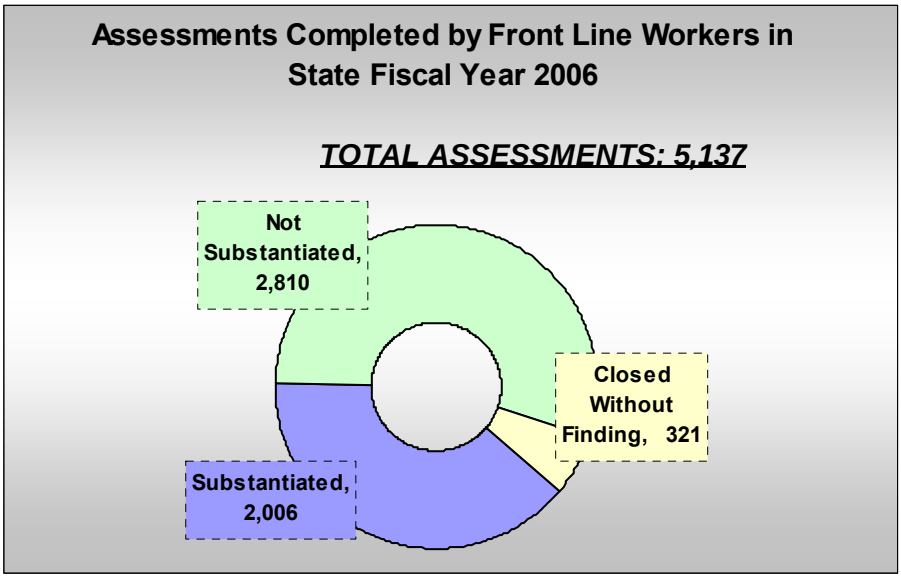
Services Provided

Front Line Social Workers

OCS Front Line Social Workers deliver services to carry out the legal mandates of the department to prevent and remedy physical abuse, sexual abuse, neglect, mental injury, and the exploitation of children. For child protective services, primary activities include investigation of protective services reports; crisis intervention; assessment of the risk of future harm in the absence of intervention; family strength and needs assessment; and case planning.

The chart below provides the number of assessments completed by workers in FY 2006. Each assessment evaluates the allegations in one or more protective services reports and determines one of the following results:

- ✓ Substantiated – the available facts indicate the child was abused or neglected;
- ✓ Not Substantiated – based on the available facts, OCS did not determine if a child was abused or neglected; or
- ✓ Closed Without Finding – there are no facts to support the allegation of child abuse or neglect.



Note: Each assessment completed by Front Line Workers may be the result of one or more Protective Services Reports received by OCS, Therefore, the total number of assessments reported on this chart will not equal the total number of reports received by OCS reported in charts that follow.

Data Source: AK DHSS, Office of Children's Services Online Resource for the Children of Alaska (ORCA) case management and provider payment system.

Additional functions include ongoing assessment toward achieving case plan goals, initiation of legal action to protect children, monitor implementation of treatment plans, and the coordination services needed to reunify children with their families.

Front Line Social Workers also arrange out-of-home care, when appropriate and necessary, in the least restrictive setting, and facilitate an alternative permanent home for children when their return to their home of origin is not possible.

Family Preservation
Family Preservation awards grants statewide to non-profit agencies to provide services that keep children safe in their own homes; strengthen and support adoptive, foster, and extended families. Grantees provide family preservation services that help children at risk of foster care placement remain safely with their families, after care once a child has been returned from foster care, and respite care to provide child care relief to families where a child is at risk of being abused or neglected.

Independent Living services support education, vocational training and life skills of youth in foster care as they enter early adulthood. These youths, 16 years and older, frequently lack the family or financial support and guidance needed to gain self-sufficiency in adulthood. Services provided to help these youths gain self-sufficiency include life skills assessments; transition learning plans; exit plans that identify a youth's goals for education, employment, housing, health care, mental health care, and family/community connections; financial assistance, and identification of additional resources the youth may require.

- 29 youth were approved for funding for college in the University of Alaska system in fall of 2006, an additional 2 have been approved for college this spring;
- Four youth received funds to attend vocational training;
- Approximately 24 youth attended an educational conference in Fairbanks where they were able to meet with representatives from the university and other in-state vocational personnel;
- The Independent Living program currently serves approximately 105 youth sixteen years old and above that are in state custody. The program also serves approximately 50 youth that are no longer in state custody;
- The Independent Living program supports a youth advisory group of youth in state custody and alumni of the foster care system. This group meets on a quarterly basis and usually has between 12-18 participants;
- OCS Independent Living Specialists conduct or arrange classes for youth in custody to address independent living and educational issues. These classes differ by region, but usually have between 4-10 youth participating;
- In Anchorage, Independent Living funds are used to fund a grantee to provide services to youth who are both in and out of state custody. Referrals are made by caseworkers, foster parents, or the youth themselves.

Foster Care Base Rate, Augmented Rate and Special Needs
OCS's Foster Care Base Rate, Foster Care Augmented Rate and Foster Care Special Needs programs enable the state to find temporary homes for children who have been abused or neglected and cannot remain in their own homes. It also provides support to those children who are at risk of being removed from their homes and their families.

The Foster Care Base Rate program reimburses foster care providers for the basic ongoing costs of raising a child.

Foster Care Base Rate Program Average Monthly FTEs Served		
Fiscal Year	FTEs	Growth
FY 2002	1,038	
FY 2003	1,076	3.7%
FY 2004	1,127	4.7%
FY 2005	1,165	3.4%
FY 2006	1,277	9.6%

Movement of children on and off the program is a common occurrence, therefore OCS calculations are based on full time equivalent (FTEs) rather than number of children. This assures that if two children come into the program for two weeks out of a month, they are counted as one. FTEs are tied to dates of service and are adjusted throughout the fiscal year.

FY 2005 data falls within the conversion between OCS's old data system, PROBER, and the new data system, ORCA. The resulting disruption in data availability may have caused FY 2005 numbers to be skewed.

The Augmented Foster Care Rate benefit covers extraordinary costs and higher levels of supervision not otherwise covered with base rate benefits for children with special needs related to, for example, a disability.

Foster Care Special Needs reimbursements are for expenditures related to the care of a child that are not covered through the Foster Care Base Rate program and that have been assessed on an as-needed basis. This program funds child care for working foster parents; respite care for parents of children at risk; clothing and food in emergency situations; travel related to the safety of the child or for continuity in placements such as foster family vacations, visitation with biological parents; and other costs associated with the individual needs of each child.

Title IV-E

OCS administers the Tribal Title IV-E Reimbursement Program. OCS, through agreements with Alaskan Tribes and Tribal Organizations, passes through approximately $1.5 million of Title IV-E federal funds annually. In conjunction with OCS, Tribal staff provide child welfare services to Alaskan Native children in out-of-home placement and children at risk of out-of-home placement. Tribal organizations work closely with OCS to provide the federal government with the required, substantial documentation for IV-E determinations.

Subsidized Adoption & Guardianships

The Subsidized Adoption & Guardianships program furnishes permanent adoptive or guardianship homes and subsidies for children with special needs that are in custody of the state. These children would likely not be adopted without a subsidy because of their documented special needs. The program has been able to celebrate its success due to an increased emphasis on permanency planning and the commitment to move children from foster care to a placement, where permanency is assured, in as safe and as timely a manner as possible.

Adoptions and Guardianships - State Fiscal Years 2005 and 2006			
Totals by Subsidy Type		**FY 05**	**FY 06**
Adoptions	**Eligible for Title IV-E Funding**		
	Continuing Adoptions (prior to 6/30/05)	1457	1542
	New Adoptions (7/01/05-6/30/06)	149	190
	Aged Out	51	68
	Disrupted	29	23
	Current = Continuing + New - Aged Out - Disrupted	1526	1641
Adoptions	**Funded by the State of Alaska**		
	Continuing Adoptions (prior to 6/30/05)	316	335
	New Adoptions (7/01/05-6/30/06)	53	35
	Aged Out	15	18
	Disrupted	5	4
	Current = Continuing + New - Aged Out - Disrupted	349	348
Guardianships	Guardianships Continuing (prior to 6/30/05)	325	303
	Guardianships New (7/01/05-6/30/06)	33	33
	Guardianships Aged Out	36	54
	Guardianships Disrupted	20	27
	Current = Continuing + New - Aged Out - Disrupted	302	255
Totals	FY 2006 New Adoptions & Guardianships	235	256
	Total Continuing Adoptions & Guardianships	2098	2178
	Total Aged Out Adoptions & Guardianships	102	138
	Total Disrupted Adoptions & Guardianships	54	52
	Total FY 2006 Adoptions & Guardianships	2177	2244

Data Source: AK DHSS, Office of Children's Services Adoptions Unit

Residential Child Care

Residential Child Care facilities provide high quality, time-limited residential treatment services for abused, neglected, and delinquent children. These facilities deliver 24-hour care for children who are unable to remain in their own home or who need more structure and treatment than foster care provides. The OCS delivers levels of residential treatment that include emergency stabilization and assessment, intensive residential treatment, residential diagnostic treatment and residential psychiatric treatment. The Medicaid program provides funding for eligible treatment and care while the state pays for core services such as room and board.

Residential Care Facilities and Bed Days			
State Fiscal Year	**FY04**	**FY05**	**FY06**
Number of Facilities	29	28	28
Occupied Bed Days	57,041	58,606	56,857

Infant Learning Program

The Infant Learning Program ensures that young children who may have disabilities or developmental delays receive an evaluation to identify the potential need for early intervention services. Comprehensive, coordinated, home-based early intervention services include individualized family service plans that outline goals for the family and the child; child development information; home visits; physical, occupational, or speech therapy; specialized equipment; and/or referrals to other needed services.

The Early Childhood Comprehensive Systems Project is a federally funded project that facilitates planning and implementation of strategies in the areas of access to home medical care, family support and parent education, early care and education, and social-emotional development of young children.

The Strengthening Families Initiative (SFI) is a child abuse prevention effort supported by the Doris Duke Foundation that targets children in early care and education programs (child care centers and Headstart) between the ages of birth through five years. The SFI works to develop the protective factors of families through these settings and by offering supportive services to parents.

Women, Infants, and Children (WIC)
The Women, Infants, and Children (WIC) component includes family nutrition programs that seeks to help pregnant women, new mothers and young children eat well, learn about good nutrition, and stay healthy. Pregnant, postpartum, and breastfeeding women and infants and children receive nutrition education, referrals, and food warrants that will improve their health and nutritional status.

In FY 2006, WIC served 302,146 families: 73,750 women, 72,058 infants, 156,518 children.

2005 Breastfeeding rates for Alaska:

- *84% initiation exceeding Healthy People 2010 goals for 75% initiation*
- *46% breastfeeding at 6 months compared to Health People 2010 goals of 50%*
- *25% at 12 months; meets the Healthy People 2010 goals of 25%*
- *45% of WIC infants are being breastfeed at 3 months old*
- *18% of WIC infants are being breastfeed at 6months as compared to the American Academy of Pediatrics goal of 25% or more*

Alaska Children's Trust
The Alaska Children's Trust program generates funds and commits resources to community-initiated projects that strengthen families and prevent child abuse and neglect. The Children's Trust awards grants from the net income of the Trust Fund to community-initiated projects on a competitive basis, monitors the approved grant projects for compliance and effectiveness, and submits to the Governor a report describing the services provided and the annual level of income and expense. The Trust solicits contributions through fund-raising activities, gifts and bequests and applies for private and federal grants consistent with the purpose of the trust, to increase the value of the fund.

Children's Services Management
Children's Services Management delivers comprehensive program, managerial and financial support to the division's child protection, family preservation, and prevention services. This component has four primary units: the Deputy Commissioner's Office; the Family Services Unit; the Program Eligibility Unit and Tribal Relations Unit. Other administrative functions provided for the OCS are located in Finance and Management Services under the department’s Office of the Commissioner.

The Online Resources for the Children of Alaska is Alaska’s child protection services case management and provider payment system. This system is a federally mandated system required to support child protective services case management and federal reporting. In 2003, when the ORCA system was still in the planning phases it represented the transfer of an existing SACWIS system to be customized to reflect Alaska’s existing workflows, policies and procedures, and the development of new functionality required by the state. ORCA implementation was in two phases: 1) Case Management, September, 2004; and 2) Financial Management, February, 2005. ORCA is now the child protection system of record and must respond to a service environment that is in continuous change and growth.

Children's Services Training
Children's Services Training, through an agreement with the University of Alaska, provides education and training for OCS child protection social workers, licensing workers, supervisors, and managers to enhance their knowledge of child protection, abuse, and neglect. This required training is intense, lasts for two weeks, and is provided for each front line worker within the first month of employment whenever possible.

Required training increases employees' assessment skills in working with children and their families, and strengthens their ability to assess child safety and evaluate options to protect children when it has been determined that they would be unsafe remaining in their homes. Further, ongoing training allows workers to better ascertain the best interests of children as OCS pursues permanency for children who have been placed outside of their homes.

Children's Services Training also includes a stipend program that gives OCS staff the opportunity to complete a Bachelors or Masters of Social Work degree program with the University while on educational leave. The staff member is obligated to return to OCS as an employee for no less than 12 months upon completion of the program.

The student recruitment program supports University students who are completing their Bachelors of Social Work degree through placement in OCS offices in special units with a practicum instructor. In an effort to attract new workers in rural areas of the state, the program offers an enhanced stipend for any student who agrees to fulfill a work agreement with the OCS anywhere in Alaska.

Protective Services Reports

Front Line Workers deliver services to carry out Alaska's legal mandates to prevent and remedy the abuse, neglect, and exploitation of children reported to OCS. This significant responsibility includes the receipt and assignment of protective services reports and the assessment of allegations of child abuse and neglect to determine whether they are substantiated or not substantiated and whether children are safe in their own homes.

During FY 2006 the Office of Children's Services (OCS) received approximately 10,200 protective services reports – 700 more than received in FY 2005.

The table and chart below show that 61.3% of the 10,195 protective service reports received by OCS are assigned to OCS staff for assessment. This is comparative to 65% of the 9,543 reports received in FY 2005 that were assigned to OCS staff.

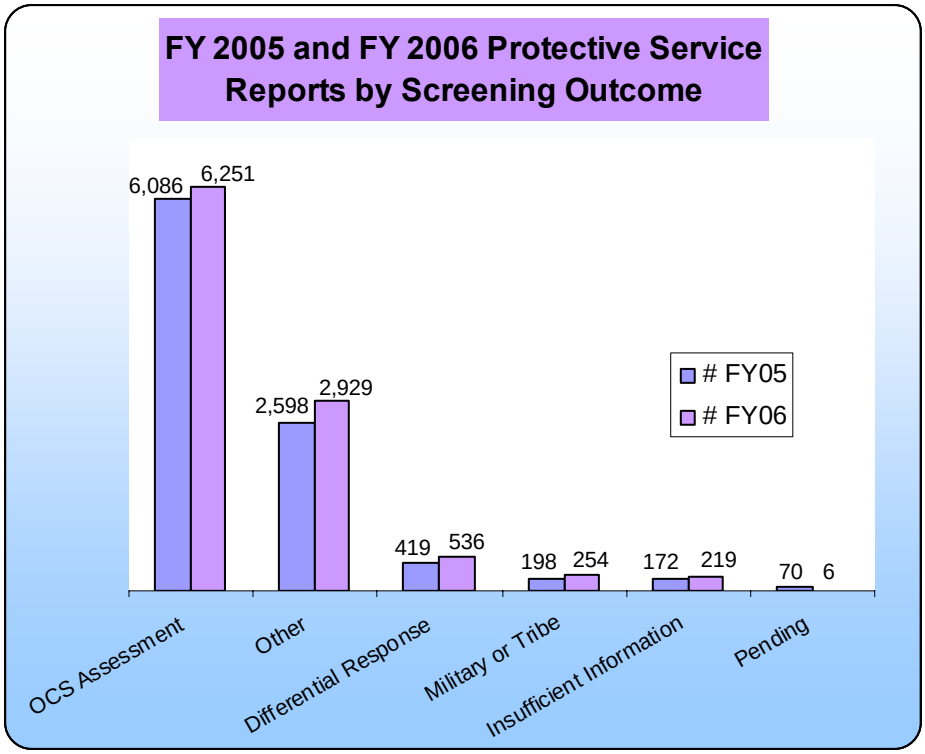
The next highest percentage, 28.7%, of protective services reports received were "Screened Out – Other", meaning they did not contain allegations that would necessitate an investigation. In FY 2005, 27% of all reports received fell into this category.

The remaining percentages illustrate the results of continuing efforts by the state to ensure that all reports that rise to the level of an assessment receive a response. Responses not assigned to OCS staff are referred to the Differential Response program, a Tribal organization, or Military agency for assessment. Percentages for FY 2005 for these remaining categories all fall within comparable ranges with the most significant change being a 1.3% increase of referrals to differential response.

Definitions for screening categories/outcomes are defined below.

Protective Service Reports by Screening Outcome
Total Reports Received by OCS - 10,195

Protective Service Report Category	# FY05	% FY05	# FY06	% FY06
Screened In for OCS Assessment	6,086	63.8%	6,251	61.3%
Screened Out - Other	2,598	27.2%	2,929	28.7%
Screened Out - Differential Response	419	4.4%	536	5.3%
Screened Out -Referred to Military or Tribe	198	2.1%	254	2.5%
Screened Out - Insufficient Information	172	1.8%	219	2.2%
Pending	70	0.7%	6	0.0%
TOTALS	**9,543**	**100%**	**10,195**	**100.0%**



Definition of Protective Service Report Screening Outcomes

Screened In for OCS Assessment includes reports that meet the criteria for assessment and are assigned to an OCS Front Line Worker.

Screened Out – Differential Response utilizes the services of community agencies in Wasilla, Anchorage, and Nome to assess lower-level protective services reports within their respective areas. The agencies contact families, conduct assessments and provide preventive services when deemed necessary. Agencies are required to report back to the OCS regarding their contacts and any services provided. OCS determines whether the intervention is successful or whether additional monitoring is necessary.

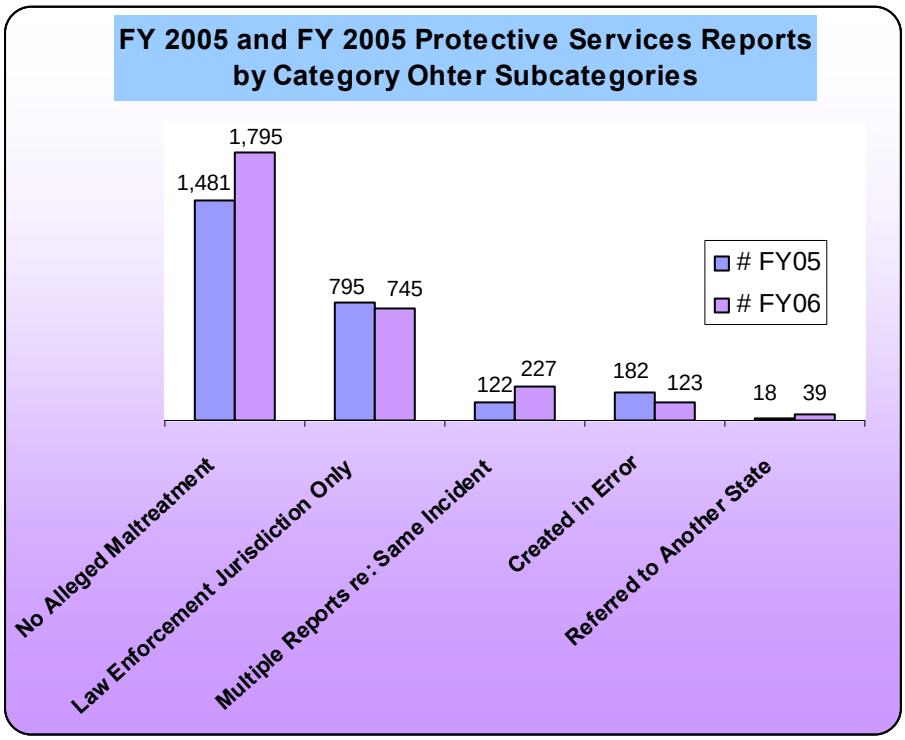
Screened Out – Insufficient Information is not assigned for assessment because there is not enough information reported to identify and locate the child or the family.

Screened Out – Refer to Military or Tribe includes reports that fall under the jurisdiction of the Military or a Tribe.

Screened Out – Other include duplicative reports and all reports that did not include allegations meeting the criteria for an OCS assessment as shown in the following charts.

Pending – includes reports not yet assigned at the time the data for this chart was pulled.

Protective Services Reports by Category Other Subcategories				
Screened Out - Other by Subcategory	**# FY05**	**% FY05**	**# FY06**	**% FY06**
No Alleged Maltreatment	1,481	57.0%	1,795	61.3%
Law Enforcement Jurisdiction Only	795	30.6%	745	25.4%
Multiple Reports re: Same Incident	122	4.7%	227	7.8%
Created in Error	182	7.0%	123	4.2%
Referred to Another State	18	0.7%	39	1.3%
TOTAL	**2,598**	**100.0%**	**2,929**	**100.0%**



From FY 2005 to FY 2006, the most notable changes in the subcategories of reports received that fall within the "Other" category were an additional 314 reports that alleged no maltreatment; 50 fewer reports fell within law enforcement jurisdiction; and an additional 18 were referred to other states.

Data Source: AK DHSS, Office of Children's Services Online Resource for the Children of Alaska (ORCA) case management and provider payment system.

Number of Children in Out-of-Home Care by Placement Category

When it is necessary to remove a child from unsafe situations, out-of-home care is required. Front Line Workers investigate allegations contained within protective services reports, and when necessary, arrange for placement in the least restrictive setting.

Options for placement include relative or non-relative foster homes (including unlicensed relatives), pre-adoptive homes, group homes, residential care, or other placements that consist primarily of closely monitored trial home visits.

Children In Out-of-Home Placement By Setting Type			
Placement Setting/Type	FY 05 Count	FY 06 Count	Change from FY 05 to FY 06
Foster Family Non-Relative Home	770	809	5.0%
Foster Family Relative Home	575	624	8.5%
Trial Home Visit	205	366	7.9%
Residential Care & Other Facilities	176	147	-16.5%
Group Home	102	98	-3.9%
Runaway	31	35	12.9%
Pre-Adoptive	31	28	-9.7%
Supervised Independent Living	5	5	0.0%
Total	**1895**	**2112**	

Data Source: AK DHSS, Office of Children's Services Online Resource for the Children of Alaska (ORCA) case management and provider payment system.

Recurrence of Maltreatment

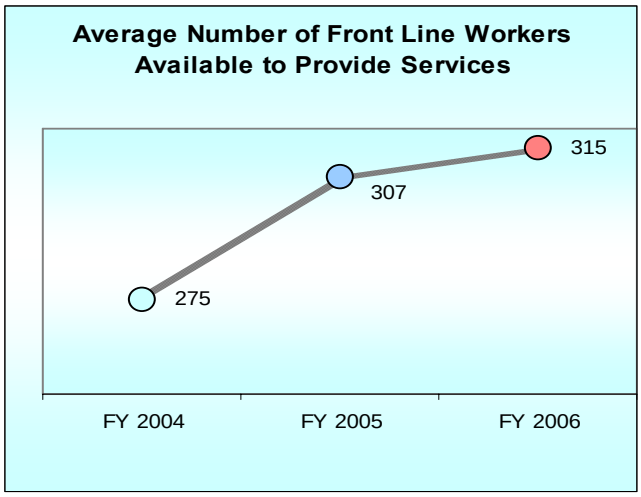
A child is considered to have a recurrence of maltreatment if two or more protective services reports are substantiated within a six month period.

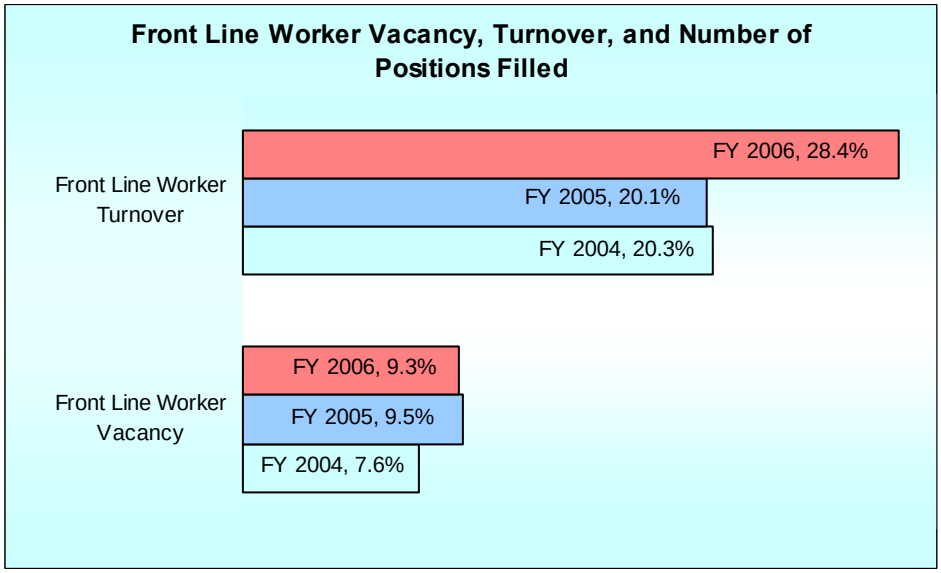
In 2002, the baseline for substantial compliance with federal criteria was set at 74 percent of cases with no recurrence of maltreatment. In 2005, OCS estimates that there was no recurrence of maltreatment in 89.4 percent of the cases. Current data is not available until completion of data clean-up in the field resulting from the transition from the old data system to the new data system. The current performance measure goal is 93.9 percent. Progress in this area will continue as OCS continues to achieve manageable caseloads, builds a well-trained stable workforce, and clear performance standards for staff and grantees are realized.

Repeat maltreatment is an OCS performance measure at the department level. C. Outcome Statement #3, Target and Measure #2.

Front Line Worker Turnover

A key indicator of the successful implementation of the OCS mission is a well-qualified and stable work force with manageable caseloads. The following chart provides a picture of the rate at which the agency's Front Line Worker force turns over. While this is a repeat of one of OCS's performance measures, this format provides a better picture of the continuing struggle to maintain a stable work force. While turnover rates have increased over the past year, the average number of employees OCS has on staff has increased meaning there have been more front line workers in the field providing child protection services to those in need.





Workforce vacancy/turnover/average number of positions filled is an OCS performance measure at the department level. C. Outcome Statement #4, Target and Measure #4.

Increased workforce retention remains one of OCS's significant challenges and commitments. The OCS continues to focus on improving leadership and accountability by supervisors and management skills. Training and technical assistance is being provided through the National Resource Center on Child Protective Services for assistance in needs assessment and planning to improve supervision. The OCS will continue to utilize training opportunities available through the federal government, Family and Youth Services Training Academy (FYSTA), and the State.

OCS Subsidized Adoption and Guardianship

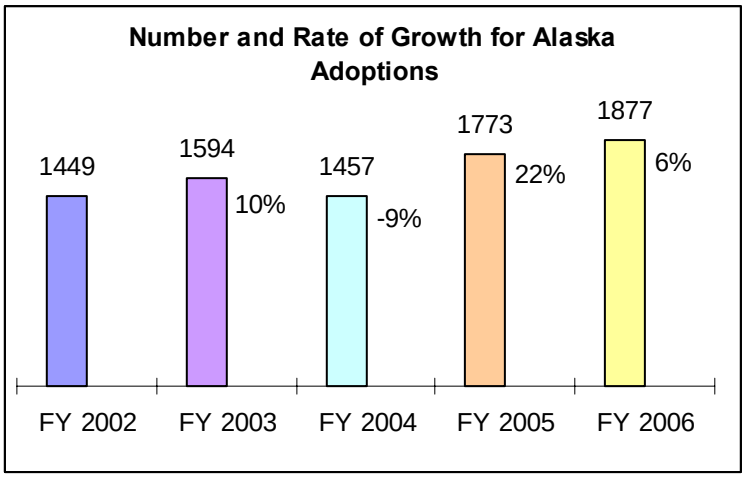
The Subsidized Adoption & Guardianship program facilitates permanent placements in adoptive homes or stable guardianships for the increasing number of children in state custody whose special needs make them hard-to-place. Adoption is viewed as the most permanent placement for a child and is therefore generally the preferable option when children cannot return to their own homes.

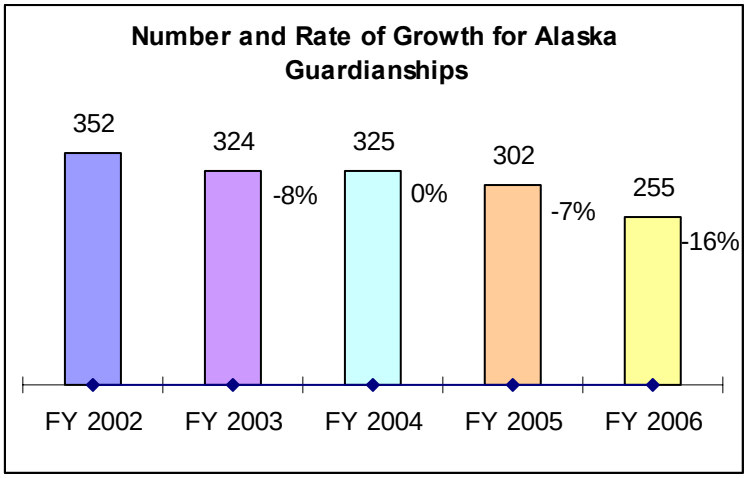
Guardianships are considered for children who cannot be freed for adoption, but for whom a reasonably permanent home can be provided through guardianship. This is often the best choice for

children who cannot live with their parents but continue to have an important emotional tie with their families that should not be severed.

Approximately 2,240 children are currently living in permanent homes provided under the Subsidized Adoption & Guardianship program.

The following charts outline the continued growth of the Subsidized Adoption and Guardianship program at the Office of Children's Services since FY 2002. Over the past five and a half years, the OCS has implemented policy changes to the subsidy program that further defined the parameters of legal guardianship versus adoption for children in OCS custody. OCS is seeing a greater increase in the number of children who are finding permanency through adoption; these numbers are reflected in the following charts.





In FY 2006, Alaska experienced approximately 52 out of 256 unsuccessful adoptions or guardianships for a multitude of reasons. This is an improvement over FY 2005 from a 23% disruption rate to 20 percent. Approximately 40 percent of Alaska's failed adoptions and guardianships occur in rural areas.

To encourage increased numbers of successful adoptions in rural areas, OCS has modified the most recent resource family training and support grant requirements to include more outreach to our rural communities. Most of this outreach is done either via telephone or email, and includes audio conference orientation, training and support groups, and online training courses. We do not yet

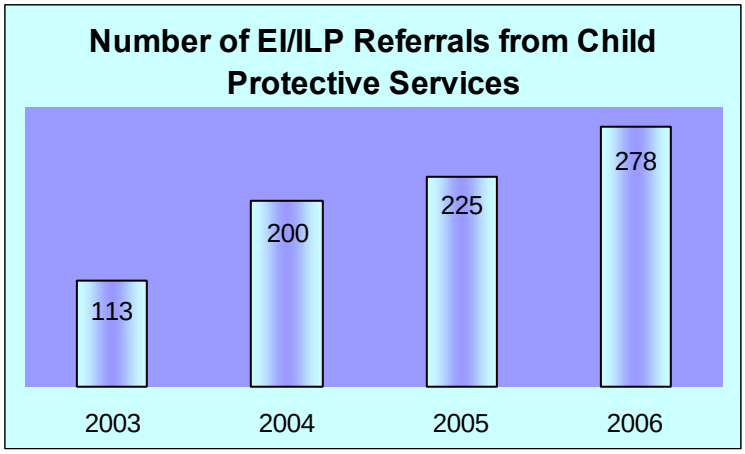
know if the disruption or dissolution numbers have been impacted as these modified services just started in FY 2007.

Early Intervention/Infant Learning Program (EI/ILP)
The early intervention/infant learning program provides family centered services for very young children who experience significant developmental delay or are at high risk to manifest such a delay without intervention. In Alaska most of the children served in Early Intervention/ Infant Learning Programs have experienced a 50% or greater delay in one area of development or have a diagnosed condition which may lead to a significant delay such as Downs Syndrome or Autism.

Children, from birth to 36 months, who meet one of the following criteria are eligible for services:

- Developmental delay of 50 percent or greater in one or more areas of development;
- Disabling condition with a high probability of resulting in a 50 percent or greater developmental delay;
- Child's development appears atypical and a multi-disciplinary team determines that the child is likely to have a severe developmental delay.

In 2003 congress passed the Strengthening Families Bill which included the Child Abuse and Prevention Act (CAPTA). The Bill requires that all children birth through three years of age who are involved in a substantiated protective services report be referred to the EI/ILP program for evaluation and determination of eligibility for services. Since 2003, Alaska has seen a 56% increase in the number of referrals from child protective services and expects this number to rise as child protection services and EI/ILP continue to improve communication and understanding of how best to support these children and families.



AS 18.05.010-070	Administration of Public Health and Related Laws
AS 25.23	Adoption
AS 25.23.190-240	Subsidy for hard-to-place child
AS 37.14	Alaska Children's Trust
AS 44.29.020 (a)	Duties of Department - Organization
AS 47.05	Administration of Welfare, Social Services, and Institutions, duties of Department.
AS 47.05.010	Duties of the Department - Administration
AS 47.07	Medical Assistance for Needy Persons
AS 47.10	Children in Need of Aid
AS 47.10.080	Judgments and orders
AS 47.14.100	Powers and duties of Department over care of child
AS 47.14.980	Grants-in-aid
AS 47.17	Child Protection
AS 47.20.070-075	Services for Developmentally Delayed or Disabled Children
AS 47.30	Mental Health Trust Authority
AS 47.40	Purchase of Services.
7 AAC 23.010-100	Infant Learning Program
7 AAC 43	Medicaid Assistance
7 AAC 43.500-43.599	Medical Transportation Services; Inpatient Psychiatric Services
7 AAC 50	Community Care Licensing
7 AAC 51	Child Placement Agencies
7 AAC 53	Social Services
7 AAC 53, Article 1	Child Care Foster Care Payments
7 AAC 53, Article 2	Subsidized Adoption and Subsidized Guardianship Payments
7 AAC 53, Article 3	Children in Custody or Under Supervision: Needs and Income
7 AAC 78	Grant Programs
7 AAC 80.010-925	Fees for Department Services
42 USC 5601 et seq.	Congressional Statement of Findings

Child Abuse Prevention and Treatment Act (CAPTA)
Children's Justice Act
Individuals with Disabilities Education Act, Part C
Personal Responsibility and Work Opportunity Reconciliation Act of 1996

Social Security Act, Title IV-A
Social Security Act, Title IV-B
Social Security Act, Title IV-E
Social Security Act, Title XIX

Title XIX Grants to States for Medical Assistance Programs
Title XXI State Children's Health Insurance Program

Office of Children's Services	2007	2008 Proposed	07 to 08 Change
General Funds	60,816.5	68,284.2	7,467.7
Federal Funds	78,818.0	76,213.2	-2,604.8
Other Funds	10,187.8	10,371.9	184.1
Total	**149,822.3**	**154,869.3**	**5,047.0**

Implement Federal Deficit Reduction Act

Rosales $2,170.4 GF/-$2,170.4 Federal
The Ninth Circuit Court ruling in *Rosales* provided the State of Alaska the opportunity to broadly apply Aid to Families with Dependent Children (AFDC) income and resource requirements to determine IV-E eligibility that did not need to be based on the same home from which a child was removed. This meant that a child's eligibility could be established using the home of any relative with whom the child resided within six months of the month in which eligibility was determined. Alaska became eligible to claim reimbursement for costs under this ruling on July 1, 2003; the date Alaska's IV-E state plan amendment became effective.

The Federal Deficit Reduction Act of 2005 (DRA) reverses that ruling and limits Ninth Circuit states' ability to claim IV-E maintenance and administrative costs by requiring all Title IV-E agencies determine eligibility for federal foster care assistance on the specified relatives home from which the child is removed.

Rosales accounts for about 15% of the foster care population resulting in a like drop in the foster care administrative (funding for OCS services provided that are related to protective services) and maintenance (funding provided for the care of foster children) penetration rate. The penetration rate determines the percent of state expenditures that will be considered reimbursable at 50% for administrative claims or the Federal Medical Assistance Percentage for Medicaid. (FMAP) for maintenance claims.

Unlicensed Relative Placements $1,022.3 GF/$-1,022.3 Federal
The Federal Deficit Act of 2005 also changed Title IV-E administrative claiming allowances pertaining to unlicensed foster care. Previously the State of Alaska was reimbursed for its Title IV-E expenditures for children in both relative and non-relative unlicensed foster care placements. The new law prohibits claiming federal fund participation for not-fully licensed non-relative foster care placements and restricts reimbursement to less than 12 months for any relative foster care placement in the process of getting licensed.

Unlicensed relative placements account for about 11% of the foster care population resulting in a like drop in the foster care penetration rate.

A summary of the calculations for each of OCS's components affected by the Federal Budget Deficit Reduction Act follows:

Children's Services Management (CSM) Component Estimate of Reimbursable Expenses:

Reimbursable Expenses

5,154.8 Total Expenditures
x 66% IV-E Administrative Penetration Rate
= 3,402.2 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 1,701.1 Pre DRA Federal Fund Participation

Rosales and Unlicensed Relative

5,154.8 Total Expenditures
x 40.7% 25.3% Reduction in Penetration Rate
= 2,098.0 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 1,049.0 Post DRA Federal Fund Participation

Component Summary

1,701.1 Pre DRA Federal Fund Participation
- 1,049.0 Post DRA Federal Fund Participation
= 652.1 FY2008 GF Need

Children's Services Training (CST) Component Estimate of Reimbursable Expenses:

Reimbursable Expenses

1,767.3 Total Expenditures
x 66% IV-E Administrative Penetration Rate
= 1,166.4 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 583.2 Pre DRA Federal Fund Participation

Rosales and Unlicensed Relative

1,767.3 Total Expenditures
x 40.7% 25.3% Reduction in Penetration Rate
= 719.3 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 359.6 Post DRA Federal Fund Participation

Component Summary

583.2 Pre DRA Federal Fund Participation
- 359.6 Post DRA Federal Fund Participation
= 223.6 FY2008 GF Need

Front Line Social Worker (FLSW) Component Estimate of Reimbursable Expenses:

Reimbursable Expenses

25,087.9 Total Expenditures
x 66% IV-E Administrative Penetration Rate
= 16,558 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 8,279.0 Pre DRA Federal Fund Participation

Rosales and Unlicensed Relative

25,087.9 Total Expenditures
x 40.7% 25.3% Reduction in Penetration Rate
= 10,210.8 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 5,105.4 Post DRA Federal Fund Participation

Component Summary

8,279.0 Pre DRA Federal Fund Participation
- 5,105.4 Post DRA Federal Fund Participation
= 3,173.6 Reduced Reimbursement
- 1,301.0 FY2007 Appropriations
= 1,872.6 FY2008 GF Need

Family Preservation (FP) Component Estimate of Reimbursable Expenses:

Reimbursable Expenses

5,138.3 Total Expenditures
x 66% IV-E Administrative Penetration Rate
= 3,391.2 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 1,695.0 Pre DRA Federal Fund Participation

Rosales and Unlicensed Relative

5,138.3 Total Expenditures
x 40.7% 25.3% Reduction in Penetration Rate
= 2,091.3 Expenditures Eligible for IV-E Reimbursement
x 50% Federal Administrative Reimbursement Rate
= 1,045.6 Post DRA Federal Fund Participation

Component Summary

1,695.6 Pre DRA Federal Fund Participation
- 1,045.6 Post DRA Federal Fund Participation
= 650.0 FY2008 GF Need

Foster Care Special Needs (FCSN) Component Estimate of Reimbursable Expenses:

Reimbursable Expenses
4,639.1 estimated total FCSN expenditures
x 44% current IV-E maintenance penetration rate
= 2,041.2 expenditures eligible for IV-E reimbursement
@ 50% federal fund participation
= 1,020.6 pre DRA federal fund participation

Reduced Federal Fund Participation for Rosales:
4,639.1 estimated total FCSN expenditures
x 29.3% with 14.7% reduction to IV-E maintenance penetration rate for Rosales
= 1,359.2 expenditures eligible for IV-E reimbursement
@ 50% estimated FY 2008 unadjusted FMAP
= 679.6 post DRA federal fund participation

FCSN Summary of Reduced Federal Fund Participation for DRA
1,020.6 pre DRA federal fund participation
- 679.6 post DRA federal fund participation
= 341.0 FY 2008 FCSN general fund need

Residential Child Care (RCC) Component Estimate of Reimbursable Expenses:

Reimbursable Expenses
1,435.9 estimated total RCC expenditures
x 44% current IV-E maintenance penetration rate
= 631.8 expenditures eligible for IV-E reimbursement
@ 50% estimated FY 2008 FMAP
= 315.9 pre DRA federal fund participation

Reduced Federal Fund Participation for Rosales:
1,435.9 estimated total RCC expenditures
29.3% with 14.7% reduction to IV-E maintenance penetration rate for Rosales
= 420.7 expenditures eligible for IV-E reimbursement
@ 50% estimated FY 2008 FMAP
= 210.4 post DRA federal fund participation

RCC Summary of Reduced Federal Fund Participation for DRA
315.9 pre DRA federal fund participation
- 210.4 post DRA federal fund participation
=105.5 FY 2008 RCC general fund need

Federally Mandated Changes:
Safe and Timely Interstate Placement of Foster Children Act of 2006
The Interstate Compact on the Placement of Children (ICPC) is a binding contract between all 50 states, the District of Columbia, and the U.S. Virgin Islands. It establishes uniform legal and administrative procedures for the interstate placement of children.

The ICPA applies to placements preliminary to adoptions; placements into foster care (foster homes, group homes, residential care, and institutions); placements with relatives; and adjudicated delinquents being placed in other states.

The ICPC also includes procedures for the uniform handling of requests for home studies between states. Home studies, through a series of interviews and home visit(s), provide information about potential adoptive or foster parents upon which a worker can make a placement decision that is in the best interest of the child and the parents.

Effective October 1, 2006, new federal legislation mandates that home studies requested by other states be completed in 60 days.

In FY 2005, 135 home studies were conducted within an average of 4 months – some were completed in less than 30 days while others took over a year. Some studies are simply much more difficult to achieve in some regions of the state than other and require more travel and resources.

	Anchorage	Southeast	Southcentral	Northern	Total
Number of Studies Per Region	46	27	35	27	135
Number Completed in 60 Days	12	5	4	16	37

Thus far, OCS has only been able to complete 27% of the required home studies within that 60 day timeframe required by the federal government due to lack of workforce and workload issues.

Implement Front Line Social Worker Workload Study Recommendations
Workload Study Findings
In response to concerns of the Legislature and the Citizen's Review Panel, OCS contracted with Hornby Zeller Associates, Inc. to evaluate whether front line workers have enough time to meet the basic requirements of their jobs and to provide management the basis for giving caseworkers reasonable caseloads.

The study defines "workload" as the amount of time needed to complete the tasks necessary as opposed to caseloads that only count the number of families served with no regard to the differences in the amount of time specific to the uniqueness's within Alaska to properly handle assigned cases. When workers are over tasked, mistakes are more easily made and needs are not met. This has a direct impact on the safety of Alaska's children.

Recommendations from the study include a plan to fill existing vacancies and monitoring workload over time before engaging in wide-scale changes to personnel that would include transferring positions from over-staffed offices to under-staffed offices. While staffing patterns need to continue to be monitored and assessed over time, the contractor did conclude that in order to meet the

workloads of the state, OCS needs an additional 19 positions to appropriately handle the state's entire caseload appropriately as mandated by state and federal policy.

The work load study also revealed that front line workers spend on average 12.4% of their time on administrative tasks. With the addition of the new front line workers in FY 2005 and FY 2006, no administrative staff has been added, therefore more of the administrative work falls to the front line workers.

Status of new positions in FY 2005 and FY 2006: Of the 57 direct service delivery positions, only 8 are currently vacant. Of the 8, half are posted on Workplace Alaska for hire. Although OCS has seen significant staff turnover, the increased number of available positions has given OCS the ability to keep more workers on payroll at any given time. As of November, the OCS's current vacancy rate is at less than 4%, down from the average 9.4% carried through FY 2005 and FY 2006.

Frontline Workers Available for Field Services	
Average Number of Direct Service Positions Filled	
FY 2004	275
FY 2005	307
FY 2006	315

OCS challenges: OCS has dealt with high staff turnover for many years. Unfortunately, there are a multitude of reasons for case workers to leave services: child protective services social work is extremely stressful and can be dangerous, there is little reward for success and much public criticism for a failure, hours are long and pay is low – a frontline worker starts state service at a Range 15, benefits continue to decrease, work-related travel is many times difficult and complicated, work facilities are substandard in some rural areas, and OCS has experienced a substantial turnover in leadership over the past four years, giving workers little continuity.

The OCS is developing a comprehensive plan to address retention and recruitment of front line staff. The OCS is also very aware that turnover continues to be high and of great concern. Previous strategies have not had an effect; therefore, OCS needs to put more effort into the planning and to the implementation of that plan once it is complete.

Foster Care Reimbursement Rates Have Not Been Increased In 8 Years

The Foster Care Base Rate component reimburses providers for expenditures associated with caring for children placed in their homes. The expenditures include food, clothing, daily supervision, personal items, school supplies, games and recreational activities, allowance, usual transportation costs, and other items relevant to raising a child.

There has been one family foster care rate increase in the last fifteen years and that was eight years ago. Rates paid to the people of Alaska willing to bring children who have had to be removed from their own homes into their homes, and to provide care for them are not adequate to cover the costs to these families, making it even more difficult to recruit foster parents.

As the costs of raising children has increased, front line workers must use other means to adequately reimburse care providers forcing expenditure increases in other areas of the budget, in particular Foster Care Special Needs.

Unmet Needs: Early Intervention/Infant Learning Services

The early intervention/infant learning program provides family centered services for very young children who experience significant developmental delay or are at high risk to manifest such a delay without intervention. In Alaska most of the children served in Early Intervention/ Infant Learning Programs (EI/ILP) have experienced a 50% or greater delay in one area of development or have a diagnosed condition which may lead to a significant delay such as Down Syndrome or Autism.

The program has identified unmet needs in the areas of adequate support services for very young children who have had substantiated reports of abuse and neglect as well as in the frequency of services for all children and families in need. In addition, funding for EI/ILP has remained level for more than five years, and the program can no longer absorb the increased costs for services required.

Traditionally EI/ILP eligibility was based on education based domains of development where children with speech and language delays, cognitive delays or motor delays are commonly served through our early intervention system. This traditional approach, however, effectively ignored very young children showing difficulties with behavior or delays in social and emotional development. Children who have been abused and neglected are at extremely high risk for social and emotional delays, and that without intervention chronic stress and/or repeated traumas can result in a number of biological reaction affecting attention, impulse control, sleep, and fine motor control.

In 2004, 58% of eligible children were identified as having mild/moderate to severe delays in their social and emotional development. The EI/ILP program needs to strengthen available supports and services for children and families as needed and evidenced by program data. These funds will ensure that grantee programs have access to adequate training, and support for the expected influx of children with high social and emotional needs as well as provide continued, enhanced services to children currently enrolled. Funds would also be used to pay for limited consultation from licensed mental health practitioners to consult and work with Individual Family Service Plan teams to develop and implement pre-clinical support.

Continued Operations and Development of the Online Resources for the Children of Alaska (ORCA)

ORCA is the OCS children protection services case management and provider payment system. This system is federally mandated and required to support child protective services case management and federal reporting. ORCA was implemented in two phases 1) Case Management, September, 2004, and 2) Financial Management, February, 2005.

ORCA is now into its fourth year and can boast many successes. Nationally, a project of this magnitude requires five to seven years to develop and requires continued support of contracted services to maintain. In the past year, ORCA accomplishments include:

- Completed federal adoption reporting capabilities
- Established expert user ORCA Help Desk
- Completed modifications necessary to enable the Division of Public Health licensing unit access and use of ORCA functionality
- Provided access to all Division of Juvenile Justice workers
- Updated all User Guidance Documents
- Completed web based statutory reports and performance measures

As part of the overall strategy to develop and implement ORCA, sole responsibility by state personnel was anticipated within one year of implementation. Since that time, the agency has

learned that the implementation of ORCA and its impact on the fundamental way child protection services does business has taken much longer than anticipated and will be continual, much like that of other states.

In addition, the ORCA software development environment is far larger and far more complex than anticipated. It has become apparent that sole responsibility for ORCA by the state, while remaining the strategy, will need to be augmented with contractual services. Without augmented services, the need for ongoing ORCA system changes related to federal mandates, new state laws, and related practice changes cannot be met. ORCA is not alone in this need; most states have had the desire to take ownership of their system, but few, if any, have the capacity to do so.

OCS must face the challenge of providing ORCA staff with the training and support required through contractual services to continue operations and development of ORCA that was not originally anticipated.

Contribution to the Department's Mission

Promote stronger families, safer children.

Core Services

- Investigate reports of harm and provide in-home services to children at-risk.
- Permanency planning for children in out of home care.
- Treatment services, early intervention and family nutrition services.
- Prevent and remedy child abuse and neglect.

Department Level Measures

C: Result - Outcome Statement #3: Children who come to the attention of the Office of Children's Services are, first and foremost, protected from abuse or neglect.

Target #1: Decrease the rate of substantiated allegations of child abuse and neglect in Alaska.
Measure #1: The rate of child abuse and neglect per 1,000 children under the age of 18.

Rate of Child Abuse & Neglect Per 1,000 Children Under Age 18 in Alaska

Fiscal Year	Rate Per 1,000	National Rate
FY 2001	32.2	0
FY 2002	27.6	0
FY 2003	23.0	0
FY 2004	22.3	0
FY 2005	N/A	0
FY 2006	16.0****	11.9

***** The Office of Children's Services is now through its second year using the new case management system - Online Resources for the Children of Alaska (ORCA). With the implementation of ORCA, new methods of measurement in compliance with federal standards have been used. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable. As a result, FY 2006 data is not comparable to FY 2001 through FY 2004.*

Due to data instability resulting from the conversion of the old data system to ORCA, the FY05 information is not reliable and not available for analysis.

The FY 2006 measures represent an unduplicated number of children with substantiated abuse or neglect per 1,000 children in the population. The population equals the number of children under the age of 18 years as of July 1, 2005, as estimated by the Department of Labor. Data reported prior to FY 2006 can be duplicative.

Source: Target of 11.9 - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

Analysis of results and challenges: The Office of Children's Services goal is to protect children from abuse and neglect. Measuring the success of children's services agencies can be done, in part, through the number of substantiated child protective services reports received per 1,000 children under the age of 18 in the state.

The Department of Labor reports 194,595 children under the age of 18 in Alaska as of July 1, 2005. The Office of Children's Services investigated 10,195 child protection reports of abuse and/or neglect and substantiated abuse and/or neglect for 3,118 children in FY 2006, or 16 per 1,000 children in the state.

In FY 2004, national levels of substantiated abuse and neglect per 1,000 children was calculated by Child Trends Databank at 11.9 and averaged 12.2 over five years. This places Alaska's victim rate at 31% higher than the national average.

While the Office of Children's Services met all of its goals as set out in the Federal Performance Improvement Plan by August 2006, outcomes affecting children and their families still need to improve. The division has embarked on several new approaches to address this issue regarding the children in our state, including a new Safety Assessment model.

When the Office of Children's Services determined that its safety assessment model was ineffective at assessing the difference between safety threats and risk factors, a new safety model was introduced and is being implemented. FY 2006 one time only training money was used to train every front line staff, supervisor, manager, key central office staff and several interested tribal partners. The new model and subsequent training focused on requiring workers to take more time to do a throughout assessment each time a new investigation is assigned.

One of the fundamental differences in the new model requires workers to do an assessment of the entire family and their overall functioning and to look beyond whether the abuse or neglect is substantiated or not substantiated. In the past, workers focused just on the maltreatment itself and did not address other issues going on in the home. This resulted in missed opportunities to engage families in remedial services to avoid subsequent abuse and neglect to the child. Further, the new model helps workers to understand the essential differences in whether the child is unsafe or at risk. Unsafe determinations require OCS intervention, while risk factors may necessitate a referral to community resources. This will result in better identification of families that must be served by the child protective services system versus those that can be served by other resources.

OCS staff, community providers and tribal partners all agree this is a better way to work with families; however, workloads make the new process very difficult to achieve given the time requirement to complete a thorough assessment.

Target #2: To decrease the rate of repeat maltreatment to meet or exceed the national standard of 6.1 percent.
Measure #2: Percentage rate of repeat maltreatment.

Year	YTD Total	Target
2000	23.6%	0
2001	25.4%	0
2002	22.6%	0
2003	17.6%	0
2004	17.3%	0
2005	10.6%****	6.1%

Data Source: National Child Abuse and Neglect Data System and Alaska's Online Resources for the Children of Alaska (ORCA).

*****Introduction of Online Resource for the Children of Alaska (ORCA). With the transition from the old case management system (PROBER) to the new system (ORCA), data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.*

Data for this measure submitted to the federal government in FFY 2005 in compliance with the National Child Abuse and Neglect Data System requirements indicated an 8% repeat maltreatment rate. Further research, data clean-up efforts, and a separate analysis cross-checking and linking different data sources indicated the 8% was under-reported. The division has incorporated new findings into this measure.

OCS is still undergoing the data clean-up process and is unable to provide FY 2006 findings at this time. Resources constructing the FY 2005 measure are no longer available, and OCS does not anticipate updates until late spring 2007.

Analysis of results and challenges: The federal guideline for repeat maltreatment includes all children who are victims of substantiated child abuse and/or neglect twice during a six month period. Because Alaska's rate of repeat maltreatment has been so high, a protocol was developed to more closely examine past investigations resulting in a substantiated finding of abuse or neglect. If there have been past substantiated investigations, the OCS worker will review the previous record to ascertain whether the newly reported allegations are against the same child by the same maltreater. If so, the worker and his/her supervisor will devise a strategy for intervention for the current investigation acknowledging that there may be a pattern of abuse that needs to be recognized. The supervisor will closely monitor the progress of the investigation and ensure the appropriate actions are taken to protect the child from further abuse.

It is expected that OCS will begin to see improvements in the number of repeat maltreatment cases not only due to this new business practice, but a positive effect is expected due to increased efforts in prevention, i.e., increased early intervention/infant learning program screenings for young children with substantiated protective services reports.

The chart above shows an adjusted rate of improvement because of the transition between the old case management system (PROBER) and the new (ORCA). FFY 2005 data has been adjusted after further work was completed. The OCS will now focus on meeting or exceeding national standards.

Target #3: Decrease the percentage of substantiated maltreatment by out-of-home providers.
Measure #3: Percentage of children maltreated by an out-of-home provider.

Percentage of Children Maltreated by an Out-of-Home Care Provider

Fiscal Year	Quarter 1	National Rate
FFY 2000	1.91%*	0
FFY 2001	2.00%*	0
FFY 2002	2.09%*	0
FFY 2003	1.35%	0
FFY 2004	1.20%	0
FFY 2005	1.10%****	0
FFY 2006	1.16%	.57%

** Data is based on a calendar year. Federal mandates changed to the federal fiscal year in 2003.*

*****Introduction of ORCA. With the transition from the old case management system (PROBER) to the new (ORCA) system, data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.*

Source: Online Resources for the Children of Alaska (ORCA) data system for the National Child Abuse and Neglect Data System (NCANDS) and federal Adoption and Foster Care Analysis and Reporting System (AFCARS).

Source: Target of .57% - United States Department of Health and Human Services Administration for Children and Families, Child Maltreatment, 2004.

Analysis of results and challenges: Recognition that the rate of abuse of children placed outside of the home by a care provider is unacceptable lead the OCS to launch a new process to assess prospective foster and adoptive parents ("resource families") before licensure and placement of children in the home. The new process was piloted in Anchorage last year and this year expanded to other regions and more rural locations. The Resource Family Assessment is far more comprehensive than the previous licensure process and continued evaluation and changes are being made to the program as determined necessary. One of the primary issues is the amount of time needed to complete the new assessment. While most all agree it is a better way to look at potential foster or adoptive families, it requires much more from already strained resources.

Target #4: Reduce the rate staff turnover and increase the number of workers providing direct services at any given time.

Measure #4: Annual employee turnover rate; number of positions available to provide direct services.

Office of Children's Services Vacancy /Turnover Rates & the Number of Positions Filled

Fiscal Year	Vacancy Rate	Turnover Rate	Avg. # Positions Filled	Target
FY 2001	N/A	24.84%	N/A	0
FY 2002	N/A	24.21%	N/A	0
FY 2003	N/A	23.55%	N/A	0
FY 2004	7.59%	20.27%	275	0
FY 2005	9.48%	20.97%	307	0
FY 2006	9.30%	28.37%	315	20%

Vacancy Rate and number of positions filled methodology is based on a calendar year average. FY 2006 turnover rate is year-to-date as of September, 2006. Turnover rates exclude lateral transfers and promotions within OCS. As of September, 2006 there were 31 (10% of average number of positions filled) lateral transfers and 23 promotions (7% of average number of positions filled).

Includes direct service (front line) workers only.

Analysis of results and challenges: The Office of Children's Services contracted with Hornby Zeller Associates, Inc. last year to complete a workload study to provide OCS leadership with a way to evaluate whether front line staff had sufficient time to meet the basic requirements of their jobs to protect children and serve families. Workload is defined as the amount of time needed to complete the tasks necessary as opposed to caseloads that only count the numbers of families served with no regard to the differences in the amount of time to properly handle assigned cases. The final report with the results and recommendations was received in May 2006. The contractor concluded that a plan needed to be developed to fill existing vacancies and monitor caseloads over time before engaging in wide scale changes to personnel that would include transferring positions from over-staffed offices to under-staffed offices. While staffing patterns over time need to continue to be monitored and assessed, the contractor did conclude in order to meet the workload of the state, OCS needs an additional 19 positions to handle the state's entire caseload appropriately as mandated by state and federal policy guidelines.

In addition, the work load study revealed that front line workers and supervisors spend on average 12.4% of their time on administrative tasks. With the addition of the new front line staff as authorized in FY 2005 and FY 2006 but no administrative staff added, more administrative tasks have fallen to workers. The OCS will request additional administrative support when allowed to do so.

Lastly, a comprehensive plan to address retention and recruitment of front line staff is currently in development. The OCS understands that worker turnover continues to be high and of great concern and previous strategies have not changed that fact; therefore, greater emphasis and planning is necessary.

This measure has been enhanced by adding vacancy rates and the average number of direct service positions filled. Turnover rates, while extremely high and disruptive, do not provide a complete picture. OCS added vacancy rates as a measure of positions vacant at any given time through a year and filled positions to show that while turnover and vacancy rates remain high, progress in the number of available workers at any time has improved.

C1: Strategy - Implementation of new safety assessment model to provide front line workers with a better tool to identify safety issues in the home.

C2: Strategy - Children placed outside of the home are protected from further abuse and neglect.

C3: Strategy - Retain an effective and efficient workforce.

Division Level Measures

A: Result - To prevent children from abuse and neglect.

Target #1: Increase the number of Early Intervention/Infant Learning Program screenings for children age 0 - 3 to meet federal requirements.
Measure #1: The number of children age 0 - 3 screened annually.

Year	No. of Screenings	Target
2003	113	800
2004	200	800
2005	225	800
2006	278	800

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) goal is to have every child under the age of three with a substantiated protective services report screened and thus achieve federal compliance within three years. Currently EI/ILP screens only 40 percent of the required screenings under the Child Abuse Prevention and Treatment Act.

In 2003 US Congress passed the Strengthening Families Bill requiring all children birth through three years of age who have been abused or neglected to be referred to the Early Intervention/Infant Learning (EI/ILP) Program. By referring all 0-3 year old children who have a substantiated finding of abuse or neglect, the EI/ILP program can do an initial screening to identify speech and language delays, cognitive and motor delays and social and emotional delays and then connect families to any needed services. By linking families with services aimed at remedying identified needs of very young children, further abuse and neglect can be negated as associated risk factors are alleviated. While called prevention services, abuse or neglect has already occurred, and by providing this screening and subsequent services, the likelihood of repeat maltreatment is reduced.

The program, as the number of screenings increase, is improving strategies to meet the 100% goal. This task becomes more complex as increased attention related to the behavioral health needs of very young children increases. In the past, the need for these services and a child's eligibility for these services were based on education based domains of development. Strategies must be developed to assure referrals of children who are not yet of school age.

In 2005 EI/ILP discovered that 58% of infants and toddlers enrolled in EI/ILP services had delays in social and emotional development greater than 15%. 182 children (10%) had social and emotional delays greater than 50%. Currently programs do not have the capacity to provide adequate training and support to address the social and emotional needs of children currently enrolled in services, much less children with difficulties solely in social and emotional delays. Since 2003, Alaska has seen a 56% increase in the number of referrals from child protective services and expects this

number to rise as child protection services and EI/ILP continue to improve communication and understanding of how best to provide supports to these children and families.

2006 data available for Fairbanks, Anchorage, and Mat-Su shows 71 referrals (from child protective services) to 7 enrollments (children receiving services) in Fairbanks; 128 referrals to 23 enrollments in Anchorage, and 11 referrals and no enrollments in Mat-Su.

A1: Strategy - Improve the referral process from Children's Protective Services to Early Intervention/Infant Learning Program services.

Target #1: Increase the percentage of screenings provided to children ages 0-3 and attain federal compliance.

Measure #1: Change in the percentage of completed referrals.

Percent of Early Intervention/Infant Learning Program Referrals

Fiscal Year	Percent Referred	Rate of Change	Target
FY 2003	14%	0	
FY 2004	25%	79%	
FY 2005	28%	12%	
FY 2006	35%	25%	100% or 800 Screenings

Analysis of results and challenges: The Early Intervention/Infant Learning Program (EI/ILP) goal is to attain federal compliance within the next three years -- meaning, 800 of 800 required screening for Alaska children ages 0-3 will be performed through the program. Currently, EI/ILP is screening approximately 40% of the required 800.

As shown above, the program has made steady progress for the past four years, but has work to do. Not only do the number of screenings need to go up, but the availability of services required as a result of each screening needs to increase. Currently, programs do not have the capacity to provide adequate training and support to address the social and emotional needs of these children.

The program, if funded, is planning to implement strategies to ensure access to adequate training and supports for the anticipated influx of children into the program.

A2: Strategy - To reunify children in out-of-home placements with parents or caretakers as soon as it is possible.

Target #1: Increase the rate of children reunified with their parents or caretakers within 12 months of removal.

Measure #1: The percent of children reunified with parents or caretakers at the time of discharge from foster care in less than 12 months from the last removal.

Rate of Reunification

Fiscal Year	Alaska Rate	National Standard
FFY 2001	62.4%	76.2%
FFY 2002	53.3%	76.2%
FFY 2003	54.7%	76.2%
FFY 2004	54.7%	76.2%
FFY 2005	53.3%****	76.2%
FFY 2006	61.5%	76.2%

Data Source: Alaska's Online Resources for the Children of Alaska submission to the National Child Abuse and Neglect Data System.

*****Introduction of the Online Resources for the Children of Alaska (ORCA) case management system. With the transition from the old case management system (PROBER) to the new ORCA system, data definitions, policies, and collection procedures have been changed to conform with federal requirements. While the underlying federal methodology for computing measures remains the same, measures computed from these two different systems should not be considered comparable.*

Analysis of results and challenges: This measure represents the percentage of children that were returned to their parents or caretakers in less than twelve months from the time of the latest removal, known as the rate of reunification. While the OCS did achieve its goal as mandated by the Federal Performance Improvement Plan, there is much room for improvement in reunifying children with their families in a twelve month period.

With so much effort being placed on the new rollout of the safety assessment and emphasis on the front end of an OCS intervention to keep children safe, outcomes aimed at achieving permanency for children have decreased by a small margin.

Efforts to improve this measure include collaboration with the Court Improvement Committee to highlight the need for Assistant Attorney Generals, Guardians ad Litem, Court Appointed Special Advocates, and judges to assist in helping the OCS to achieve permanency goals more timely.

By implementing the new safety model, permanency workers will be better equipped to determine whether children can be returned to their families sooner if the safety threats have been remedied and risk factors are all that remain. The premise behind the new safety model encourages workers to continue to assess through the life of the case whether children can be safely returned to their parents before all of the case plan requirements are met. If the reason OCS took children into custody was due to the child being unsafe, than the threshold for their return ought to be the same. On-going case plans can be monitored with children in their homes more easily with the family reunified than by requiring the family have achieved success by reducing all the risk factors as well.

Further, in 2004 the OCS released a new Request for Proposals (RFP) for Time Limited Family Reunification. The RFP was designed to help reduce the numbers of children experiencing repeat maltreatment and also to help increase the numbers of children being reunified with their families when they were in out-of-home care.

This model provided that the grantees use an assessment process to be completed with the family upon entry into the program and at different intervals in the life of the case, in order to assess the progress and safety factors as well as increase family functioning to ensure reunification. The RFP also provided for an in-home component to provide face-to-face contact with the family to gather assessment information and formulate a reunification plan. Reunification data is being captured from quarterly narrative reports and results should be available January 2007.

B: Result - Safe and timely adoptions.

Target #1: Increase the annual number of completed adoptions.
Measure #1: Number of children placed in adoptive homes annually.

Number of Children Adopted from State Custody by Federal Fiscal Year

Fiscal Year	Children Adopted	Annual Change
FFY 2001	278	75
FFY 2001	222	-56
FFY 2003	201	-21
FFY 2004	179	-22
FFY 2005	191	12
FFY 2006	197	6

Data Source: Online Resources for the Children of Alaska (ORCA)

Analysis of results and challenges: Since the passage of the Adoption and Safe Families Act of 1997, Alaska has seen an increase in the number of finalized adoptions for children from the Office of Children's Services (OCS) custody. As of June 30, 2006, there were 1,989 children (approximately 87% federally funded and 13% state-funded) in the subsidized adoption program. Each year the OCS sees at least 150 children who are able to achieve permanency through adoption in the OCS system. The chart above shows the number of finalized adoptions as reported by Federal Fiscal Year. It is anticipated that over the next year the adoptions of children in the OCS custody will increase as OCS places continued emphasis on meeting the 15 out of 22 month timeframes outlined in the Adoption and Safe Families Act.

B1: Strategy - Implement resource family assessments.

Target #1: Increase the number of resource family assessments completed annually.
Measure #1: Number of resource family assessments completed annually.

Annual Number of Resource Family Assessments Completed

Fiscal Year	RFAs Completed	Change
FY 2005	15	0
FY 2006	27	12

Data Source: Office of Children's Services Adoption Subsidy Unit.

Prior year data is not available at this time. FY 2006 marks the first year this plan was administered by the Adoption Subsidy Unit.

Analysis of results and challenges: During the past fiscal year, the Office of Children's Services (OCS) has initiated an implementation plan for resource family assessments. Under previous OCS policy and practice, the process of licensing a resource family for foster care and the process for approving a family for an adoptive home were treated as separate, yet duplicative processes. Thus, families who initially were licensed for foster care (relative or non-relative) who were selected as the

adoptive family for a specific child, were required to undergo a second assessment of their home and family before the adoption could be finalized.

The resource family assessment consolidates the licensing and approval processes into one streamlined process. Additionally, the resource family assessment provides a better assessment outcome so that matching of families with a child's needs is more appropriate. This matching allows for adoptive placements of children which are sensitive to the child's familial, cultural, and emotional ties at an earlier stage in the placement process. Thus, when the adoption plan is made for the child, the child does not need to make a placement change.

Phase I and Phase II of the implementation plan included an urban pilot in Anchorage and a rural pilot in several remote communities in Alaska. The results of these phases have indicated that improved placement decisions and outcomes are occurring through resource family assessments, with a greater emphasis on the assessment of risk and safety to children in the adoptive homes.

A total of 42 resource family assessments were completed during the Phase I and Phase II of the plan. The OCS anticipates a 100% increase in the number of completed resource family assessments during FY 2007 as compared to FY 2006, as the new resource family assessment procedures are incorporated into the OCS practice.

During the next fiscal year, the OCS will work to reach its goal of a 100% increase in the number of resource family assessments that are completed throughout Alaska to insure greater safety outcomes to adoptive children.

B2: Strategy - Promote the use of adoption exchanges to recruit adoptive homes.

Target #1: Increase recruitment of resource family homes.
Measure #1: Number of resource family homes recruited annually.

Number of Resource Family Homes Recruited Annually

Year	Initial Inquiries	# of Families Processed	Percent Processed
2006	102	63	62%

Data Source: Office of Children's Services Adoption Subsidy Unit.

Prior year data is not available at this time. FY 2006 marks the first year this plan was administered by the Adoption Subsidy Unit.

Analysis of results and challenges: The Office of Children's Services (OCS) participates in a state, regional, and national adoption exchange to assist with the identification of potential adoptive families for children in the OCS custody. The exchanges provide an opportunity to list the child and describe the family that would be best suited to meet the child's special needs in an effort to locate a family to adopt the child.

In Alaska, the use of the Alaska, Northwest and AdoptUsKids exchanges allows for the OCS to reach a broader network of waiting adoptive families throughout Alaska and the United States.

A total of 102 potential resource families made initial inquiries to the OCS for information on becoming a licensed resource family with the OCS. Of these 102 families, 63 families (60% of the initial inquiries) continued with the resource family orientation, training and licensing process with the OCS. OCS intends to increase the percentage of resource families who initiate the resource family licensing process to 70% of the total number of initial inquiries during the next fiscal year.

B3: Strategy - Promote the adoption of older youth ages 12 - 18.

Target #1: Increase the number of adoptions for youth age 12-18.
Measure #1: The annual number of youth age 12-18 who are adopted.

Number of Youth Age 12 - 18 Adopted by Federal Fiscal Year

Fiscal Year	# Adopted	Change
FFY 2005	36	0
FFY 2006	36	0

Data Source: Online Resources for the Children of Alaska (ORCA) to the federal Adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis of results and challenges: In the summer of 2006, the national focus for adoption was on the adoption of older youth from the child protection system. In Alaska, the focus on the increase of older youth adoptions (children 12-18 years of age) is a specific target for the next fiscal year. National research studies have indicated that children who age out of the foster care system have greater life challenges than children who leave the foster care system with connections to significant adults (parents, mentors, adoptive parents, guardians). For this reason, the OCS has focused on assisting older youth with developing and maintaining permanent connections in their lives, and for many of these youth, the connections will need to be legally permanent as well.

In FFY 2005, 36 children between the ages of 12-18 were adopted through the OCS foster care system. In FFY 2006, this number remained consistent within the same age group.

In FFY 2005, nearly 19% of the children who were adopted through the OCS were between the ages of 12-18; in FFY 2006 it is estimated that this percentage is closer to 15%. For the next fiscal year, the OCS is anticipating increasing the number of finalized adoptions for children 12-18 years of age by 25% from the FFY 2006 numbers.

Health Care Services

Mission

Manage health care coverage for Alaskans in need.

Introduction

Under the Department of Health and Social Services (DHSS), the Division of Health Care Services (HCS) maintains the Medicaid core services including hospitals, physician services, pharmacy, dental services, and transportation. Other Medicaid core services maintained by the division include physical, occupational, and speech therapy; laboratory; radiology; durable medical equipment; hospice; and, home health care. On a department-wide basis, HCS administers the following:

Core Services

- State Children's Health Insurance Program (SCHIP)
- Medicaid Management Information System (MMIS)
- Claims payments and accounting
- Third-party liability collections and recoveries
- Federal reporting activities
- Medicaid financing activities
- Chronic and Acute Medical Assistance Program

In addition, the division's major goal has been to support services through management efficiencies and the capitalization of Medicaid financing.

Services Provided

Pharmacy and Ancillary Services Unit
Provides management including researching, analyzing and implementation changes in coverage of services for the following Medicaid Provider service programs: Pharmacy, Private Duty Nursing, Hearing and Audiology, Home Infusion Therapy, Respiratory Therapy. This unit provides policy, planning, regulation development, oversight, and management. Other programs administered in this unit include Drug Utilization Review, Preferred Drug List, Pharmacy and Therapeutics Committee, and the Behavioral Pharmacy Management Service.

Facility Relations Unit (FRU)
Performs policy and program management for Medical Assistance services performed at institutional facilities such as hospitals and ambulatory surgical centers and services performed by end-stage renal disease dialysis centers, federally qualified health centers, and rural health clinics. It is the responsibility of the FRU to ensure that the applicable federal and state regulations are applied to the provision and reimbursement of these services, evaluate program policy, procedures and operations to assure effective and efficient compliance, and develop and implement new or revised programs or initiatives for these service categories. In addition to the provision of contract monitoring and oversight of the full spectrum of fiscal agent services for all these provider types, the FRU is responsible for oversight and monitoring of the quality improvement organization (QIO) contracted to perform both utilization management through the prior authorization of selected inpatient stays and outpatient procedures, and case management services for clients with complex medical conditions.

Practitioner Relations Unit (PRU)
The PRU is responsible for assuring that program policies are consistent with current medical standards of practice; and, ensures the relationships with consumers and medical providers are maintained at the highest possible level. The PRU has developed and maintained relationships with various professional organizations and seeks their professional input into policies and programs. The PRU assists in answering difficult clinical questions which arise from medical providers, recipients, and the fiscal agent. The PRU is responsible for reviewing and determining coverage of services to assure that they are in compliance with both state and federal regulations and statutes.

Program Integrity (PI) Unit
The PI Unit is responsible for complaint investigations, reviews, and audits. Program integrity processes and activities are designed to provide for efficient, economical, and effective administration of the Medicaid Program. The PI unit assures that processes are in place to identify inappropriate activity, investigate, and refer suspected cases of fraud and abuse to the Office of Program Review, which in turn may be referred to the Medicaid Fraud Control Unit. Through contract management assures that complaints are received and investigated. Complaints may involve either recipient conduct or a providers Medicaid billing practices. PI staff along with the fiscal agent may periodically analyze and profile providers to determine which providers may need investigation.

Accounting and Recovery Section
The accounting and recovery section is currently comprised one manager and two sub-sections, an Accounting Unit and a Third Party Liability and Recovery (TPL) unit. The TPL unit consists of one supervisor, three technical support staff and one clerical support staff. The accounting and collections sub-unit consists of, one professional accountant and three technical support staff. The

Accounting and Recovery section provides financial services to support the Division of Health Care Services as well as the other Medicaid divisions.

The primary responsibilities of the TPL sub-unit include working pended claims related to TPL, collection of third party payments, working Pay and Chase claims, administration of the Medicare buy-in and Drug Rebate programs, and the oversight of our post payment review and cost avoidance contractor, Health Management Systems. The TPL unit also administers the disabled working program, the estate recovery program, and the unit works with the Department of Law on Subrogation cases. TPL recoveries are made on behalf of the Division of Health Care Services (DHCS) Division of Senior and Disability Services (DSDS), and the Division of Behavioral Health (DBH).

The primary responsibilities of the Accounting unit include the oversight and management of the accounting interface between the Medicaid Management Information System (MMIS) and the State Accounting System, ensuring weekly check writes are approved, reconciled, and issued. The internal accounting functions are provided for the DHCS, DSDS, and DBH. The unit also provides financial oversight for the State Pharmaceutical Assistance Program (SPAP).

Recipient Services Unit (RSU)
The RSU is responsible to assist Medicaid recipients and health care providers in appropriately accessing benefits and resolving grievances. RSU monitors recipient travel under the State Travel Office, manages the statewide Early Prevention, Screening, Diagnosis, and Treatment program, coordinates Fair Hearing requests, represents the Agency at Fair Hearing, and monitors the Fiscal Agent's performance with prior authorization, the Recipient Helpline, provider enrollment and the Care Management Program. Recipient Services intercedes in recipient and provider disputes regarding eligibility and claims processing.

Chronic and Acute Medical Assistance (CAMA)
The CAMA program provides a limited package of health services to those individuals with chronic medical conditions who do not qualify for the Medicaid program. CAMA's limited benefits are used to reimburse providers of medical care treatment of a person suffering from illness or accident where unpaid medical costs incurred results in financial catastrophe to the person or the person's family.

For qualified applicants, a formula is developed to determine an applicant's share of the total medical expenses. This formula is adopted in light of appropriated funds and expected needs. This formula is derived based on the applicant's annual gross income, number of dependents, amount of assets, and forthcoming third-party payments. Once this criteria is taken into consideration, the applicant's share is calculated and shall be paid to the provider on a payment schedule covering a period of at least three years.

These funds provide services to Alaska's indigent for prescription drugs for the terminally ill, chemotherapy patients, and people with certain chronic conditions that without treatment would lead to disability, death, or financial disaster.

Health Care Medicaid Services

- In SFY06, Health Care Medicaid Services provided benefits to 122,000 Alaskans, 92% of the 132,000 enrolled.

- Hospital and physician services comprised 62% of the total costs for this component (40% and 22%, respectively). Physician services grew 2% from FY05 to FY06; hospital services decreased 5% during the same period.

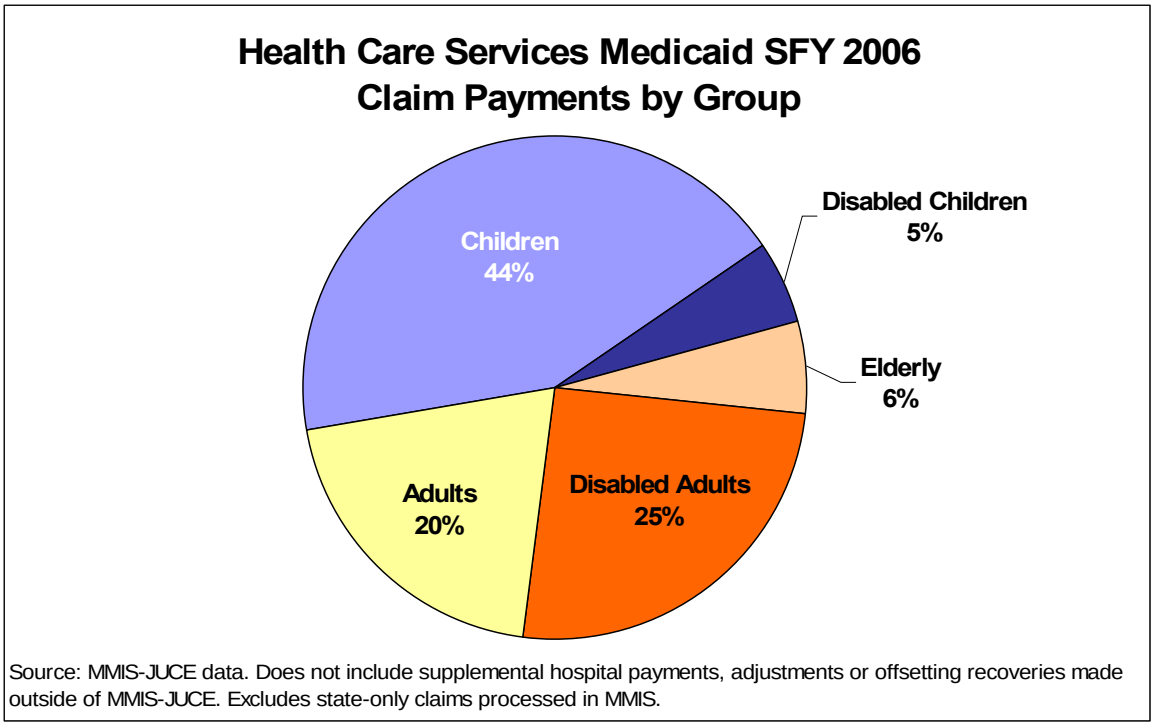
- Children received nearly half (49%) of the dollars spent on Health Care Medicaid Services' claim payments. Claim payments for adults represented 45% of Medicaid payments for benefits, while the elderly accounted for 6%.

Number of Medicaid Beneficiaries in SFY 2006 in the Top 5 Service Categories in HCS Medicaid

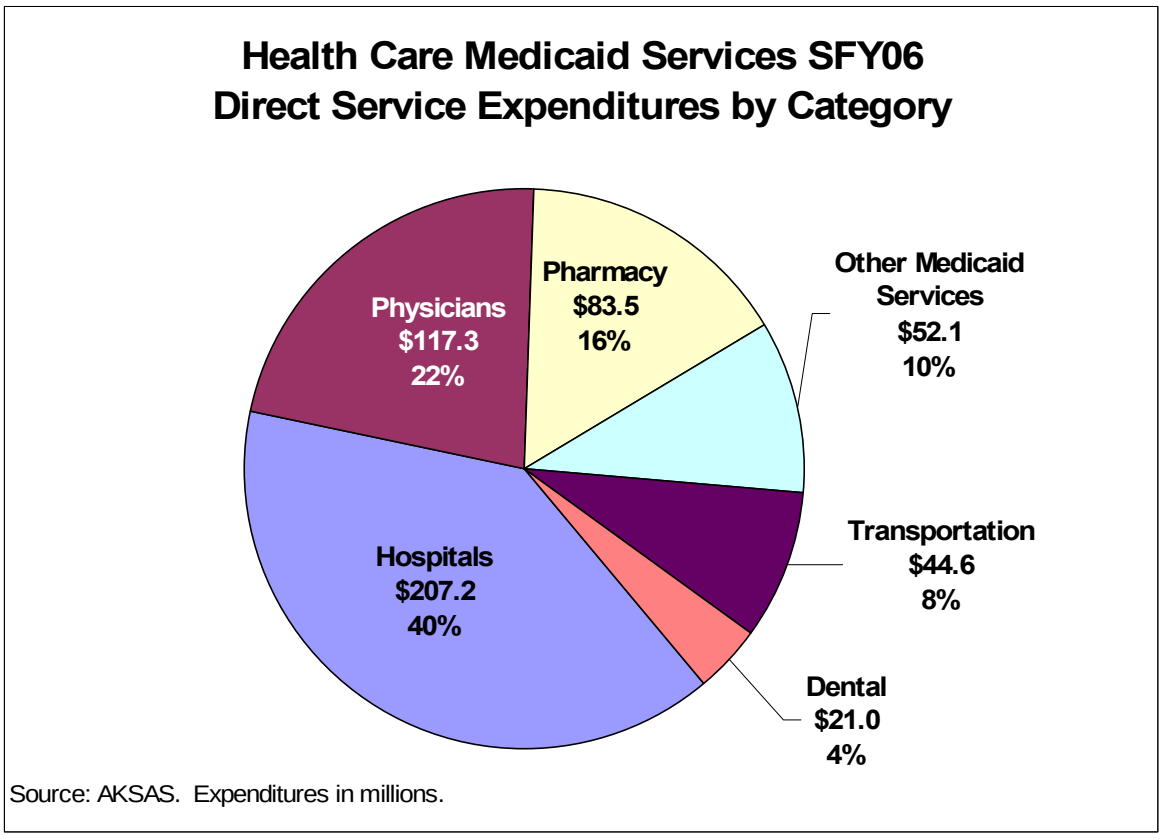
	Hospital Services	Physician Services	Prescription Drugs	Transportation Services	Dental Services	Total (Sum)	Unduplicated by Benefit Group
Children	37,812	64,581	43,778	12,835	33,070	192,076	78,551
Adults	14,428	18,660	15,781	4,891	3,953	57,713	22,536
Elderly	4,887	6,155	6,185	2,474	597	20,298	7,295
Disabled Childre	925	1,451	1,358	517	681	4,932	1,830
Disabled Adults	9,545	11,792	11,645	3,578	2,315	38,875	13,817
Total (sum)	67,597	102,639	78,747	24,295	40,616	313,894	
Unduplicated by Service	66,873	101,441	77,827	24,094	40,537		122,020

Source: MMIS-JUCE. Unduplicated count of individuals.

*The sum of the groups may not equal the total for the category because beneficiaries can receive services in multiple categ



Source: MMIS-JUCE data. Does not include supplemental hospital payments, adjustments or offsetting recoveries made outside of MMIS-JUCE. Excludes state-only claims processed in MMIS.

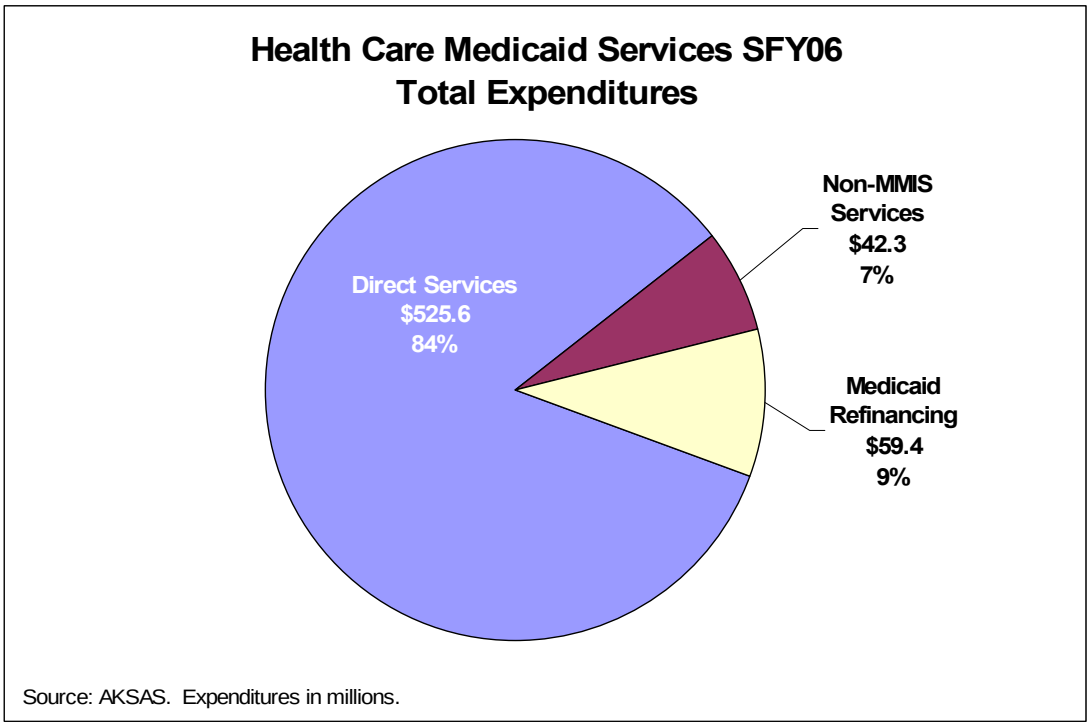


Source: AKSAS. Expenditures in millions.

- Of the almost $631 million Health Care Services spent on Medicaid services in SFY06, 84% were for payments to health care providers for direct service claims.

- Hospitals garnered the largest share of direct services claims (40%); physician services accounted for 22% of the claims and pharmacy was responsible for another 16%. The

remaining 22% was split between transportation, dental, and other services (including durable medical equipment, vision, and physical/occupational/speech therapy, home health and hospice, and chiropractic care).



SFY 2006 DIVISION LEVEL SUMMARY: Health Care Services Medicaid	DHCS MEDICAID CLAIMS (DIRECT SERVICES ONLY)						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Annual Total	Annual Total		Recipients *	Payments
Medicaid, Unduplicated Annual		**122,020**		**$554,859,335**	**$4,547**	**99.2%**	**56.7%**
Gender							
Female	57.0%	69,625	60.0%	$332,840,909	$4,780	99.4%	59.8%
Male	43.0%	52,453	40.0%	$222,017,835	$4,233	99.0%	52.6%
Unknown	0.00%	2	0.0%	$590		100.0%	100.0%
Race							
Alaska Native	37.2%	45,894	43.8%	$242,920,461	$5,293	99.4%	65.9%
American Indian	1.4%	1,775	1.4%	$7,984,191	$4,498	99.5%	60.1%
Asian	5.2%	6,460	3.7%	$20,496,614	$3,173	99.6%	45.6%
Pacific Islander	2.6%	3,217	1.8%	$10,249,287	$3,186	99.5%	55.4%
Black	5.1%	6,317	4.4%	$24,411,242	$3,864	99.1%	54.8%
Hispanic	3.5%	4,329	2.5%	$13,917,194	$3,215	99.7%	62.5%
White	41.5%	51,104	39.6%	$219,760,991	$4,300	99.0%	50.2%
Unknown	3.4%	4,194	2.7%	$15,119,353	$3,605	98.2%	52.3%
Native	38.9%	47,635	45.2%	$250,904,653	$5,267	99.4%	65.7%
Non-Native	61.1%	74,856	54.8%	$303,954,682	$4,061	99.1%	50.9%
Age							
under 1	9.1%	12,059	15.1%	$83,926,535	$6,960	99.9%	99.7%
1 through 12	37.3%	49,319	18.5%	$102,486,486	$2,078	99.4%	70.5%
13 through 18	16.9%	22,395	12.4%	$68,542,398	$3,061	98.4%	41.8%
19 through 20	3.2%	4,258	3.4%	$18,847,506	$4,426	98.6%	73.5%
21 through 30	10.1%	13,342	12.4%	$68,710,989	$5,150	99.2%	67.9%
31 through 54	13.8%	18,316	23.7%	$131,477,771	$7,178	99.2%	62.0%
55 through 64	3.3%	4,393	7.8%	$43,385,747	$9,876	98.9%	55.6%
65 through 84	5.4%	7,105	6.0%	$33,469,728	$4,711	97.8%	25.8%
85 or older	0.9%	1,168	0.7%	$4,012,175	$3,435	95.1%	10.4%
Benefit Group							
Children	63.3%	78,552	43.5%	$241,188,253	$3,070	99.4%	68.9%
Adults	18.2%	22,536	20.2%	$112,050,490	$4,972	99.5%	96.7%
Disabled Children	1.5%	1,830	5.0%	$27,971,207	$15,285	95.2%	51.1%
Disabled Adults	11.1%	13,823	25.3%	$140,567,587	$10,169	98.8%	46.7%
Elderly	5.9%	7,295	6.0%	$33,081,798	$4,535	97.4%	21.1%

Payments: Net amount of paid claims. Amounts do not reflect payments for Medicaid services made outside of the Medicaid management information system such as lump-sum payments, recoveries, or accounting adjustments. Therefore, these amounts will not tie to AKSAS or ABS.

Enrollment: Number of persons eligibile for Medicaid and enrolled at some time during state fiscal year 2006. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,benefit group, and region categories). Some duplications may occur in subgroup counts. For example, a child might be counted in the under 1 subgroup but also in the 1 through 12 subgroup after their first birthday.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2006. Service may have been incurred in a prior year. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,benefit group, and region categories). Some duplications may occur in subgroup counts.

Participation: Recipients as a percent of eligible persons (as a percent of enrollment). The percent of eligible persons having claims paid or adjusted during the fiscal year. The number of persons with claims paid in this fiscal year for services incurred in a prior fiscal cycle may cause the calculated %participation to exceed 100%.

Department-wide recipient counts are unduplicated across divisions.

Source: HSS, Finance and Management Services, Medicaid Budget Group.

AS 47.07 Medical Assistance for Needy Persons
AS 47.08 Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25 Public Assistance

Title 42 CFR Part 400 to End
Title XVIII Medicare
Title XIX Medicaid
Title XXI Children's Health Insurance Program

7 AAC 43 Medicaid
7 AAC 48 Chronic and Acute Medical Assistance

Health Care Services	2007	2008 Proposed	07 to 08 Change
General Funds	201,085.4	230,399.1	29,313.7
Federal Funds	535,355.5	566,386.4	31,030.9
Other Funds	21,759.1	23,509.1	1,750.0
Total	**758,200.0**	**820,294.6**	**62,094.6**

**Totals include Adult Preventative Dental Medicaid Svcs. This is a new component for partial year FY2007 as appropriated by fiscal note CH 52 SLA2006 (HB105) (Ch33 P41 L30 & Ch 34 P34 L9). Increase from 2007 to 2008 is due to the programs partial implementation in FY07, this program will be fully operational in FY08. Fund source breakdown for FY2007 is $219.7 GF/$1,988.3 Fed/$425.0 Other; and for FY2008 $1,309.2 GF/$7,557.8 Fed/$1,425.0 Other.*

Health Care Services Medicaid

Upper Payment Limit Decline – ProShare Fund Change $4,044.0 Federal / $4,044.0 GF Match
This change record replaces a federal funding reduction in the Medicaid ProShare program. The ProShare program allows the state to make payments to qualifying hospitals for the difference between Medicare and Medicaid rates. This difference is called the Upper Payment Limit or UPL.

Typically Medicaid rates do not cover the full billed amount for services so some providers choose not to see Medicaid patients. General hospitals, however, are required to see patients regardless of their income or insurance coverage. UPL helps to compensate these hospitals for the cost of providing care to persons who are publicly insured. The department has made payments to hospitals and community health care providers for several years under this program and ProShare is an important part of the department's strategy to provide access to quality health care services. ProShare funds have supported rural health care, mental health care, and children's health care programs that benefit many Alaskans.

ProShare payments are eligible for average federal reimbursement of 53.76% in FY08 (57.58% from July-Sept. 2007 and 52.48% from Oct. 2007-June 2008), but only up to the amount of the UPL allotment. Any amount of ProShare over the allotment does not receive federal reimbursement. Since 2003 the UPL allotment had increased annually and the total amount of ProShare expenditures was below the cap. The funding need arose because an audit finding changed the way the department calculates the UPL and shortened the amount of time to expend it. The additional funding is needed because the change resulted in a UPL allotment lower than our current ProShare payment level. Without ProShare the same services would have to be funded through grant programs that are totally GF.

The department is committed to continue ProShare funding at the same level in support of its mission to manage health care for Alaskans in need. The additional GF would allow the department to continue providing the same level of services.

Medicaid Rate Increase - Primary Care $4,257.6 Federal / $3,742.4 GF
Reimbursement rates for Medicaid physician services (fee for service only) are tied to Medicare rates through relative value units (RVU's) determined by the Centers for Medicaid and Medicare Services (CMS). CMS will be re-basing Medicare reimbursements for each covered procedure, effective January 1, 2007. The State bases its Medicaid rates on the Medicare rates, and will need to change them as Medicare rates change.

Both Medicare and Medicaid use the resource-based relative value scale (RBRVS) formula to determine reimbursement rates for procedures billed by primary care physicians. In the formula, both RVU and geographic cost payment indexes (GCPI) have separate components adjusting for the cost of work, operating costs, and insurance/malpractice costs. Medicare rates are determined by RVU, GCPI, and state conversion factors established by the CMS. Alaska Medicaid reimbursement is determined using the Medicare RVUs for a procedure, coupled with the GCPIs and conversion factor established in Alaska regulation [7 ACC 43.108]. The Medicaid conversion factor has not been changed since its implementation in 1997, when the RBRVS methodology was adopted.

Reimbursement rates for Medicaid primary care services provided by IHS physicians are adjusted annually by the Indian Health Service (IHS) and are not subject to the RBRVS formula. Encounter rates for clinics (IHS, federally qualified health clinics, and rural health clinics) are also not subject to the RBVRS method for re-basing.

Because of the large number and variety of Current Procedural Terminology, or CPT codes, used for billing physician services and the fact that each is reviewed separately for RVU's by CMS, it is difficult to estimate the net impact of Medicare rate adjustments on the division's Medicaid budget until CMS publishes the new rates in the federal register. CMS has predicted that they will be lowering RVU's for some procedure codes but substantially increasing the RVU's for evaluation and management procedures.

Evaluation and management procedures such as office visits and hospital visits are the most frequently billed codes for Medicaid primary care services in Alaska. Fee for service claims comprised almost 95% of physician services payments in 2005 and about two thirds of that was for procedures billed by non-IHS physicians. About 60% of non-IHS physician fee for service payments were for evaluation and management procedures in 2005.

Medicaid Facility Rates Rebased – Hospitals $3,224.8 Federal / $2,779.4 GF
This increment is necessary to maintain acute care hospital services at their current level.

By regulation, payment rates for most facilities must be re-based at least every four years [7 AAC 43.685(a)(6)(B)]. Hospital, nursing home, and inpatient psych hospital facilities were last re-based in SFY04.

Hospital payment rates for FY08 will be adjusted based on review of FY06 operating expenses and Medicaid billing activity for each facility. The new rate for each facility will become effective at the start of that facility's 2008 fiscal cycle. The department estimates that rates will be adjusted by an average of 8%.

Hospitals that will bill under re-based rates for the full 12 months of FY08 include Petersburg Medical Center, Sitka Community Hospital, South Peninsula Hospital, Providence Seward Medical Center, and Providence Valdez Medical Center. Alaska Regional Hospital, Fairbanks Memorial Hospital, Providence Alaska Medical Center, and Valley Hospital will only bill under new rates for the last six months of the fiscal year. Remaining in-state hospitals subject to review under this regulation will re-base effective FY09.

Not all hospitals providing services to Alaska Medicaid patients are subject to the re-basing addressed by this increment. Payment rates for smaller in-state facilities (acute care, specialty, or psychiatric hospital or combined acute care hospital-nursing facilities billing 4,000 or fewer acute care patient days, or freestanding nursing home facilities billing 15,000 or fewer nursing facility

days) are determined using a different methodology, established under a separate regulatory authority [7 ACC 43.689]. Payment rates for out-of-state facilities are determined by that outside state. This analysis assumes no significant rate changes for small Alaska facilities or for out-of-state facilities.

Data for Indian Health Service (IHS) facilities has been excluded from this analysis. The only IHS hospital facility currently subject to re-basing by the department under 7 ACC 43.685 is Norton Sound Regional Hospital. It will rebase effective July 1, 2008 (FY09) and its re-basing will not affect the requested increment. Payment rates for most other IHS facilities are determined annually by the federal government.

To calculate the increment required to cover facilities rate increases in FY08, the percentage of non-IHS hospital payments made to hospitals scheduled to re-base for the full 2008 fiscal year and the percentage made to non-IHS hospitals scheduled to re-base for only the last six months were determined, based on Medicaid claims payments for all non-IHS inpatient, outpatient, and outpatient surgery hospitals in SFY06. Less than a third (29%) of payments for non-IHS hospital services will be impacted by re-based rates in FY08.

Increase Disproportionate Share Hospital (DSH) - Hospitals Uncompensated Care $11,499.7 Federal / $11,201.9 GF/Match

This increment allows the department to fully utilize its annual Medicaid Disproportionate Share Hospital (DSH) federal allotment by providing the necessary GF match. Hospitals that provide a disproportionately high share of care to persons who are uninsured or underinsured may qualify for DSH payments to help offset their loss of revenue for uncompensated charity care.

The State of Alaska will use the additional Medicaid funds to make payments to hospitals for the otherwise uncompensated cost of charity care for the uninsured or underinsured. The state plans to negotiate agreements with qualifying hospitals to preserve or expand health care services that will benefit the state or local community.

Full utilization of the DSH allotment furthers the department's mission to manage health care coverage for Alaskans in need. The number of uninsured adults has grown steadily since 2000. Many underinsured and uninsured patients wait to seek needed care until it becomes an emergency, increasing the cost of their care and placing pressure on the health care system. They are seriously impacted by waiting until they have a health care emergency - their recovery may take longer, and sometimes they will put their lives in jeopardy. The health care needs of the uninsured and underinsured have a huge impact on hospitals and other health care providers in Alaska, as well as on the Department of Health and Social Services. Many Alaska hospitals have a high amount of uncompensated care. These hospitals often have low private caseloads and are thus less able to shift the cost of uncompensated care to privately insured patients.

The department does not currently have sufficient funding to expend the full allotment. Under federal and state laws, there are mandatory programs for qualifying hospitals that must be met: institutes for mental disease (such as Alaska Psychiatric Institute), Medicaid inpatient utilization, low-income DSH, single-point-of-entry psychiatric hospital, and designated evaluation and treatment hospitals. Without additional funding the department can only make the mandatory DSH payments.

In FFY08, Alaska's allotment of federal DSH funds is projected to be $19,186.7 (federal) which will require $16,864.9 GF in matching funds to expend the full $36,051.6. The increment of $22,701.6

(11,499.7 fed/11,201.9 GF) is the difference between the amount allocated in the HCS Medicaid Services component for DSH of $13,350.0 ($7,686.9 federal/5,663.1 GF) and the amount needed to fully utilize the FFY08 allotment.

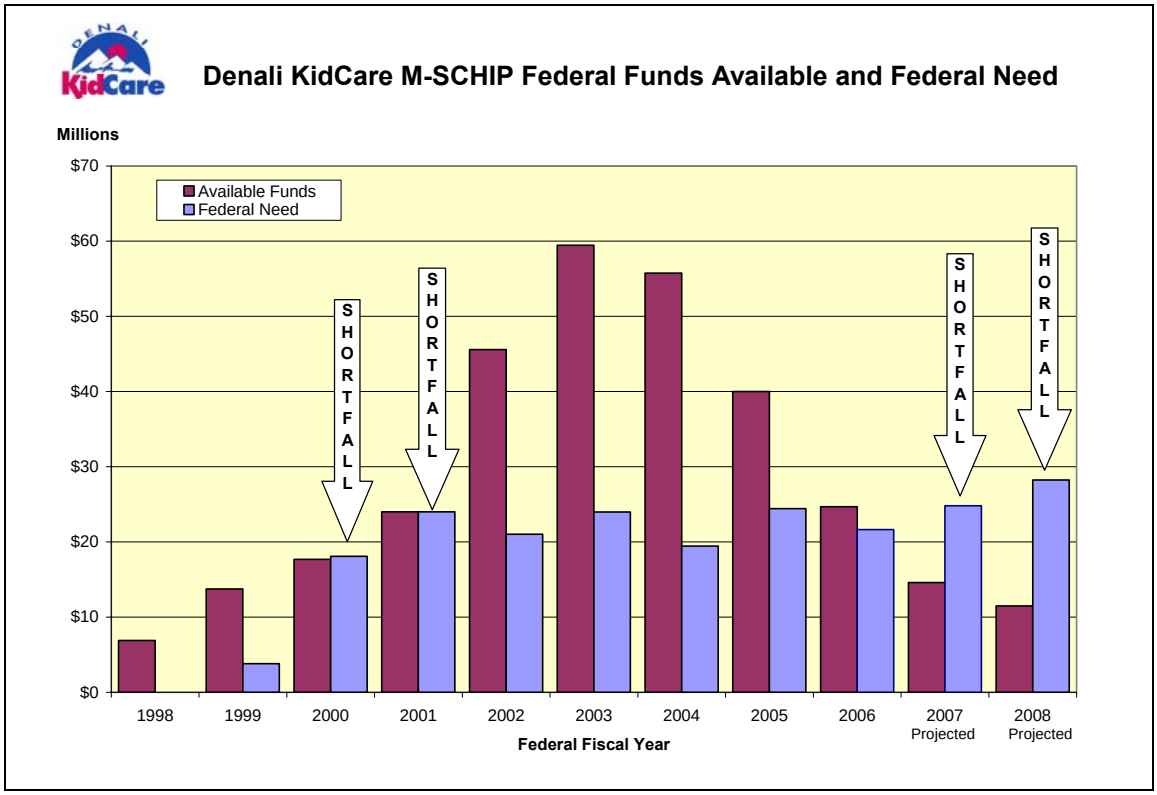
FFY08 Medicaid SCHIP Allotment Shortfall Fund Change $2,612.1 Federal / $2,612.1 GF/Match

This request replaces lost federal revenues resulting from a decrease in the amount of federal funds available for the State Children's Health Insurance Program (SCHIP), a part of Alaska's Medicaid program operated through Denali KidCare. This increment is necessary to maintain the current level of health care provided to these children and supports the department's mission to manage health care for Alaskans in need.

SCHIP helps reach uninsured children whose families earn too much to qualify for regular Medicaid but not enough to afford private coverage. Each month, SCHIP provides health coverage for about 9,000 uninsured children under age 19. Without this funding, low-income children now enrolled in Denali KidCare could lose their SCHIP health coverage and become uninsured.

The federal and state governments jointly fund SCHIP. The amount of federal funding depends on the federal SCHIP allotment which has not grown to keep pace with SCHIP expenditures. The federal medical assistance percentage, or FMAP, determines the amount of state matching funds. The state receives a higher, enhanced FMAP for SCHIP than for regular Medicaid; however, this enhanced reimbursement is capped at the SCHIP allotment. If costs exceed available SCHIP funds, claims are reimbursed at the lower, regular FMAP, resulting in reduced federal revenues. Alaska will have only 41% of the federal SCHIP funding needed to cover program expenditures in 2008, exhausting its SCHIP funds in the second quarter. When it reverts to regular Medicaid, the difference in federal reimbursement rates means that Health Care Services Medicaid Services component will need an additional $2,612.1 GF in 2008.

Alaska's annual allotment has fluctuated between $7 and $11 million. Since Alaska's annual allotment represents only about 25% of our costs, we have relied heavily on unspent funds from other states which were redistributed to Alaska to maintain access to the enhanced FMAP. As more and more states have increased their SCHIP programs, there is less and less redistributed funding available and we do not anticipate any further redistributions.



FY08 Projected Medicaid Growth $17,194.9 Federal / $7,696.2 GF/ $750.0 SDPR

For FY08, Health Care Services' Medicaid costs are projected to grow 3% over the authorized amount of $ 725,226.2. This increment request is necessary to maintain the current level of long term health services in Medicaid. The Medicaid Services component funds acute health care services such as hospitals, physicians, pharmacy, and dental and other Medicaid services such as premium assistance and supplemental hospital payments.

Similarly, the Kaiser Commission on Medicaid and the Uninsured recently released a "50-state annual survey about budget conditions and Medicaid cost containment actions in FY2006-07 which found that an improved economy combined with the implementation of the new Medicare prescription drug benefit has contributed to the lowest rate of Medicaid spending growth in a decade (3%)…Despite the slowed growth, state Medicaid officials indicate that growing health care costs and the erosion of employer-sponsored health coverage are two reasons that overall pressure to constrain Medicaid spending has not subsided. In fact, based on budgets states adopted for FY 2007, Medicaid spending growth is projected to increase to 5 percent next year."

In FY06 Health Care Services' Medicaid provided services to approximately 122,000 beneficiaries at an average cost of $379 per person per month. Medicaid Services' claims grew 3% from FY04 to FY06. The projection for FY08 is for the growth rate to remain the same.

Most of the increase can be attributed to hospital services which experienced a 6% increase from FY05 to FY06 due to an increase in the number of hospitalizations. The fastest growing segments are some of the smallest categories of service and therefore do not affect the total growth rate by much. Diagnostic services (laboratory and x-ray), durable medical equipment, and rehabilitation services (occupations/physical/speech therapy and chiropractic) all grew more than 10%. Another contributing factor is an increase in tribal claims for early, periodic, screening, diagnosis and treatment services, which are 100% federally funded.

The fund source projection is based on the actual amount of federal revenue collected in FY06 in this component, 69%, and assumes that the proportion of expenditures eligible for each type of federal reimbursement remains the same. It also assumes that the FY08 average federal medical assistance percentage remains at 57.58% for regular Medicaid and 70.31% for SCHIP.

This increment also provides $750.0 authority for statutory designated program receipts (SDPR) in the Behavioral Health Medicaid Services component for recoveries of overpayments to Medicaid providers discovered through audits.

Per AS 47.05.200 the department is required to audit Medicaid provider payments. Overpayments to the providers must be returned by the provider to the state. The overpayment includes both the federal and state match portion of the original claim. The amount actually recovered can include only the federal funds or the state matching funds, too. This increment provides budget authority to collect the state matching fund portion of the audit recovery.

Year 2 Fiscal Note (HB426) Medical Assistance Eligibility & Insurance Coverage One Time Item $4,218.0 Federal / $3,931.7 GF/Match
HB 426-This bill contains provisions that would help to ensure repayment to the Medicaid program for cases involving Medicaid recipients receiving settlements or judgments from third party payers and would change medical assistance eligibility for minors and persons eligible for Medicaid. The majority of cost reductions are anticipated from the provision that requires Medicaid enrollees who are also Medicare eligible to enroll in Medicare, thereby shifting health costs to the federally-funded Medicare program.

This decrement is for Year 2 of the fiscal note (#4 of 5) and represents a full year's cost reduction.

Transfer funds to Support Rate Review Medicaid Activities $142.0 Federal / $142.5 GF
This is to transfer funds into the Rate Review component for critical Medicaid items:

Independent Certified Audits for Disproportionate Share Hospital Payments: By federal law, beginning with FY 2005 each state must submit an independent certified audit of its Medicaid disproportionate share hospital (DSH) program to the federal Centers for Medicare and Medicaid (CMS) Services to receive Federal disproportionate share hospital payments. The department relies almost exclusively on the DSH program for operational expenses at the Alaska Psychiatric Institute. Annual DSH expenditures of over $15 million generate almost $8 million in federal funds for Alaska.

Although this statutory requirement has been in place since 2005, CMS has not yet adopted regulations regarding the administration of the requirement and therefore has not required submission of the audit. CMS is now under pressure to release the regulations and will likely adopt guidelines outlining the details of the audit requirement in FFY07.

Efficiency Audits of Facilities for Exceptional Relief: Alaska's Medicaid Rate Setting Regulations and State Plan provide for additional payments to hospitals, nursing facilities, federally qualified health centers and rural health clinics under the exceptional relief program. Efficiency auditors are needed to justify exceptional relief by analyzing the facilities staffing models, staffing levels and employee compensation, patient census, length of stay and acuity, physical plant, purchasing and the market within which the facility operates for opportunities to reduce costs. Efficiency audits will allow the department to pay the minimum required in exceptional relief circumstances.

Other critical contracts are needed to ensure the Medicaid rate system is run efficiently.

Adult Dental Change Records

Year 2 Fiscal Note (HB105) Adult Dental Preventative Medicaid Services $5,569.5 Federal / $1,089.5 GF/Match / $1,000.0 MHTAAR

Under this bill, Medicaid dental benefits for the 41,000 adults enrolled in the Medicaid program were expanded to include preventative and restorative care up to a cap of $1,150 per person annually. Prior to the passage of HB 105 only emergency dental care was offered to relieve pain or to fight acute infection. This service expansion makes available such dental services for Medicaid eligible adults as exams, cleanings, tooth restorations or extractions, and upper or lower full dentures, in addition to the existing dental emergency services. The coverage level allows adult Alaskans to receive a complete set of dentures over a two-year period.

The bill has provisions in place to keep total program costs within the fiscal limits set by the legislature. There is an annual cap of $1,150 for dental services for each individual, and a three-year sunset on the program which provides a trial period and an opportunity to evaluate the program. Medicaid program staff will monitor emergency dental service expenditures to assess the impact of preventive/restorative coverage in reducing emergency dental treatment needs.

The budget is based on about 15,800 Medicaid eligible adults receiving preventive and restorative dental services. Of these adults it is estimated about 3,950 Alaska Mental Health Trust Authority beneficiaries would receive these dental services and 5,100 Alaska Natives adults would receive services through the tribal dental programs. The budget estimate includes estimates for increased transportation costs as a result of the service expansion and factors for annual changes in utilization. This utilization increase is partially off-set under the assumption that some adults with longer program eligibility will have decreased treatment needs in later years.

FY2008 will be the first full year of services as implementation is not expected until the 4th quarter of FY2007.

Challenges

In order to provide affordable access to quality health care services to eligible Alaskans, a sufficient supply of providers must be enrolled in Medicaid. A strategy to maintain provider participation is for provider reimbursement rates to keep pace with health care costs. Since provider participation in Medicaid is voluntary, if Medicaid's rates are too low providers may stop seeing Medicaid clients. In FY08 there are several budget proposals to increase rates.

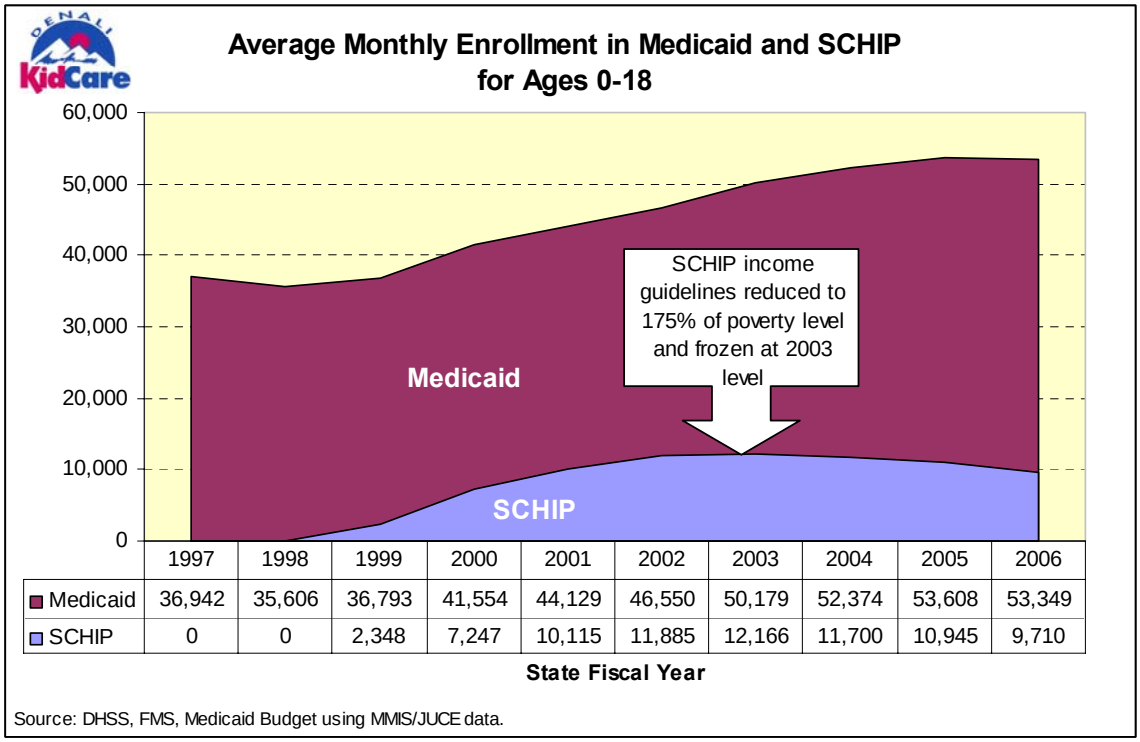
Another issue facing the state is whether or not to restore the Denali KidCare upper income eligibility standards for children and pregnant women. About 8,800 of the state's low-income children are now enrolled in Denali KidCare, compared to 12,500 at the program's peak in 2003.

Many of the children who lost eligibility under SCHIP were able to maintain coverage under the regular Medicaid program. Reducing SCHIP eligibility has cost Alaska federal revenue as regular Medicaid claims have a lower FMAP (52.48% compared to 66.74% for SCHIP).

In September 2003, the Denali KidCare federal poverty limit (FPL) upper guideline for children was reduced from 200% to 175% and frozen at $3,355 per month for an Alaskan family of four.

As the poverty level nationally increases each year with inflation, because Alaska's upper income standard is frozen at the 2003 income level, the percent of the federal poverty limit that the income represents declines.

When the law was changed in 2003 to a fixed amount and became frozen in statute, an income of $3,355 per month for an Alaskan family of four represented 175% of poverty. In 2007 that same $3,355 represents only 160% of the poverty level.



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Medicaid	36,942	35,606	36,793	41,554	44,129	46,550	50,179	52,374	53,608	53,349
SCHIP	0	0	2,348	7,247	10,115	11,885	12,166	11,700	10,945	9,710

State Fiscal Year

Source: DHSS, FMS, Medicaid Budget using MMIS/JUCE data.

Contribution to Department's Mission

To manage health care coverage for Alaskans in need.

Core Services

- Provide access to appropriate health care services.
- Assure access to a full range of health care service information to our customers.

Department Level Measures

D: Result - Outcome Statement #4: To provide quality management of health care coverage services to providers and clients.

Target #1: Decrease average response time from receiving a claim to paying a claim.
Measure #1: Average number of days per annum from receipt of claims to payment of claims.

Operation Performance Summary-Annual Average Days /Entry Date to Claims Paid Date

Fiscal Year	Claims	Avg Days	Days Changed
FY 2000	3,720,254	10	0
FY 2001	4,409,121	12	2
FY 2002	4,959,864	12	0
FY 2003	5,615,072	10	-2
FY 2004	6,690,344	10	0
FY 2005	7,903,523	13	3
FY 2006	7,721,709	12	-1
FY 2007	1,793,488	22	10

Note: Between FY02 and FY03 reports were based on six months of data. Since SFY04 reports are based on annual data. .
Source: MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between first quarter State Fiscal Year (SFY) 2006 and first quarter SFY 2007 increased from 16 days in 2006 to 22 days in 2007.

Three new initiatives, two in the second half of SFY 2006 and the other in first quarter 2007 may provide explanations for the increase of average days. The Personal Care Program instituted a prior authorization process during the third quarter 2006. As part of this new initiative, claims became subject to prior authorization editing. Additionally, regulatory changes for certain Durable Medical Equipment (DME) high-volume supplies occurred during the second half of SFY 2006. This resulted in additional claims pending for evaluation and pricing. Lastly, during the first quarter 2007, several new home and community-based waiver program edits were initiated.

Adding to the hindrance, the Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry. As training is completed and staff becomes more proficient, holdups are improving for the second quarter of SFY 2007.
All of the above would have had impact on processing time.

Target #2: Increase the percentage of adjudicated claims paid with no provider errors.
Measure #2: Change in the percentage of adjudicated claims paid with no provider errors.

Error Distribution Analysis-Change in the percentage of adjudicated claims paid with no provider errors

Fiscal Year	Claims Pd	% No Errors	% Change
FY 2000	3,076,978	72%	0
FY 2001	3,670,331	73%	1%
FY 2002	4,202,677	74%	1%
FY 2003	4,776,730	73%	-1%
FY 2004	5,106,692	76%	3%
FY 2005	6,150,027	72%	-4%
FY 2006	6,082,318	74%	2%
FY 2007	1,363,276	72%	-2%

Chart Notes
1 Between FY01 and FY03 reports were based on six months of data. Since FY04 reports are based on annual data.
2. This measure was updated annually through SFY 2005; beginning with SFY 2006, it is being updated quarterly.
3. Source: MARS MR-0-11-T.
4. FY07 numbers are for the first quarter of FY07.

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

During SFY2006, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required HSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

Target #3: Reduce the rate of Medicaid payment errors
Measure #3: Improper payment estimates as provided to Center for Medicare and Medicaid Services

Analysis of results and challenges: The Improper Payments Information Act of 2002 (Public Law 107-300) requires Federal agencies to annually review and identify those programs and activities that may be susceptible to significant erroneous payments, estimate the amount of improper

payments and report those estimates to the Congress, and if necessary, submit a report on actions the agency is taking to reduce erroneous payments. The effect of this rule is that States are now to be required to produce improper payment estimates for their Medicaid and SCHIP programs and to identify existing and emerging vulnerabilities.

The PERM program commenced nationally on July 1, 2005 with Phase I and one-third of the states participated. Alaska is a year 3 state and will be required to participate during calendar year 2007. There will be an impact on the resources in each division managing Medicaid Services to assist the PERM staff with access to policies, procedures and data. Division staff may be called upon to assist in the interpretation of medical records pertaining to claims associated with services that division manages. The PERM process includes expectations for corrective actions. Divisions will need resources to implement corrective actions resulting from PERM findings.

D1: Strategy - Continue to develop new Medicaid Management Information System (MMIS).

Division Level Measures

A: Result - Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses replacing them with alternate funds.
Measure #1: Percent of general funds replaced with alternate funding.

HCS Medicaid Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
1999	66.0%	34.7%	.8%
2000	65.3%	25.5%	9.2%
2001	66.4%	22.7%	10.9%
2002	66.6%	27.8%	6.1%
2003	67.5%	25.5%	7.1%
2004	71.1%	16.6%	12.4%
2005	71.5%	17.5%	11.0%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, Indian Health Service, Breast and Cervical Cancer, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in ABS as percentages. Note FY04 is the first year reported after the reorganization. Prior year actuals will include the complete Medicaid Program and therefore do not provide exact comparisons between fiscal years.

A1: Strategy - Increase Indian health services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian health services (IHS) Medicaid participation by 5% in expenditures.
Measure #1: Percentage of IHS direct service expenditures.

Health Care Services IHS Participation (in millions)

Year	Total Exp	IHS	% of Total	% Increase
1999	228.6	37.5	16%	
2000	268.4	49.4	18%	2%
2001	323.0	73.3	23%	5%
2002	385.9	89.3	23%	0%
2003	466.6	134.9	29%	6%
2004	503.6	154.5	31%	2%
2005	558.2	177.8	32%	1%
2006	316.5	98.4	31%	-45%
2007	119.5	33.6	28%	-1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS Direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

The FY2007 data is for the first quarter of FY2007 only.

DHSS, Finance and Management Services, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: Indian Health Service (IHS) expenditures decreased from first quarter FY06 to first quarter FY07 by $12 million. The decrease is largely due to the termination of the FairShare Program, a federally-approved program wherein the state increased payments to a tribally-operated hospital. When the program ended, provider rates, as well as expenditures, decreased.

As the program readjusts itself to not including FairShare, evaluation of quarters and state fiscal years will yield more accurate comparisons.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation whereas non IHS facility patient costs require a state match on expenditures.

Background:

Increased IHS billing capacity by tribal entities assists with revenue generation. This directly contributes to tribal entities being able to maintain and hire staff to serve recipients closer to home on a more consistent basis. It also decreases the number of American Indian/Alaska Native (AI/AN) beneficiaries going to non-tribal facilities. Tribal entities with 638 status receive 100% FMAP for service delivery to AI/AN beneficiaries, thus assisting the State with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that AI/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an AI/AN beneficiary is connected to a tribal healthcare delivery system which is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door the beneficiary enters, whether it's behavioral health, clinic, or dental for example, they become a part of the larger tribal healthcare delivery system of that region. The more revenue they generate per service category, the more consistent the long term system becomes.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Measure #1: Change in amount of funds recovered.

Medicaid Recoveries: Drug Rebates & Third Party Liability Collections (in millions)

Year	Drug Rebates	TPL	Total	% Change
2003	17.0	8.0	25.0	N/A
2004	19.4	10.1	29.5	18%
2005	30.2	8.7	38.9	24%
2006	27.5	9.4	36.9	-5%

Analysis of results and challenges: Health Care Services has seen an overall decline in its collections for drug rebates and third-party liability by 5% from FY05 to FY06. This is mainly attributable to a decline of drug rebate receipts that resulted from the implementation of the Medicare Part D program. More prescription drugs are covered by this federal program. Therefore, there are less state expenditures that qualify for drug rebate recoveries.

B: Result - To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase by 2% the number of providers enrolled in Medicaid.
Measure #1: Change in number of providers enrolled in Medicaid.

Number of Providers in Selected Provider Types Enrolled in Medicaid

	FY2003	FY2004	FY2005	FY2006	FY2007 (YTD)
Physicians	6,440	7,076	6,486	6,406	6,002
Dentists	587	597	578	553	540
Pharmacies	359	356	287	224	205
Hospitals	734	841	739	751	634
Nursing Facilities	36	33	29	32	35
Sum	8,156	8,903	8,119	7,966	7,416

Source: DHSS, Finance & Mgmt Svcs,
Medicaid Budget Group, MARS MR-0-06-T. The FY07 YTD information is for 1st quarter FY07.

Analysis of results and challenges: Provider enrollment is difficult to compare from any one period to another for a variety of reasons:

1. Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons. A participating provider may enroll without rendering services, and a provider may be enrolled and stop billing for services without dis-enrolling.
2. The time limit for submission of claims is one year from the date services were rendered and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year;
3. Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically

cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters;

4. There are, at present, no strategies to increase provider enrollment or participation.

Timely payment is part of the strategy for retaining providers who participate in Medicaid. Provider retention is necessary if the department is to meet its goal of affordable access to health care. While it probably does not contribute to increased provider participation, failure to pay timely could negatively impact access to care if dissatisfied providers stop seeing Medicaid patients.

B1: Strategy - Improve time for claim payment.

Target #1: Decrease by .5% the average time HCS takes to pay a claim.
Measure #1: Change in the average time HCS takes to pay a claim.

Analysis of results and challenges: This measure is reported at the department level.

B2: Strategy - Improve payment efficiency.

Target #1: Increase percentage of claims paid by provider without error to promote timely and accurate payment.
Measure #1: Change in percentage of adjudicated claims paid with no provider errors.

Error Distribution Analysis – Percentage of Adjudicated Claims Paid with no Provider Errors [1,2,3]

	FY02	FY03	FY04	FY05	FY06	FY07 (YTD)
Total Claims Paid (fiscal year) [2]	4,202,677	4,776,730	5,106,692	6,150,027	6,082,318	1,363,276
Percent Paid with No Errors (total claims)	74%	73%	76%	72%	74%	72%
Hospitals	60%	65%	64%	65%	68%	74%
Physicians	67%	65%	64$	63%	66%	64%
Dentists	73%	74%	74%	73%	80%	75%
Nursing Home Facilities	65%	62%	62%	49%	54%	68%
Pharmacy	83%	80%	77%	77%	72%	64%
Mental Health	73%	76%	77%	74%	76%	78%
Transportation/Lodging	88%	86%	86%	75%	84%	86%
Home and Community Based Care	77%	78%	81%	87%	89%	88%
Vision	80%	77%	69%	76%	76%	81%
Psychiatric Hospital (Inpatient)	71%	42%	47%	55%	60%	65%
Clinics	71%	58%	49%	65%	67%	69%
Behavioral Rehabilitation Services	91%	86%	84%	87%	88%	92%
Chiropractic	60%	49%	51%	53%	54%	54%

Notes
[1] Between SFY02 and SFY03 reports were based on six months of data. Since SFY04 reports have been based on annual data.
[2] Total claims include all provider types.
[3] Source: MARS MR-0-11-T. FY07 YTD numbers are based on the 1st quarter of FY2007.

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first quarter of FY06 and FY07 is in Pharmacy. During FY06, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

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Division of Juvenile Justice

Mission

The mission of the Division of Juvenile Justice is to hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

Introduction

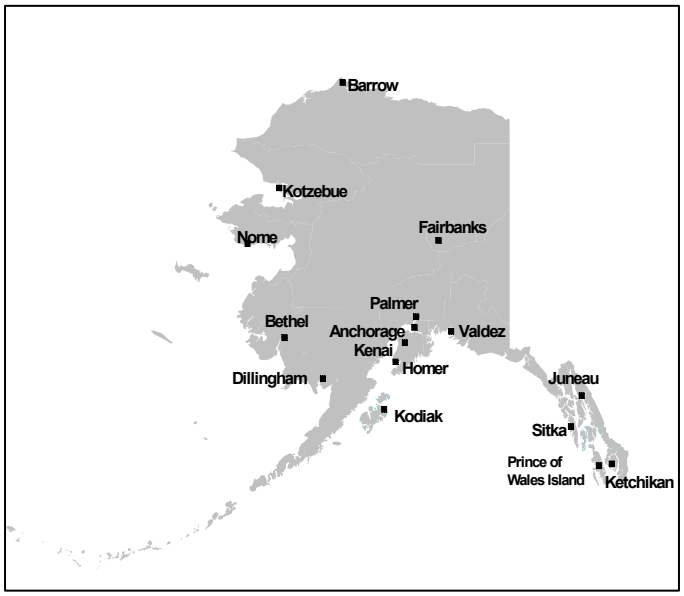
The Division of Juvenile Justice (DJJ) provides services to juveniles who commit a delinquent offense. The division responds to the needs of juvenile offenders in a manner that supports community safety; prevents repeated criminal behavior; restores the community and victims; and helps youth develop into productive citizens. Services are provided in the least restrictive setting that will both ensure community protection and promote the highest likelihood of success for the juvenile offender.

Core Services

- Short-term secure detention
- Court-ordered institutional treatment for juvenile offenders
- Intake investigation and outcome
- Probation supervision and monitoring
- Juvenile offender skill development

Services Provided

Division of Juvenile Justice services can be divided into three main categories: Probation Services, Juvenile Detention and Treatment Facilities, and Director's Office functions.

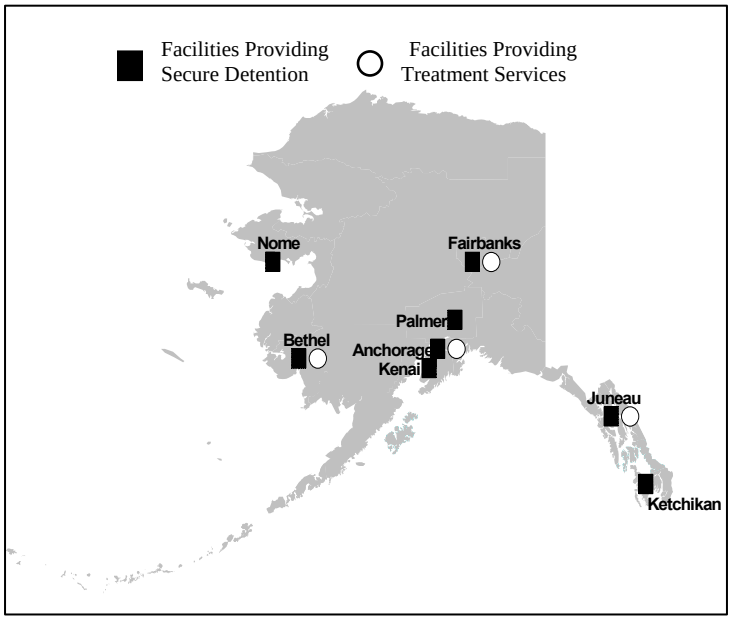


Probation Services

Juvenile probation officers provide preventive and rehabilitative services by conducting intake investigations of youth who are alleged to have committed delinquent acts, including determining legal sufficiency to take further action; completing detention screening; implementing diversion plans; initiating formal court action against juvenile offenders; contacting victims; providing formal community probation supervision services for adjudicated youth; assisting in re-entry into the community following release from secure juvenile institutional care. Alaska's juvenile probation officers work out of offices based in 16 communities around Alaska.

Juvenile Detention and Treatment Facilities

Youth facilities in Alaska perform two primary functions: 1) Detention Units are designed as short-term secure units for youth awaiting court hearings; and 2) Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment. There are eight Detention Units and four Treatment Units around the State. The division is continuing the process begun last fiscal year to have stand-alone detention facilities develop a continuum of detention services that will include some facility staff providing non-secure detention and transitional, re-integration services in the community.



McLaughlin Youth Center (MYC)

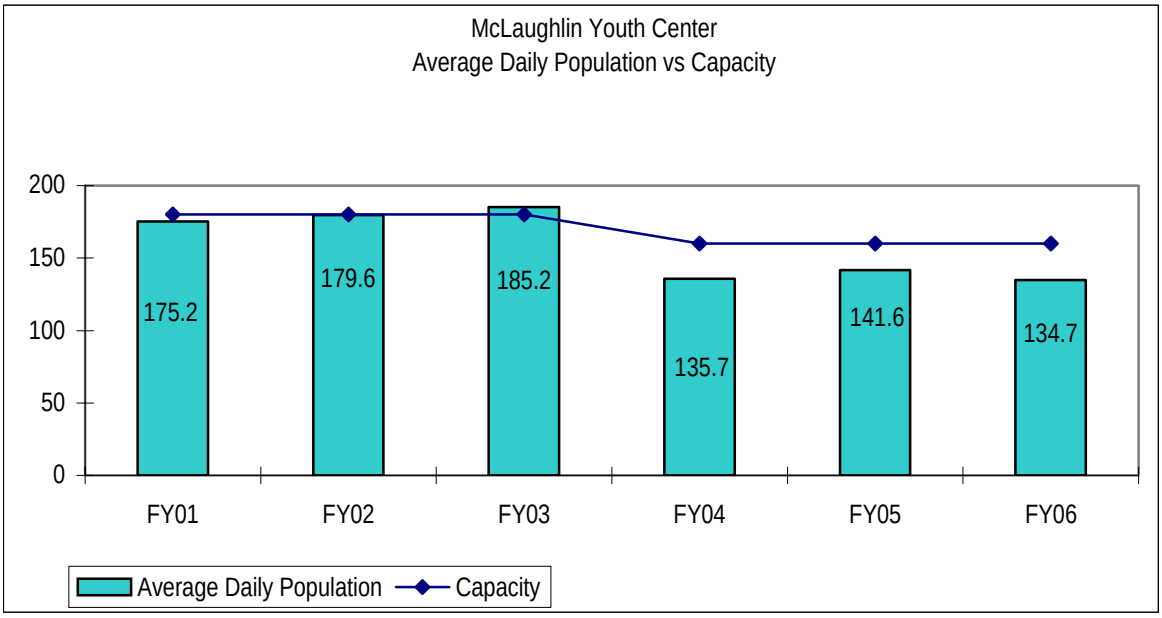
MYC currently has 160 beds (60 detention beds, 95 longer-term treatment/training school beds and 5 beds which can be used as either detention or treatment). The Detention Units serve the Third Judicial District, which includes the Municipality of Anchorage, Matanuska-Susitna Borough, Cordova, Valdez, Kodiak, Dillingham and Aleutian/Pribilof Islands. The Training School (three Cottage Programs, Special Treatment Unit, Closed Treatment Unit, Transitional Services Unit and Intensive Community Supervision) provides long-term residential services for institutionalized delinquent adolescents, primarily from the Third Judicial District. MYC, because of its size and history as the State's first facility, has developed a range of program options that do not exist in most of the smaller facilities. In addition to secure detention and long-term treatment, MYC also provides

community detention, sex offender treatment, a separated female detention and treatment unit, a closed treatment unit (CTU) for juveniles whose behavior or history require a high level of security and treatment, and transitional services for youth leaving long-term institutional treatment.

McLaughlin Youth Center (MYC) has gotten off to a successful start in implementing the national quality assurance process of Performance-based Standards program (PbS). McLaughlin is currently working on Level I Certification involving Data Compliance and has the goal of working towards Level II Certification in Critical Outcome Measures in FY08.

The McLaughlin Youth Center's Transitional Services Unit (TSU) was created in FY04 continues refine and expand its' program. Staff members of the TSU will continue to assist staff in other units at McLaughlin and in other youth facilities statewide in helping youths make the transition to their home communities following long-term confinement.

The chart below indicates the average daily population and capacity during several fiscal years. In FY01, the Classification Unit moved to a new location and increased the capacity for that unit by five; that same year Cottage 5 increased the bed number by five also, bringing the total capacity to 180. In FY04, the total capacity was reduced to 160 with the closure of Cottage 3 and conversion of the program to the Transitional Services Unit. Community Detention opened in FY01 with a capacity of 20; however these are now classified as "soft" beds and not counted in the overall capacity.



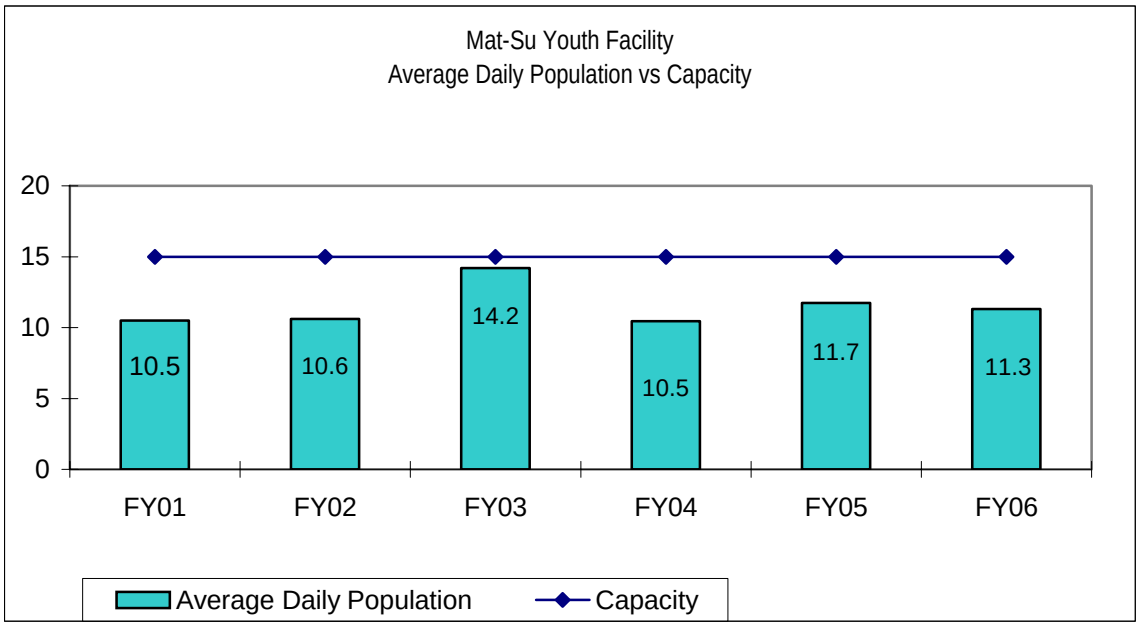
Mat-Su Youth Facility (MSYF)

The Mat-Su Youth Facility is a 15-bed juvenile detention center located in the city of Palmer, Alaska, serving a population base exceeding 64,000 in addition to the outer lying areas of the Copper River basin, Valdez, Cordova, Kodiak and a portion of the Aleutian Chain. The facility provides secure detention to juveniles alleged to have committed a crime and the facility also developed a transitional services unit in FY05 to assist juveniles from the region transition more successfully from long-term secure treatment into a community-based setting. The facility also houses the Mat-Su Juvenile Probation offices.

Services provided to residents of the facility focus on education, physical and mental health, substance abuse and a variety of related activities and groups geared toward competency development and the restoration of victims of juvenile crime and the communities in which these crimes occur. A primary service to the community is that of public safety as we house juvenile offenders who are awaiting legal proceedings, placement or diagnostic evaluation to help determine a longer term plan of intervention and rehabilitation that is appropriate to their needs. In an effort to closely address substance abuse and mental health issues present with many Mat-Su kids, active planning and implementation of educational and support services to mitigate these circumstances are part of the programming at the facility. This requires active participation by community partners inside the facility as they assess the immediate and long-term treatment needs of kids.

The facility is currently working on Level 1 Certification involving Data Compliance of the Performance-based Standards program and has the goal of working toward Level II Certification in Critical Outcome Measures in FY08.

The Mat-Su Youth Facility continues the effort to develop alternatives to detention resources based on local need. This is a critical component of the division's overall system improvement plan to ensure that sufficient community-based resources are available in order to prevent "default" use of secure detention resources. These resources will also help to bolster the Transitional Services Unit by enhancing supportive community resources for kids re-entering the community from long-term treatment.



Kenai Peninsula Youth Facility (KPYF)

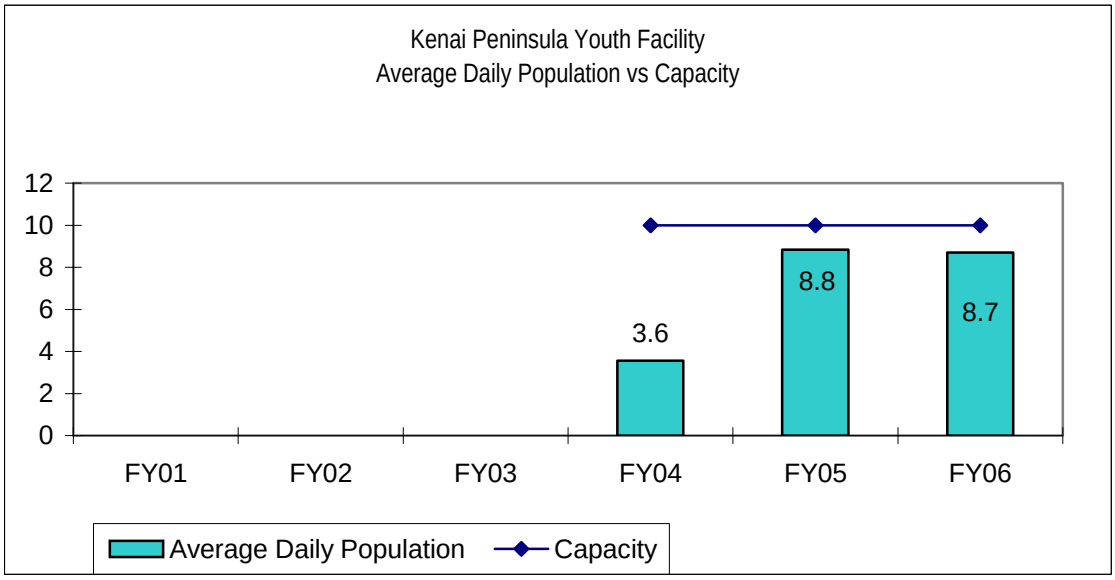
The Kenai Peninsula Youth Facility provides a ten-bed, secure placement setting for youth from the Kenai Peninsula area that are awaiting further court action, or pending transfer to or from an institutional program. The facility also houses the Kenai Juvenile Probation Offices and provides educational services in partnership with the local school district. Services provided to the residents of the facility and to the community focus on the restorative justice principles of community safety, offender accountability, skill development, and restoration of communities and victims.

Core services include basic community protection, through the detention of youth with the highest potential to further harm the community, and the provision of basic physical needs for detained

youth, such as food, shelter, and clothing. Services also include the provision of educational, recreational, and psychological services to promote the growth and maturation of the youth, with the intent of reducing the likelihood of further harm to the community. The development of transition services for these youth remains a significant agency strategy to improve youth outcomes.

The facility is currently working on Level 1 Certification involving Data Compliance of the Performance-based Standards program and has the goal of working toward Level II Certification in Critical Outcome Measures in FY08.

The Kenai Peninsula Youth Facility opened in December of 2003. The data collected in FY04 is for 6.5 months.

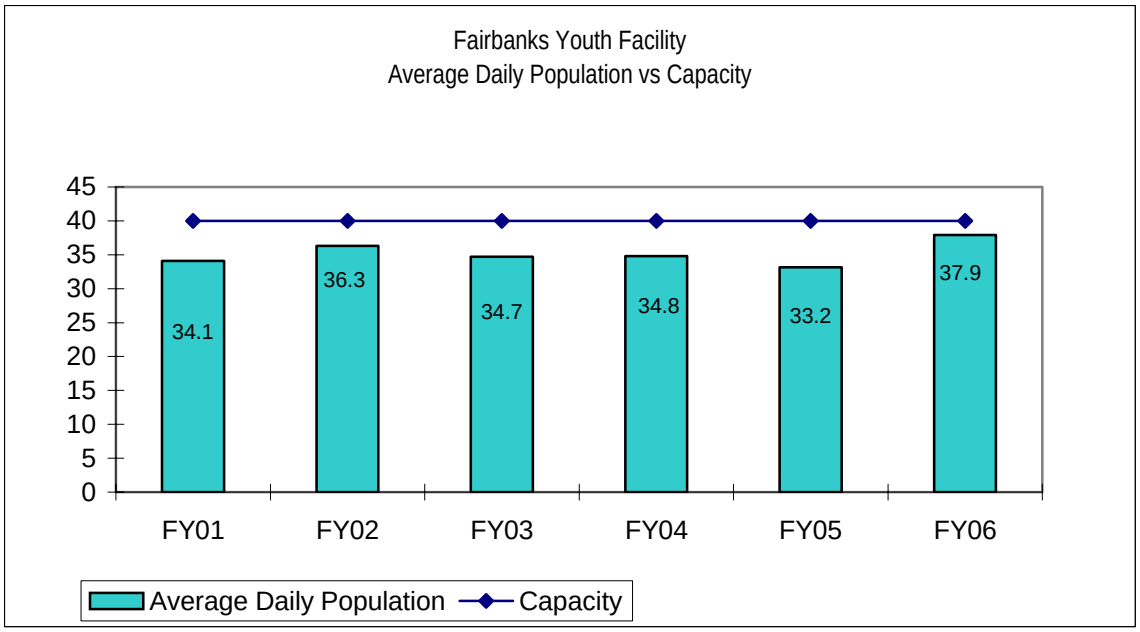


Fairbanks Youth Facility (FYF)

FYF consists of a 20-bed Detention Unit and a 20-bed Treatment Unit. The Detention Unit houses and offers services to alleged and adjudicated offenders who require secure confinement while awaiting disposition of their case in court. The Treatment Unit houses and makes rehabilitative services available to adjudicated offenders who have been institutionalized by the Court for long-term treatment. The Fairbanks Youth Facility is the second largest of Alaska's juvenile correctional facilities and the Northern Region is the largest geographical area served by the division in the state.

In FY08, like all of Alaska's youth facilities, Fairbanks will continue to gather data for the national Performance-based Standards (PbS) program. The next phase of PbS implementation is to continue to improve the integrity of the data generated and to integrate the outcome-oriented standards into the ongoing operations of the program.

FY08 will demonstrate continued improvement in the treatment services provided in Fairbanks. In FY06, the staff was trained in a variety of subjects. Additional training in Aggression Replacement Therapy during FY07 will continue to develop treatment competencies of the facility staff.



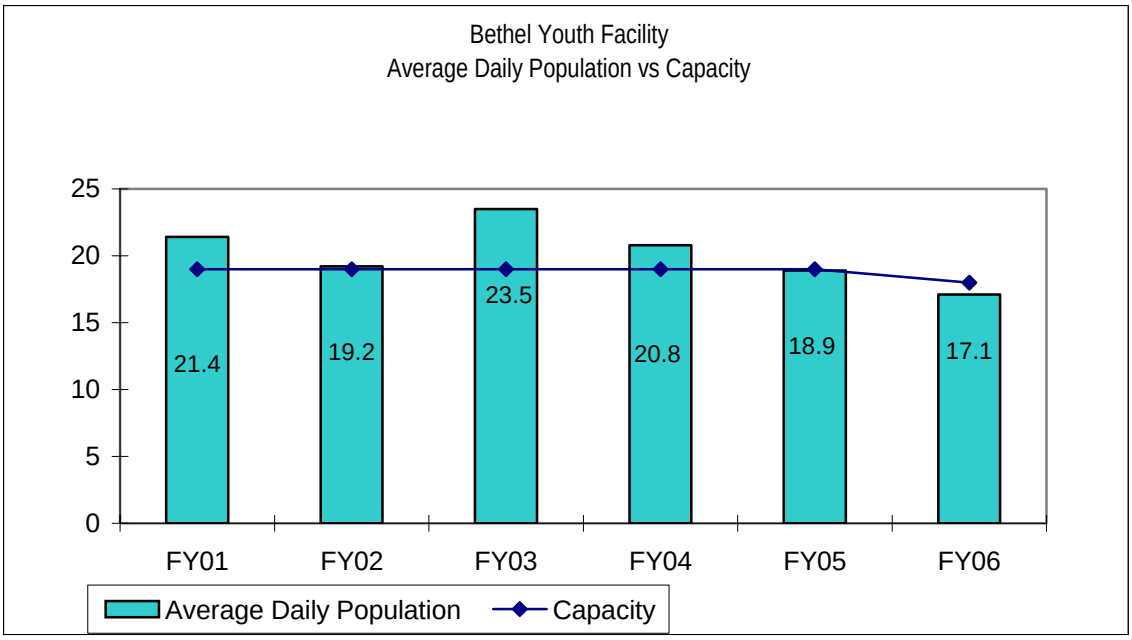
Bethel Youth Facility (BYF)

The Bethel Youth Facility (BYF) is the only youth facility in the entire Yukon-Kuskokwim Delta, an area the size of Oregon. The facility consists of an eight bed Detention Unit and an 11-bed Treatment Unit. In FY06, one of the treatment rooms was needed for the Mental Health Clinician that was hired, reducing the capacity to 10. This is reflected in the graph below.

The Detention Unit houses and offers services to alleged and adjudicated offenders who are either involved in the court process or awaiting other placement. The Treatment Unit houses and provides rehabilitative services to adjudicated offenders who have been institutionalized by the Court. Both Units are co-ed; the Treatment Unit is the only co-ed institutional treatment program in the Northern Region of Alaska. The facility's population is largely Alaska Native, particularly Yup'ik Eskimo. Youth come to the facility from a wide geographical area encompassed by the Yukon-Kuskokwim Delta and from other areas of the State as needed.

During FY06, juvenile offenders were housed at BYF for a broad range of offenses, including adjudications for murder charges. A significant percentage of residents have Fetal Alcohol Spectrum Disorders and other mental health needs.

The facility is currently working on Level 1 Certification involving Data Compliance of the Performance-based Standards program and has the goal of working toward Level II Certification in Critical Outcome Measures in FY08.



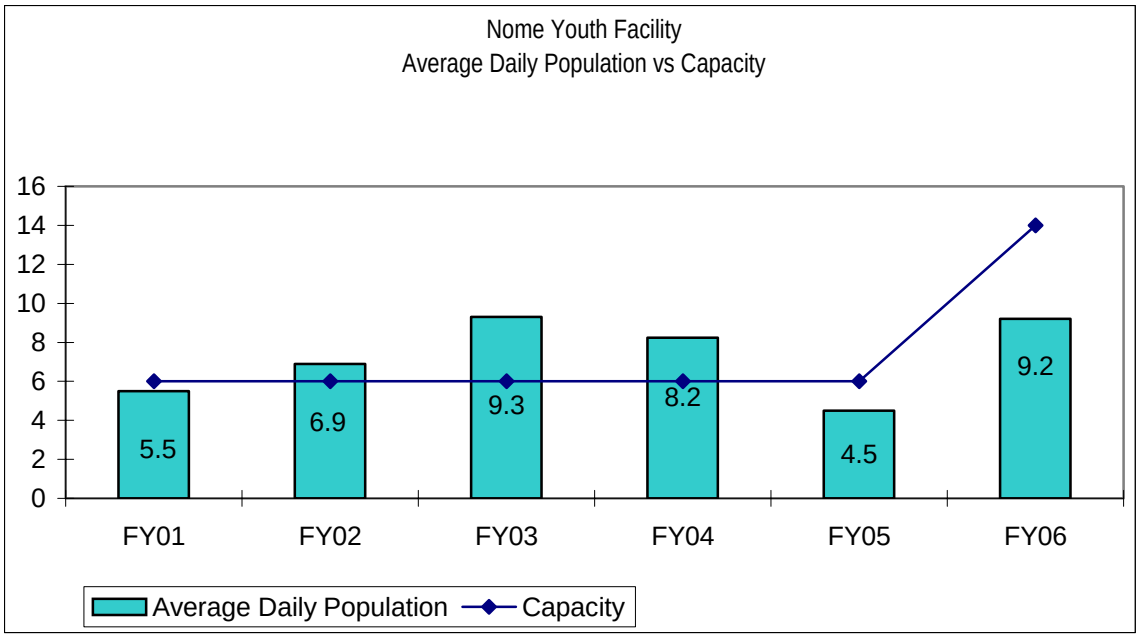
Nome Youth Facility (NYF)
The Nome Youth Facility operates as a short-term detention facility for juveniles of the Nome and Kotzebue region. Treatment services have steadily grown for the residents in the past few years with a program that emphasizes offender accountability. The facility is considered minimum security and in FY06 expanded from a 6-bed to a 14-bed facility.

The resident population is primarily male and nearly all Alaska Native. The residents are commonly detained for property crimes but there has been an increase in the number of residents charged with major assaults and/or sexual crimes. Many of the youth have a history of substance abuse and/or inhalant abuse.

In FY08, the Nome Youth Facility will continue to train and maintain staff in the provision of long-term treatment services. The staff began training in FY06 on a variety of different subjects including Aggression Replacement Therapy training, building relationships with families, and the new Aftercare/Transitional Services program.

Currently, the facility is working towards Level I Certification involving Data Compliance of the Performance-based Standards program; in FY08 the goal is to work towards Level II Certification in Critical Outcomes Measures.

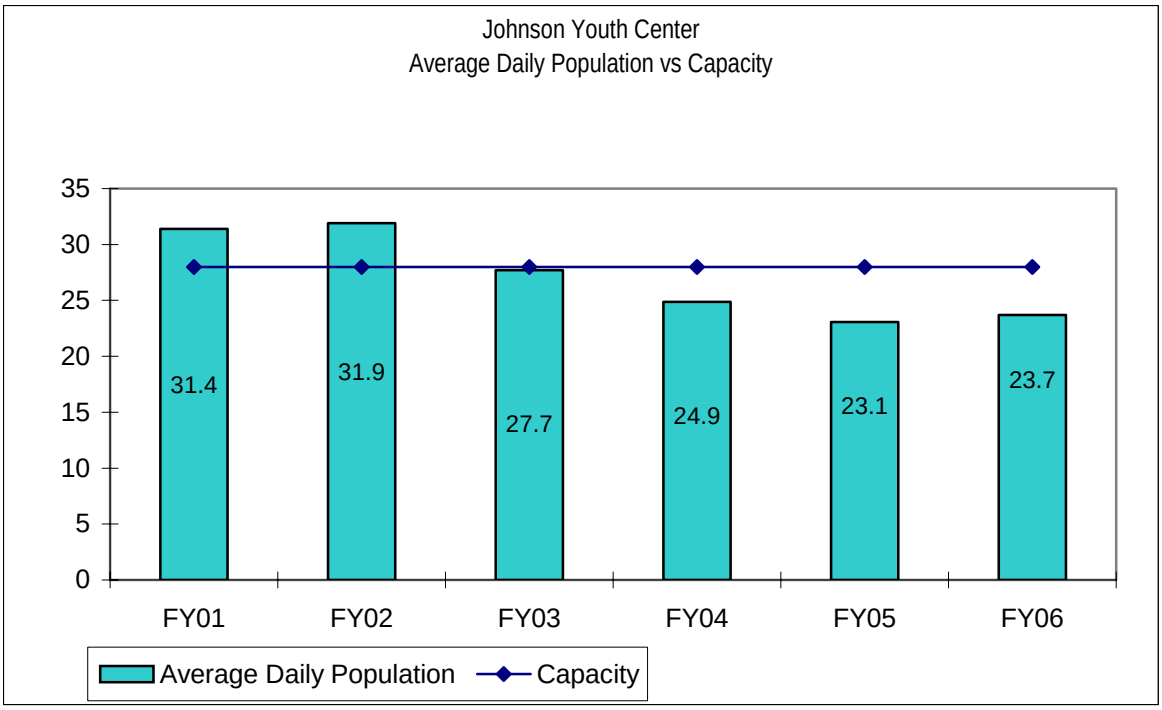
During FY05, the NYF was partially closed due to the renovation of the building. The renovation was complete at the end of FY05; the increased capacity is not reflected on this chart until FY06.



Johnson Youth Center (JYC)
JYC is a 28-bed facility (8 detention and 20 treatment) that provides short-term, pre-trial detention, control and intervention for juveniles who have been ordered confined by the Superior Court due to the danger they present to the public and/or to themselves. The Johnson Youth Center Detention Unit provides an array of basic and specialized delinquency intervention services. The Treatment Unit provides rehabilitative services to adjudicated offenders who have been institutionalized by the Court.

In FY08 JYC will focus on several activities. Detention Unit staff will continue working on the development of the Alternatives to Detention program. This program will enable facility staff to monitor and assist juveniles currently on probation to successfully remain out of detention and in the community. Participation in the Performance-based Standards (PbS) will continue, ensuring positive program outcomes and enhanced public safety. The facility is currently working on Level I Certification involving Data Compliance and has the goal of working towards Level II Certification in Critical Outcome Measures.

The JYC Treatment Unit staff has implemented a new best practice strength-based assessment tool to assist them in developing treatment plans. This assessment will complement the Youth Level of Service/Case Management Inventory, one of the division's system improvement initiatives that assist workers in understanding the risks and needs that give rise to criminal behavior in youth.

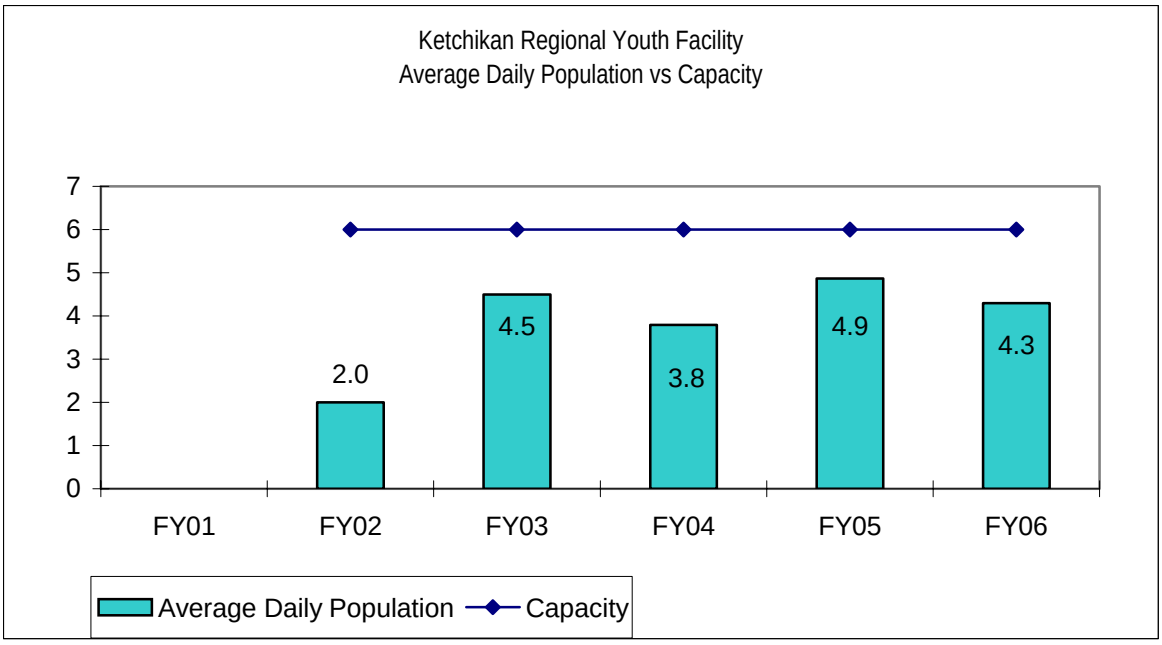


Ketchikan Regional Youth Facility (KRYF)

The Ketchikan Youth facility is a 10-bed dual function facility that provides detention of youth who are awaiting a court hearing or who are court-ordered into the facility (six locked detention beds) and a short-term-crisis respite and stabilization services for youth experiencing a mental illness (four bed staff secure). The unique combination of a detention unit and a crisis stabilization unit (CSU) in one location is an innovative feature for a youth facility, both in Alaska and in the United States. To date, the majority of the youth served in detention have been drug-affected and in serious conflict with their community, as evidenced by suspension, expulsion or drop out educational status and a pattern of frequent violations of prior court orders.

The CSU program, due to its uniqueness, originally took some time to develop and integrate into the community of Ketchikan and the surrounding areas. During the past year the CSU maintained its utilization goal of approximately 75% capacity. This goal was established as a result of regional meeting held in 2004 between the division, Ketchikan, and regional mental health providers. In coordination with the Juvenile Probation Office in Ketchikan, KRYF implemented an electronic monitoring program for five youth beginning in the latter part of FY04. Electronic monitoring has always been a program favored by the Ketchikan courts as an alternative to detention. Youth on electronic monitoring, check in with facility staff. Parents are also offered instruction on appropriate discipline and supervision techniques by staff. Facility staff contacts schools and respond to any alarms from the electronic monitoring equipment. This program is aligned with the division's system reinvestment plan to develop a balanced juvenile justice service continuum that uses resources effectively and efficiently. The electronic monitoring program in Ketchikan has been modified and adapted for use by other detention facilities across Alaska.

In FY08, Ketchikan will continue implementation of the Performance-based Standards program to improve facility operations. The facility is currently working on Level 1 Certification involving Data Compliance and has the goal of working towards Level II Certification in Critical Outcome Measures in FY08.



*The capacity for KRYF includes only the six locked detention beds.

Director's Office

The division Director's Office in Juneau oversees a number of functions that compliment and support the public, the Legislature, other executive branch agencies, and field staff around the state. These functions include:

Grants Program Management - Alaska, as a participating state in the federal Juvenile Justice and Delinquency Prevention Act, receives approximately $1.7 million dollars in federal funding each year that help ensure that the state's juvenile justice system abides by the mandates of the Act. Federal funds are also used to improve juvenile programming and build community partnerships throughout the state.

Research and Analysis - The division provides statewide and local juvenile crime statistics, analyses of juvenile delinquency policies and legislation, and other information to the Legislature and public as needed.

Training - The division's single statewide Training Specialist works with staff to develop and implement staff training programs across the division, including the development of specific competencies for probation and institutional field staff.

Administrative Support - The division's Administrative Manager and staff prepare the division's budget, make monthly projections on spending, and process grant payments and service agreements.

In FY03, the division launched a "system improvement" effort that resulted in the adoption of several nationally recognized, research-based initiatives that will help guarantee that Alaska's juvenile justice system is using its resources effectively and efficiently, that decisions are based on objective criteria, and that the agency is continually using data to improve the quality of services offered. These initiatives include:

The use of assessment instruments to assist staff in accurately determining a youth's risk of re-offense and need for secure detention;

A quality assurance process to improve the safety and security of juvenile facilities;

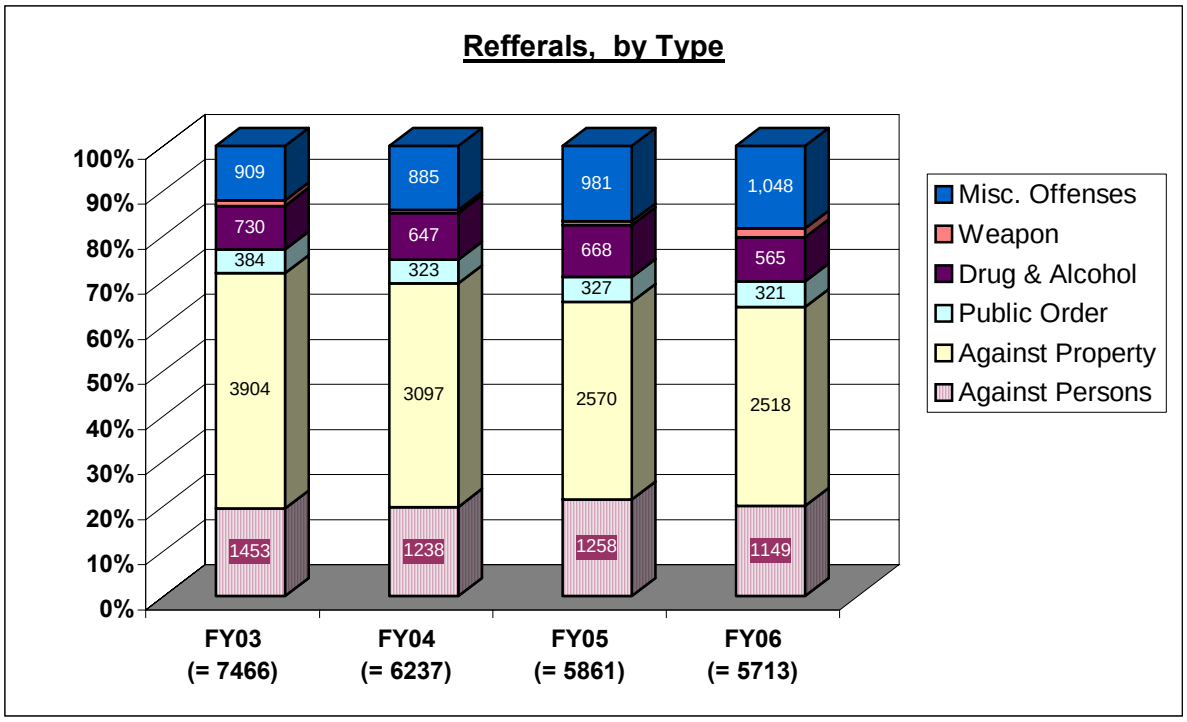
Improved use of juvenile facilities as a statewide resource for youth receiving secure treatment and those transitioning back to their home communities;

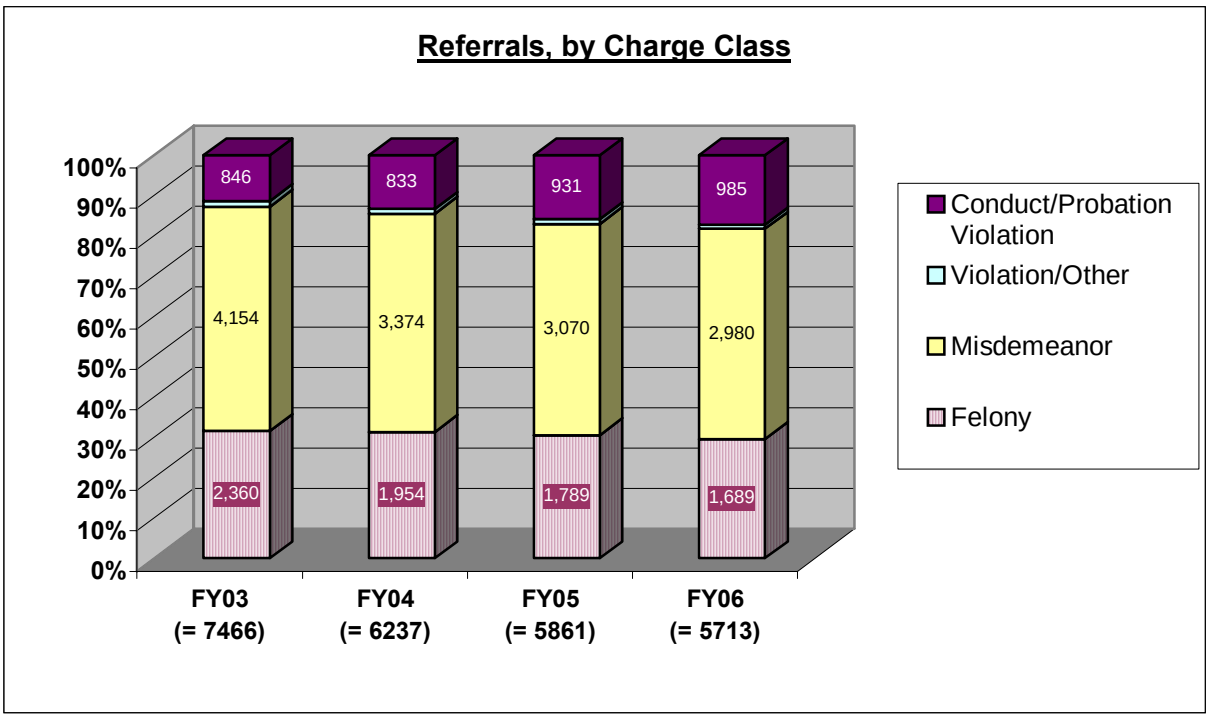
A nationally recognized program for juveniles demonstrating aggressive behavior.

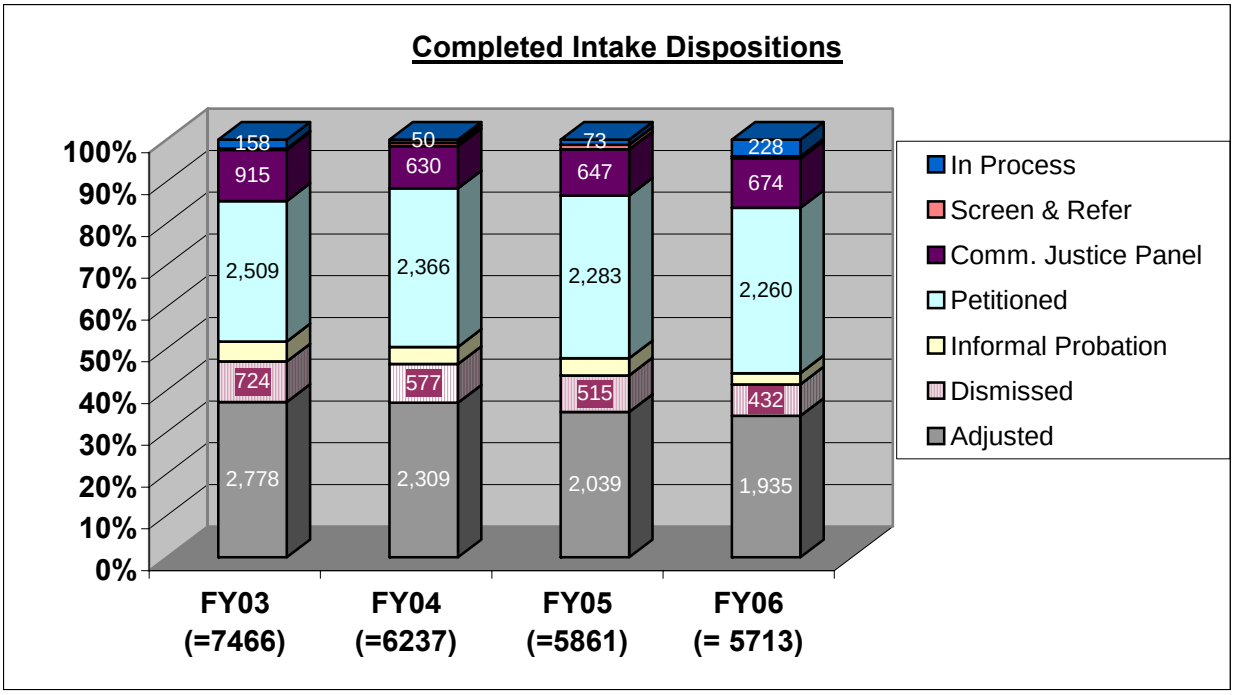
In FY08, the division's new leadership will work to incorporate these system improvement projects into a new strategic plan and vision for juvenile justice in Alaska that will improved public safety, ensure that victim needs are met and offenders are being held accountable.

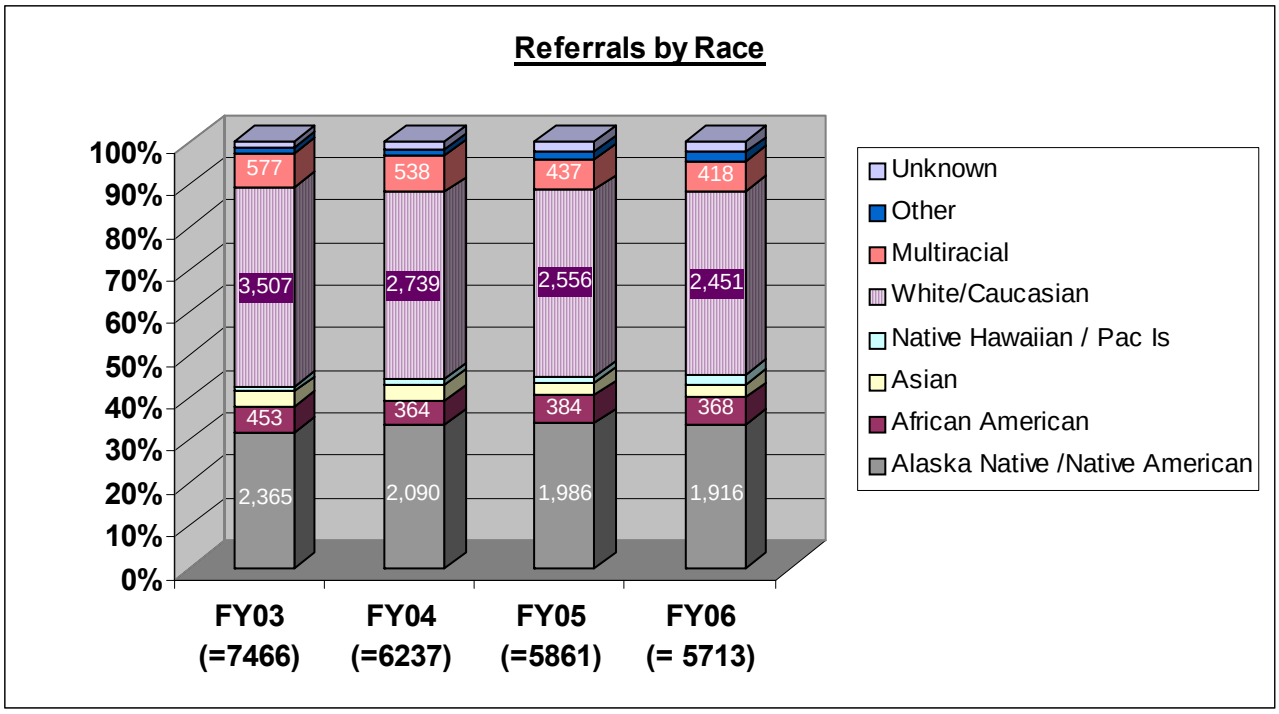
FY2006 Delinquency Referral Summaries

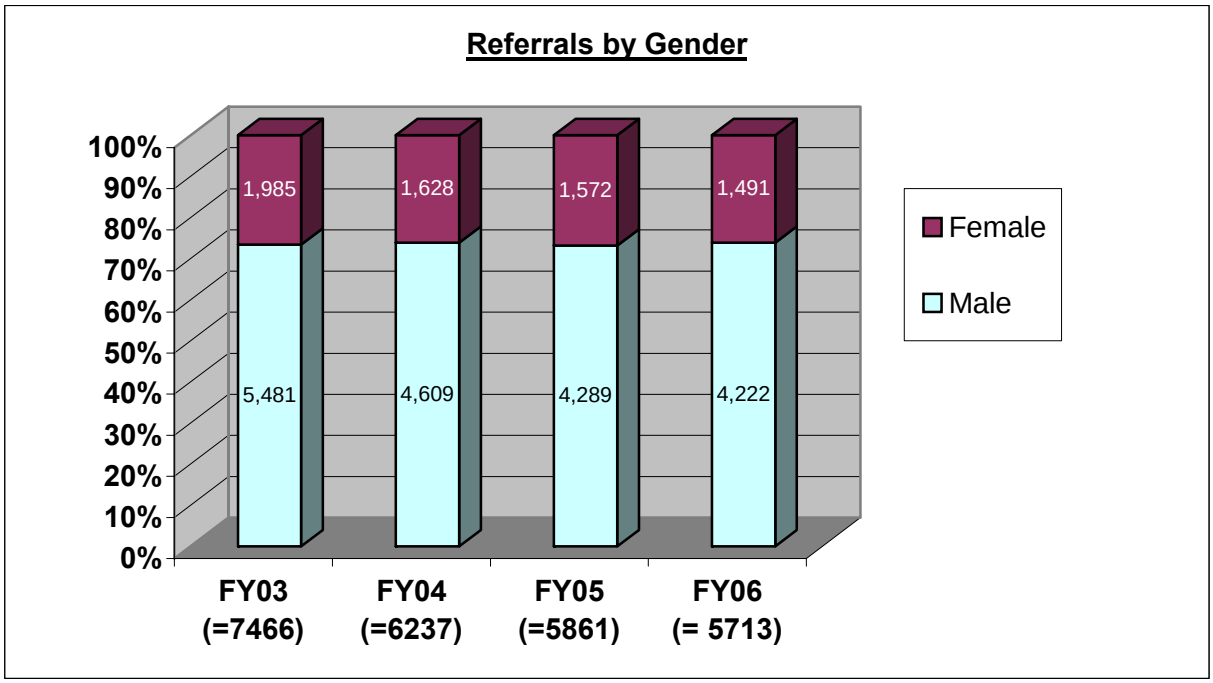
The following charts provide a summary of referrals for fiscal years 2003-2006.






Completed Intake Dispositions
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
158
915
2,509
724
2,778
50
630
2,366
577
2,309
73
647
2,283
515
2,039
228
674
2,260
432
1,935
FY03 (=7466)
FY04 (=6237)
FY05 (=5861)
FY06 (= 5713)
In Process
Screen & Refer
Comm. Justice Panel
Petitioned
Informal Probation
Dismissed
Adjusted


Referrals by Race
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
577
3,507
453
2,365
538
2,739
364
2,090
437
2,556
384
1,986
418
2,451
368
1,916
FY03 (=7466)
FY04 (=6237)
FY05 (=5861)
FY06 (= 5713)
Unknown
Other
Multiracial
White/Caucasian
Native Hawaiian / Pac Is
Asian
African American
Alaska Native /Native American



This next table indicates the number of hard beds that existed during FY06. The table shows the Nome Youth Facility's bed capacity increased by 8 beds. This increase occurred with the completion of the renovation of that facility.

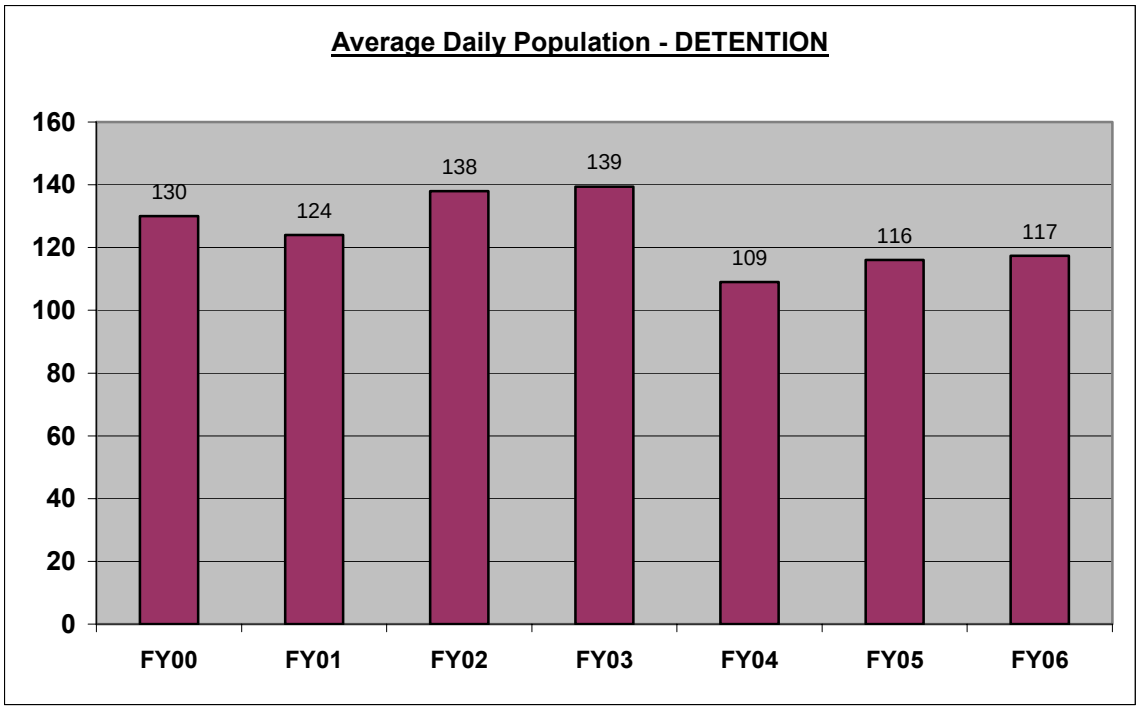
Youth Facility Existing Hard Bed Capacity

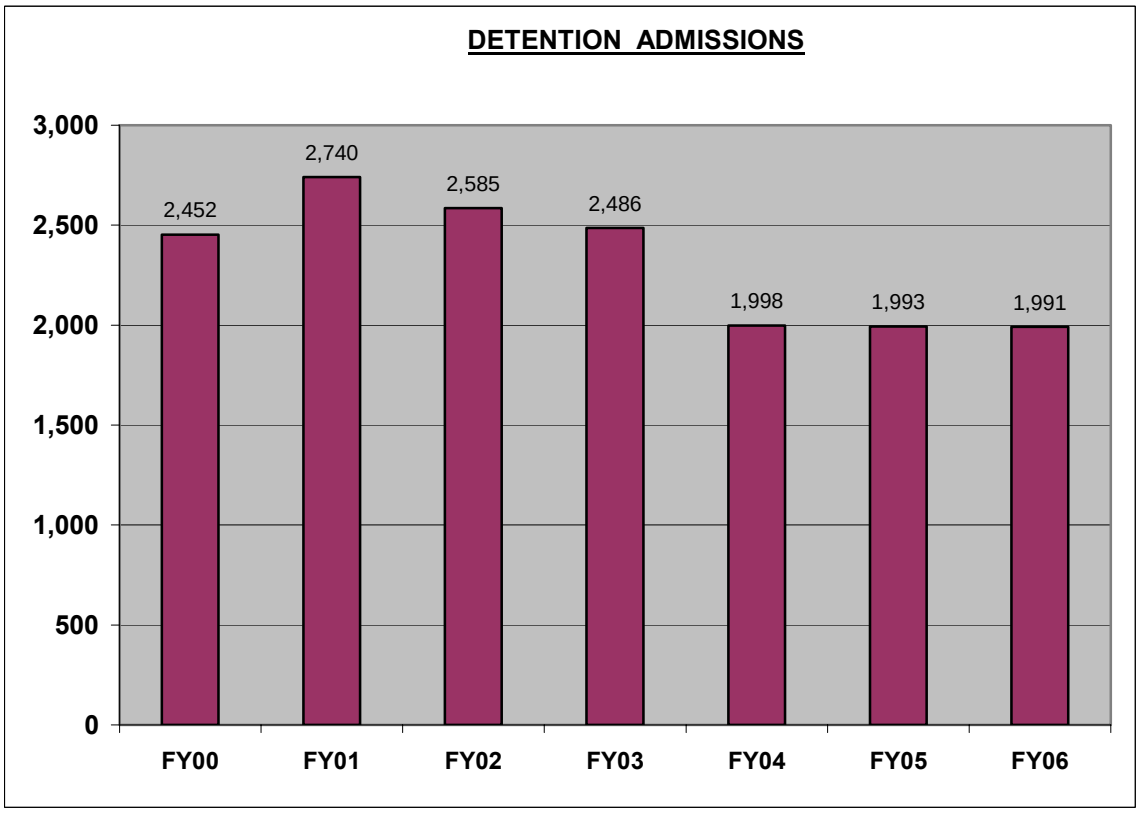
	Existing Capacity	Changes	Total Beds
McLaughlin Youth Center	160		160
Fairbanks Youth Facility	40		40
Johnson Youth Center	28		28
Bethel Youth Facility	18		18
Nome Youth Facility	14		14
Mat-Su Youth Facility	15		15
Ketchikan Youth Facility	10		10
Kenai Peninsula Youth Facility	10		10
Total	295		295

Facility Data

Detention Units – Detention and Treatment Units

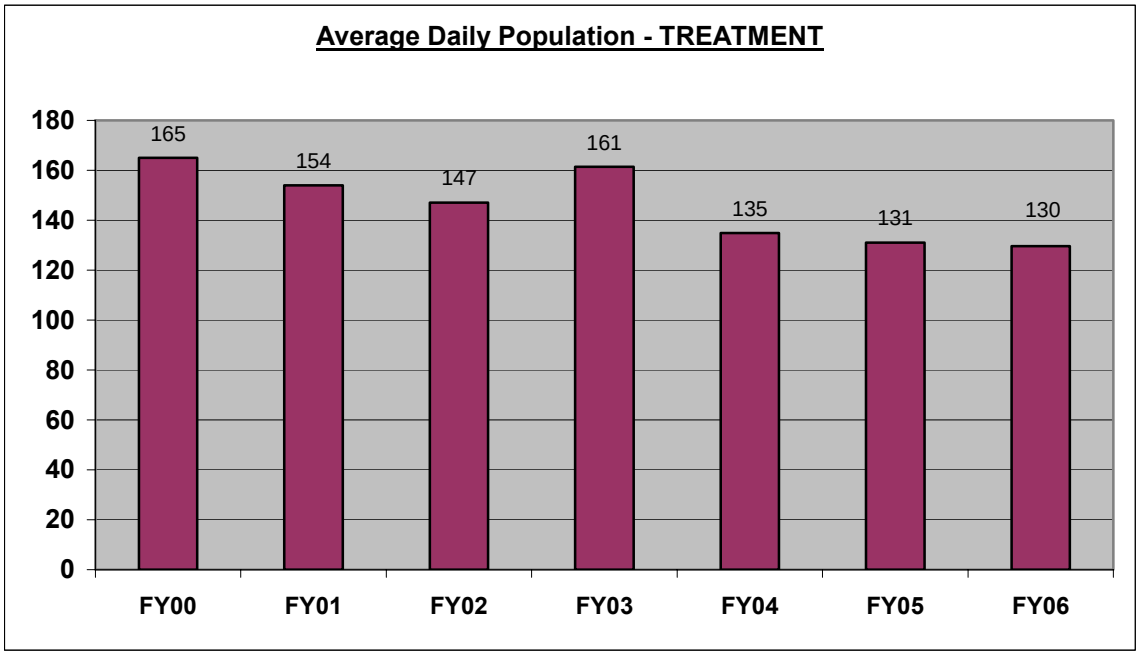
Below are charts showing juvenile detention average daily population and admissions for FY00 through FY06. Detention Units are designed as short-term secure units for youth who are awaiting court hearings. Statewide detention capacity in FY06 was 141 beds.

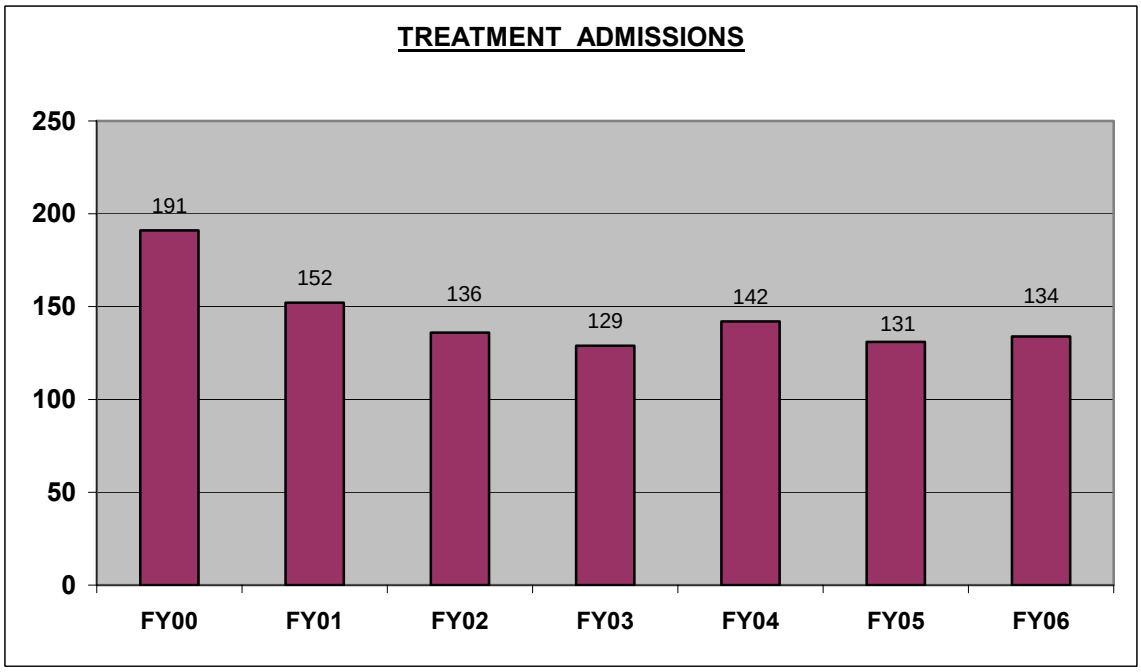

Average Daily Population - DETENTION
160
140
120
100
80
60
40
20
0
130
124
138
139
109
116
117
FY00
FY01
FY02
FY03
FY04
FY05
FY06


DETENTION ADMISSIONS
3,000
2,500
2,000
1,500
1,000
500
0
2,452
2,740
2,585
2,486
1,998
1,993
1,991
FY00
FY01
FY02
FY03
FY04
FY05
FY06

Treatment Units

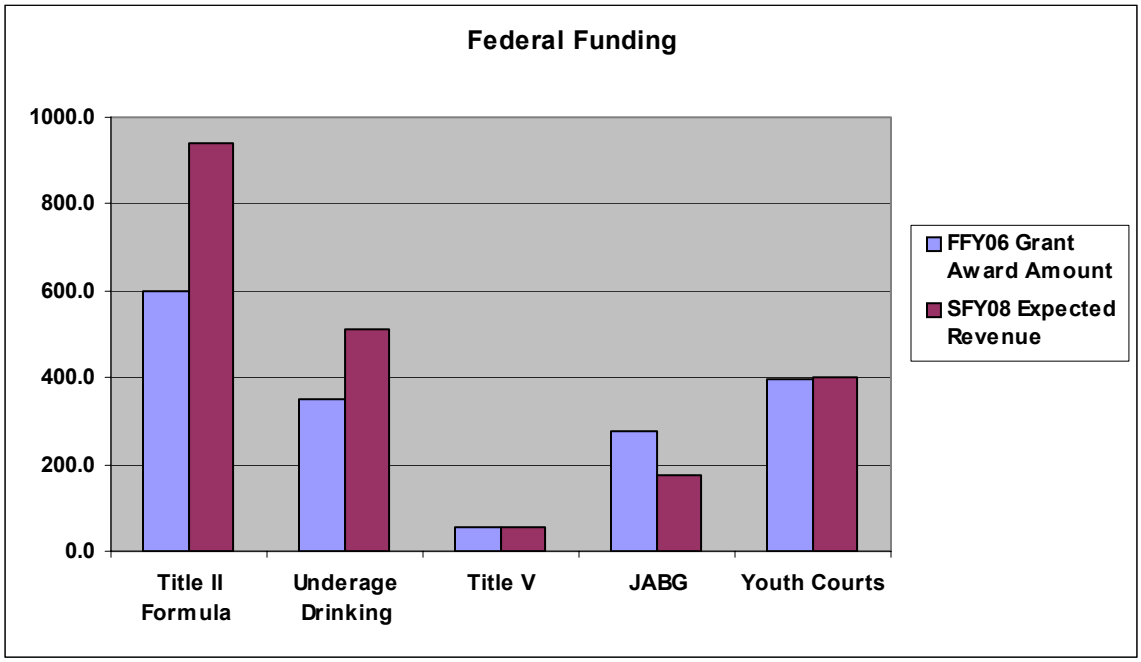
Below are charts showing juvenile program average daily population and admissions for FY00 through FY06. Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment. Statewide treatment bed capacity in FY06 was 150, excluding the 4 unlocked crisis stabilization beds in Ketchikan.





The Alaska Juvenile Justice Advisory Committee (AJJAC) serves as the congressionally mandated state advisory group to the division in its use of federal funds and juvenile justice programming focused on juvenile justice system improvements and compliance with the four core mandates of the Juvenile Justice Delinquency Prevention Act. The following chart provides a visual breakdown of the FFY06 grant programs funded and the revenue we expect to receive in SFY08. Note that in

some cases the expected revenue exceeds the award amounts. This is because of carryover from previous years of various grant awards.



AS 09.35	Execution
AS 11.81	General Provisions
AS 12.25	Arrests and Citations
AS 12.35	Search and Seizures
AS 25.27	Child Support Enforcement Agency
AS. 47.05	Administration of Welfare, Social Services and Institutions
AS 47.10	Children in Need in Aid
AS 47.12	Delinquent Minors
AS 47.14	Juvenile Institutions
AS 47.15	Uniform Interstate Compact on Juveniles
AS 47.17	Child Protection
AS 47.18	Programs and Services Related to Adolescents
AS 47.21	Adventure Based Education
AS 47.30	Mental Health
AS 47.35	Child Care Facilities, Child Placement Agencies, Child Treatment Facilities, Foster Homes, and Maternity Homes
AS 47.37	Uniform Alcoholism and Intoxication Treatment Act

7 AAC 52	Juvenile Correctional Facilities and Juvenile Detention Facilities
7 AAC 53	Social Services
7 AAC 54	Administration
7 AAC 78	Grant Programs

Alaska Delinquency Rules
Alaska Rules of Civil Procedure
Alaska Rules of Criminal Procedure

Juvenile Justice	2007	2008 Proposed	07 to 08 Change
General Funds	40,013.2	44,473.6	4,460.4
Federal Funds	3,169.8	3,169.8	0.0
Other Funds	922.6	995.0	72.4
Total	**44,105.6**	**48,638.4**	**4,532.8**

The division is statutorily mandated to protect the public, hold juvenile offenders accountable, restore victims and communities and develop offender competencies to reduce the likelihood of re-offense. A balanced and restorative justice approach to services and programming ensures that juvenile offenders take personal responsibility for repairing the harm caused to victims and communities as a result of their delinquent conduct.

Division-wide

Transfer in Nursing Salary Market Based Pay $100.8 GF
Finance and Management Services has transferred funds to our various facility components for the increased salaries for our nurses.

Statewide

Insufficient Staffing in Facilities

Several of the division's facilities lack sufficient permanent staffing to meet best practice levels of supervision for the safety, security, and habilitation of the youth, making use of non-permanent staff as a means of filling the gaps in supervision levels. For example, several of Alaska's facilities are unable to conduct an adequate number of room checks recommended to ensure that residents are not at risk of suicide or self-injury because they lack permanent staff. Other facilities may be unable to reduce the number of hours residents spend in idle, unproductive activity, alone in their rooms, without enough staff to engage these youth in productive activities that can aid in their rehabilitation. Without enough permanent staff, the division pays for more nonpermanent employees than is necessary and drives up costs for overtime for current staff. The affected facilities are the McLaughlin Youth Center, Bethel Youth Facility, Ketchikan Regional Youth Facility and the Johnson Youth Center.

Recruitment and Retention

Recruitment of professional staff has become a key challenge for the agency as the division's workforce ages and long-term dedicated staff, many with 20-30 years of quality service, retires. In the past couple of years, the component experienced a significant turnover in several key leadership positions, including facility superintendents, regional probation managers, district probation supervisory positions, several long time probation officers and critical positions in the Director's office. Although some of these positions have been filled through promotions or transfers within the division, vacancies at the mid-manager level are created. The ability to attract qualified applicants to these positions has become increasingly difficult due to reduced benefits and lack of ability to compete with salaries offered for similar positions across the country. This has been a significant issue for all rural offices. Two promotions came from Bethel, creating vacancies there that have been difficult to fill. Several of the supervisory staff are very new to their positions, and will continue to receive the necessary training and mentoring opportunities which will allow them to become more independent and successful in their new roles.

Mental Health Clinicians

Nationally, the trend to treat behavioral health residents in juvenile detention and treatment facilities is moving in two directions. Either complete units are being built at facilities to treat residents with these problems or staff are being hired to work with them within existing facilities. The Division of Juvenile Justice is taking the latter approach.

It is recommended that one Mental Health Clinician be on board for every 20 residents. Currently at the McLaughlin Youth Center, we have one for the entire facility (160 beds); at the Fairbanks Youth Facility, we currently have one mental health clinician for 40 beds.

Clinicians assist with identification of a youth's behavioral health needs, improve our ability to provide targeted behavioral health treatment and assist with transition and after-care planning back to the community. Having added clinical capacity within DJJ facilities will help to ensure there is an appropriate and robust continuum of care for youth with behavioral health needs who are also involved with the juvenile justice system.

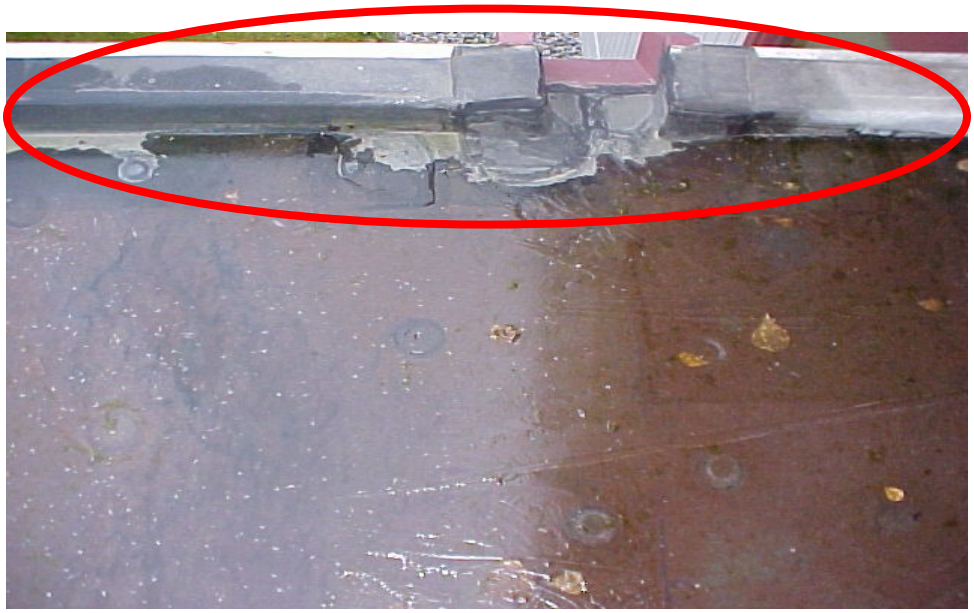
Quality Assurance
Another of the division's most critical overall needs is an adequately staffed Quality Assurance Unit that will ensure system improvement initiatives underway since 2003 will result in data that is accurate, sound, and is being actively used to make meaningful improvement to division practice. New risk and needs assessment instruments in probation, and quality assurance standards in facilities, have the potential to allow the division to make great strides in improving its services and outcomes throughout the juvenile justice continuum; however, the division is currently trying to manage the data and information generated by these projects with just a single employee devoted to quality assurance and oversight. Many of these initiatives are at risk of failure without staff dedicated to oversight, data integrity, and programmatic changes based on the information they produce.

Management Information System Platform
The department has recommended that the division's Juvenile Offender Management Information System be moved to the State technology standard, to increase performance in rural locations (remote field probation offices and facilities), and to capitalize on the efficiencies that can be realized when system enhancements and a new user interface are developed simultaneously. The division's management information system currently uses Visual FoxPro and a client-server system to deliver a remote connection to its centralized database. Visual FoxPro is an older technology that is not destined to be supported by its manufacturer for much longer. It also does not meet the department's technology standard. Moving to the department's technology standard makes it possible that this application could be maintained and enhanced by department staff rather than a contractor, if so desired in the future. The cost to move to the web-based platform is to be borne by the Division of Juvenile Justice.

Alternatives to Detention
The Division continues the effort to develop alternatives to detention resources based on local need. This is a critical component of the division's overall system improvement plan to ensure that sufficient community-based resources are available in order to prevent "default" use of secure detention resources.

Facility Maintenance and Office Space Shortages
Facility Maintenance and Office Space Shortages: The division's aging youth facilities are becoming increasingly difficult to maintain as these buildings sustain hard use 24/7 in challenging climates ranging from the cold arctic climate at the Bethel Facility to the damp climate of Southeast at the Johnson Youth Center. McLaughlin Youth Center, the oldest of the division's facilities, is in need of significant capital investments due to the age of the treatment cottages and the increasing maintenance requirements for this facility encompassing 18 acres and 11 buildings. Severe overcrowding for probation staff remains a serious concern, with the highest need sites being Anchorage and Bethel. In the Bethel and Anchorage locations, probation officers often share single-person offices, making it extremely challenging to meet with clients or families, conduct thorough and confidential risk/need assessments or interface with service providers to ensure appropriate services to promote positive juvenile outcomes. In addition, the medical suite at the McLaughlin Youth Center is not adequate for the needs of the nurses and medical staff that work there. Two of McLaughlin's four treatment cottages are in such need of extensive repair and a cost analysis completed by the department demonstrated that a significant renovation or replacement of the cottages is needed.

McLaughlin Youth Center



This picture shows the roof of one of the McLaughlin cottages where leaks occur because of poor drainage. You can see the ice that has formed from the standing water.

This picture shows the day room floor being held up by a rigged up beam under one of the McLaughlin cottages.

Kenai Peninsula Youth Facility

Community Outreach and Transitional Services

Programmatically, key challenges continue to be the use of facility staff for community outreach and the transitioning of youth back into the community. The development of transition services for these youth remains a significant agency strategy to improve youth outcomes. This will include the development of mentoring, programming and supervision partnerships. Refinements in the delivery of transitional programming will include the development of a Transitional Services handbook that outlines the program and services offered to youth leaving secure care and an evaluation of the program's effectiveness.

Overcrowding Concerns
During the last quarter of FY06, the facility saw population statistics increase to 110.33%, 117.09% and 131.00% of capacity; with a spike in population of 105.33% also observed during November 2005. This is a trend that is being closely monitored in order to provide for advance planning for any needed capital improvement and expansion requests. The superintendent and juvenile probation officer will routinely need to review the scores of youth on the Detention Assessment Instrument (a structured decision-making tool that guides detention decisions for youth referred for detention) and Transition Placement Plans, which are completed to make sure that a youth's detention episode is being actively managed. In addition, ongoing discussions with the courts regarding the continuances of court issues allowed and the impact that has on the overcrowding population, need to continue.

Bethel Youth Facility

Inadequate Work Space for Staff
In Bethel, visiting contract service providers must use offices of facility staff (compromising the ability of both workers to perform their duties), and the maintenance worker for the facility remains without a work place. Other visitors, such as attorneys and clinicians, must frequently see their clients in the Detention time-out room. As mentioned earlier, in FY06 at the Bethel Youth Facility, one of the treatment rooms was converted to accommodate the Mental Health Clinician that was hired, reducing the capacity to 10.

This is a photo of a two-person probation office in Bethel.

This is a photo of the workspace for the Aftercare Probation Officer, which is also the reception area. This room opens to the waiting room and copy room.

Overcrowding Concerns

Daily averages of 2.12 youth from Bethel were in other DJJ facilities to relieve overcrowding in the Bethel Youth Facility. Although the severity of overcrowding has been addressed through transporting youth out of region, detention overcrowding has not been completely solved, nor is it desirable to transfer youth several hundred miles from their home community and their culture to receive detention services.

Facility Maintenance Needs

The Bethel Youth Facility is now a 20-year-old building, and is showing wear and tear of the years. There are a multitude of deferred maintenance needs, including renovations to window replacement, carpet replacement, security systems upgrades, and exterior siding. A lift station upgrade was recently completed, but it needs to be relocated. Much of the furniture in the facility dates to the facility's opening and needs to be replaced or repaired.

Alternatives to Family Placement

There are currently few alternatives to family placement in the Yukon-Kuskokwim Delta. Finding appropriate placements for youth preparing for release from the treatment unit continues to be a substantial challenge. Many of the current residents appear to have exhausted multiple family placements prior to admission; finding an appropriate family member willing to have the youth placed with them continues to be an ongoing and at times an impossible challenge. In FY08 we will continue to work towards developing other community-based resources such as foster care, therapeutic foster care, and independent living options.

Contribution to Department's Mission

The mission of the Division of Juvenile Justice is to address juvenile crime by promoting accountability, public safety and skill development.

Core Services

- Short-term Secure Detention
- Court ordered institutional treatment for juvenile offenders
- Intake investigation and outcome
- Probation Supervision and Monitoring
- Juvenile Offender Skill Development

Department Level Measures

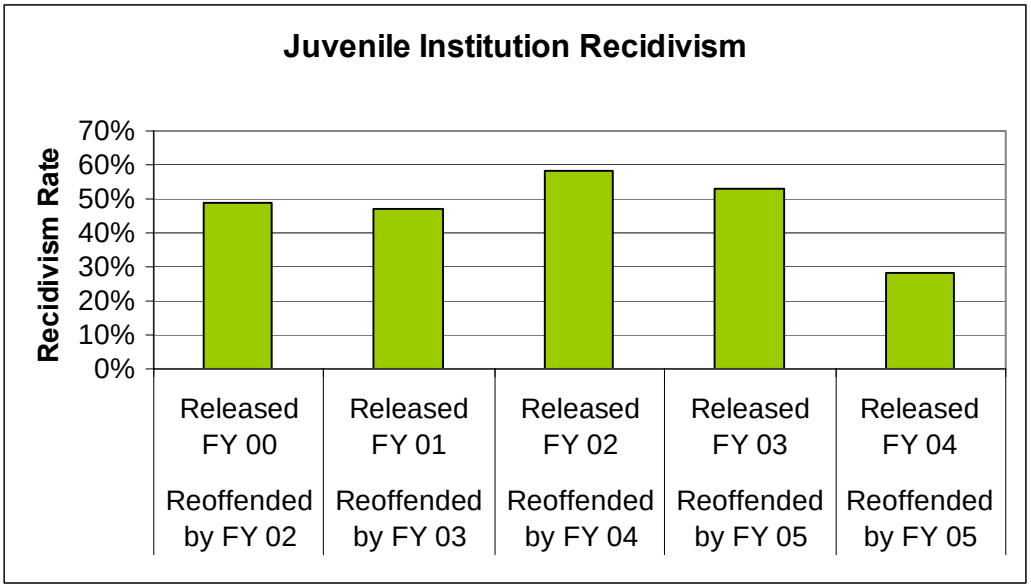
E: Result - Outcome Statement #5: Improve juvenile offenders' success in the community following completion of services resulting in higher levels of accountability and public safety.

Target #1: Reduce percentage of juveniles who re-offend following release from institutional treatment facilities to less than 40% of the total.

Measure #1: Percentage change in re-offense rate following release from institutional treatment.

Facility	Number released in FY 04	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Bethel Youth Facility	10	3	30%
Fairbanks Youth Facility	22	9	41%
Johnson Youth Center	18	8	44%
McLaughlin Youth Center	94	20	21%
Total	**144**	**40**	**28%**

Race	Number released in FY 04	Number of reoffenders 12 months after release	Percentage of offenders who reoffended
Caucasian	59	15	25%
African American	9	6	67%
Native Alaskan/American Indian	57	12	21%
Asian	2	2	100%
Pacific Islander	1	1	100%
Multiple Races	15	4	27%
Other	1	0	0%
Total	**144**	**40**	**28%**



Analysis of results and challenges: This measure examines recidivism only for youth who have been committed to and released from one of the Division's four juvenile treatment facilities. These youth typically have the most intensive needs and are the state's more chronic and serious juvenile offenders compared with youth who only receive probation supervision. Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

The major reason for the demonstrated drop in recidivism among this group was the change this fiscal year from surveying recidivism among juveniles in a 24-month window to 12 months. This change was made to better align Alaska's reporting of recidivism with the national norm of reporting recidivism on a 12-month basis. (Sixteen of the 32 states that track recidivism do so on a 12-month basis.) Among those states that measure recidivism based on a 12-month follow-up period, and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 28% rate, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Re-offenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The Division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review institutional treatment components and research-based practices as it seeks to improve its outcomes for youths leaving institutions.

Note: Re-offenses by juveniles released from Alaska's treatment institutions are determined through analysis of entries in the Division of Juvenile Justice's database and the Alaska Public Safety Information Network. Re-offenses are defined as: any offenses resulting in a new juvenile institutional order, a new juvenile adjudication, or an adult conviction. Adjudications and convictions for motor vehicle, Fish & Game, non-habitual Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudication and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their release date, and the offense must have

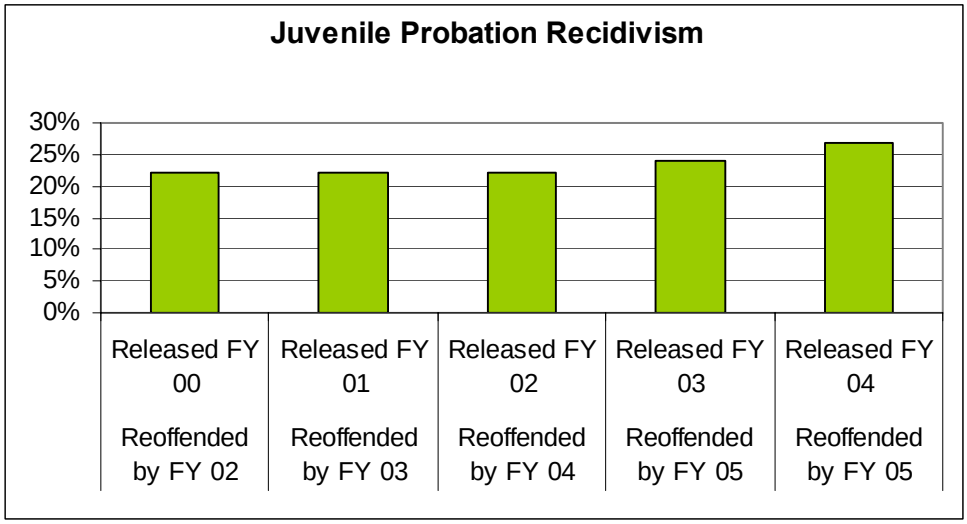
resulted in an adult conviction, a new juvenile adjudication, or a new juvenile institutional order for a probation violation.

Target #2: Reduce percentage of juveniles who re-offend following completion of formal court-ordered probation supervision to less than 20% of the total.

Measure #2: Percentage change in re-offense rate following completion of formal court-ordered probation supervision.

Region	Percentage re-offenders	Number of re-offenders 12 months after release	Percentage of offenders who re-offended
Anchorage	70	22	31%
Northern Region	103	33	32%
Southcentral Region	89	21	24%
Southeast Region	47	10	21%
Total	**309**	**86**	**28%**

Race	Number released from formal probation in FY 05	Number of Re-offenders 12 months after release	Percentage of offenders who re-offended
Asian	11	2	18%
African-American	17	5	29%
Multi-race	30	11	37%
Alaska Native/American Indian	133	41	31%
Pacific Islander	8	2	25%
Other	1	1	100%
Caucasian	109	24	22%
Total	**309**	**86**	**28%**



Analysis of results and challenges: This measure examines re-offense rates for juveniles who received probation supervision while either remaining at home or in a non-secure custodial placement. These youths typically have committed less serious offenses and have demonstrated less chronic criminal behavior than youth who have been institutionalized (and whose recidivism rate is discussed in measure #1). Recidivism rates for these two populations are considered separately because of the distinctively different levels of risk and need presented, and the different types of interventions and programming received.

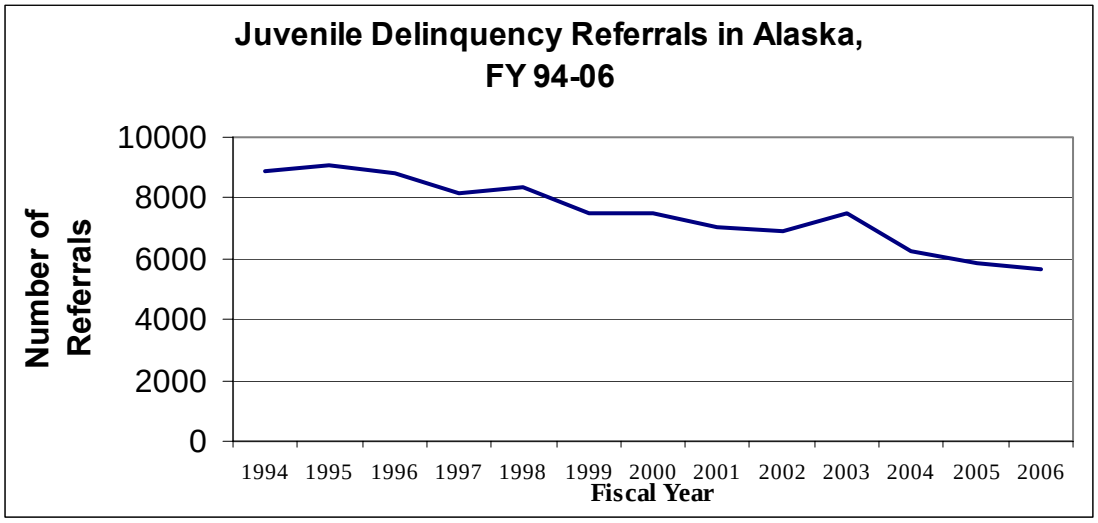
As with the institutional population performance measure, this measure was changed this year such that re-offenses were counted as recidivism if they occurred within 12 months, rather than 24 months, from the time offenders were released from formal probation. This measure also was changed to better correlate with the institutional recidivism measure (as well as national recidivism statistics) in that an offense needed to result in a new adjudication in the juvenile system or a conviction in the adult system to be counted as a re-offense (previously, only referrals to the juvenile system were counted as re-offenses). The increase in recidivism among the population of youth released from formal probation in FY 04 is primarily due to the inclusion of offenses occurring within the adult system. Inclusion of adult offenses is a more accurate measure of the activity of offenders once they are released from juvenile probation.

Sixteen of the 32 states that track recidivism do so, on a 12-month basis. Among those states that measure recidivism based on a 12-month follow-up period and that consider offenses "recidivism" if they result in a conviction or adjudication in the juvenile or adult systems (8 states, including Alaska), the average recidivism rate was 33%. Alaska, at a 28% rate, compares favorably with this average. (Source: Juvenile Offenders and Victims: 2006 National Report, National Center for Juvenile Justice, Pittsburgh, 2006, page 234.)

Re-offenses, like the original offenses that brought the juveniles to the Division's attention, may be felonies, misdemeanors, drug offenses, weapons crimes, crimes against persons, crimes against property, and other state crimes. Often these crimes are committed while the juvenile is under the influence of alcohol or other drugs, or in the context of domestic violence. The Division has adopted a new risk and needs assessment tool to better work with juveniles to address the root causes of their law-breaking behavior, and will continue to review and incorporate research-based practices as it seeks to improve its outcomes for youth on probation supervision.

Note: Re-offenses for juveniles released from formal probation are determined by checking for entries in the Division's Juvenile Offender Management Information System and the Alaska Public Safety Information Network. This table reports the number of youth for whom court-ordered probation episodes closed during the fiscal year for one of the following reasons: Completed Successfully, Order Expired, Non-compliant Closed, Waived to Adult Status, Declared Incompetent, or Deceased. Youth whose formal probation ends because of Court Termination Resulting in a new Supervision, Modified, Revoked, or Supervision Transfer are not included. This analysis also excludes youth who were ordered to an Alaska treatment institution, as these youth are included in the analysis for our institutional recidivism performance measure, above. Re-offenses are defined as offenses resulting in a new juvenile adjudication or an adult conviction. Adjudications and convictions for Motor Vehicle, Fish & Game, non-habitual violations of Minor in Possession/Consuming Alcohol, and misdemeanor-level Driving While Intoxicated offenses are excluded. Adjudications and convictions received outside Alaska are excluded from analysis. To be counted as recidivists, youth must have committed an offense within 12 months of their release date, and the offense must have resulted in an adult conviction or new juvenile adjudication.

Target #3: Alaska's juvenile crime rate will be reduced by 5% over a two-year period.
Measure #3: Percentage change of Alaska juvenile crime rate compared to the rate one and two years earlier.



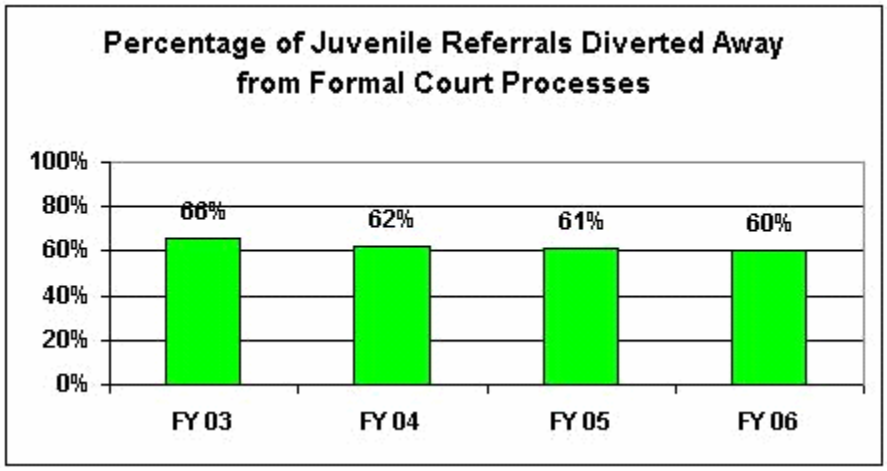
REGION	DISTRICT	Juveniles	Referrals	Charges
ANCHORAGE	ANCHORAGE	1531	2111	3221
ANCHORAGE	***Total***	***1531***	***2111***	***3221***
NORTHERN	BARROW	44	78	141
	BETHEL	227	368	768
	FAIRBANKS	459	662	1170
	KOTZEBUE	103	171	430
	NOME	104	172	301
NORTHERN	***Total***	***937***	***1451***	***2810***
SOUTHCENTRAL	DILLINGHAM	90	129	228
	HOMER	52	70	122
	KENAI	273	394	632
	KODIAK	81	131	267
	MAT-SU	367	477	865
	VALDEZ	44	55	109
SOUTHCENTRAL	***Total***	***907***	***1256***	***2223***
SOUTHEAST	JUNEAU	270	458	713
	KETCHIKAN	154	240	417
	PETERSBURG	18	27	49
	PRINCE OF WALES	30	37	64
	SITKA	54	75	126
SOUTHEAST	***Total***	***526***	***837***	***1369***
Grand Total		**3901**	**5655**	**9623**

Analysis of results and challenges: The number of referrals and the percentage of these referrals per 100,000 juvenile population was very slightly reduced in FY 06 compared with FY 05, representing virtually no statistical difference between the these years. Nevertheless, the target of reducing referrals by 5% from two years prior (FY 04) was surpassed. Definitive reasons for changes in referral levels are unknown, although possible causes could include changes in economic conditions, changes in prevention and intervention techniques, changes in law enforcement practices or resources, or a combination of some or all of these.

Note: Population data is based on estimates for the previous fiscal year (FY 05) from the Alaska Department of Labor. Juvenile referral data was extracted from the Division of Juvenile Justice's Juvenile Offender Management Information System (JOMIS) database on August 1, 2006 and includes referrals for youth who are under 10 years old (these referrals make up less than 1% of the total). This data is continually refined and corrected and numbers in future reports may change slightly.

Target #4: Divert at least 60% of youth referred to the Division away from formal court processes as appropriate given their risks, needs, and the seriousness of their offenses.

Measure #4: The percentage of referrals that are managed through informal processes.



Analysis of results and challenges: In FY 06 the proportion of juvenile referrals (reports from law enforcement that allege a juvenile perpetrator) that were diverted from the formal court process remained high, at 60%. This means that approximately 2,360 juveniles out of the total 3,929 that entered the juvenile justice system in FY 06 had their cases managed through non-court adjustments, informal probation, referral to community panels such as youth court, or were dismissed.

Diversion of youth from formal court processing serves a number of important, valuable purposes. It helps low-risk juveniles who are unlikely to re-offend avoid the stigma and needless harm that can result from delinquency adjudication. Diversion can provide opportunities for community partners and victims to take more active roles in addressing low-risk juvenile offenders. Diversion processes reduce burdens on the court system, which otherwise would find it impossible to adjudicate every offender referred to them. Diversion is a considerably less expensive and faster process than the formal adversarial court process and reduces probation caseloads as well, enabling the Division to better allocate resources and staff time to more serious offenders.

Note: For this measure, youth are considered to have been diverted away from the formal court system if the intake decision for their delinquency referral results in the referral being adjusted, dismissed, placed on informal probation, or forwarded to a community justice panel such as youth court. Additionally, diverted would include those referrals that are screened and referred elsewhere (1% of total in FY06), such as back to law enforcement for further information, and those that were still in process (4% of the total in FY06) at the time this data was collected.

*Referral: A request for a Division of Juvenile Justice response service following the arrest of a juvenile or submission of a police investigation report alleging the commission of a crime or violation of a court order by a juvenile offender.

E1: Strategy - Implement and review information from research-based assessment tools, and incorporate practices proven to reduce recidivism and criminal behavior among youth.

Division Level Measures

A: Result - Outcome Statement #1 Improve the ability to hold juvenile offenders accountable for their behavior.

Target #1: Improve the ability to collect ordered restitution at the time of case closure to 100% of what was ordered.

Measure #1: Percentage of ordered restitution collected at the time of case closure compared to what was ordered.

Year	Amt Ordered	Amt. Completed	% of Amt Ordered	Goal
2004	$160,165.43	$144,140.73	90.0%	100%
2005	$70,911.20	$69,343.23	97.8%	100%
2006	$54,420.30	$52,349.60	96.2%	100%

Amount completed is amount at case closure.

Analysis of results and challenges: This measure provides a gauge of the Division's effectiveness in assisting youths in their efforts to make reparations to those impacted by their criminal behavior. Juvenile probation officers are responsible for ordering and monitoring payments made outside the formal court system. Restitutions assigned through informal procedures are included in this measure, as are assignments of Permanent Fund Dividends made by juvenile probation officers. The amount of restitution reported as paid is that amount provided by the youth at the time of case closure. Restitutions tracked and gathered through youth courts and other community diversion programs are not included in this measure for FY 06. Since January 1, 2002, restitution payments by juveniles who are processed formally through the Alaska Court System have been tracked, collected, and reported by the Alaska Department of Law Collections & Support Unit and those restitution payments are also not included in this analysis.

The reduction in restitution ordered and paid in FY 06 through informal court processes may primarily be due to two factors: First, in the years since the Department of Law took over the restitution collections function, probation officers have gradually had less formal court-ordered restitutions to manage. Formal court-ordered restitutions are typically much larger than informally ordered restitutions that make up the final measure this year. Second, in previous years some probation offices counted restitutions that were ordered and collected from youth referred to youth courts. These restitutions are no longer counted in this measure since this would credit the Division with work that outside agencies are doing.

The Division this year integrated restitution tracking procedures into its Juvenile Offender Management Information System. It is believed that this change has resulted in more thorough and accurate reporting of restitution than in years past. Despite the overall decline in raw dollars ordered and collected, the percentage collected by DJJ staff remained high, indicating that DJJ staff continues to demonstrate a high degree of effectiveness in collecting on restitution payments they order.

Note: FY 06 data for this measure was retrieved from the JOMIS report, "Statewide Summary Restitution Report," on August 8, 2006.

Target #2: Improve the amount of community work service performed by juvenile offenders to 100% of what was ordered.

Measure #2: Percentage of community work service hours performed by juvenile offenders compared to what was ordered.

Community Work Service Hours

Fiscal Year	Hrs Ordered	Hours Completed	Percentage	Goal
FY 2004	24,379	23,720	96%	100%
FY 2005	34,167	30,642	90%	100%
FY 2006	33,214	27,429	82%	100%

Hours completed are at closure of service record.

Analysis of results and challenges: Like restitution, community work service is a way for juveniles to repair harm caused to those impacted by juvenile crime. This performance measure reports the percentage of community work service performed for cases in which community work service was ordered either through formal, court-ordered processes or informal processes directed by a juvenile probation officer. The record of community work service must have been closed in FY 06 to be included in this measure. Community work service ordered through youth courts or other alternative justice processes are not included.

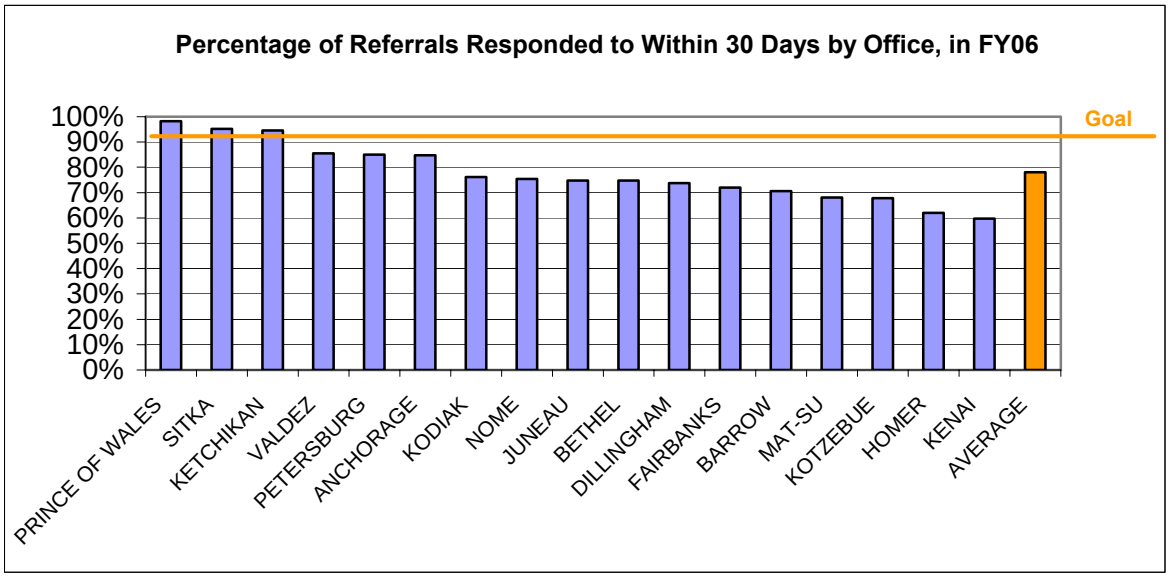
The percentage of community work service completed to what was ordered appears to have declined this year. This is likely due to changes in reporting of this measure. FY 06 marked the first full year that Community Work Service was tracked through the Division's Juvenile Offender Management Information System. In preparation for this change several inconsistencies and differences in the way offices tracked community work service were revealed. The Division recognized these concerns and has set explicit guidelines on how this information is to be entered in JOMIS. In the coming year we will monitor this information to make sure it is as accurate and complete as possible.

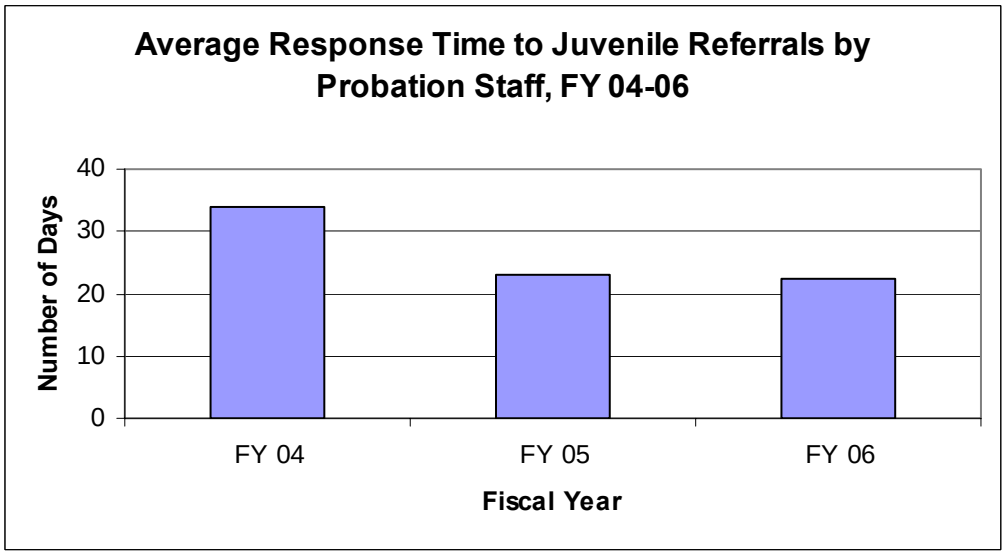
Note: FY 06 data for this measure was retrieved from the JOMIS report, "Statewide Summary Community Work Service Report," on August 15, 2006.

A1: Strategy - Strategy 1a: Improve the timeliness of response to juvenile offenses.

Target #1: Seventy-five percent of juvenile referrals will receive an active response within 30 days from the date that the report is received from law enforcement (see note below).

Measure #1: The percent of delinquency referrals receiving an active response from juvenile probation within 30 days of the date the complete referral is received from law enforcement.





Analysis of results and challenges: This measure enables the Division to monitor the percentage of cases that receive an active response within the target response time of 30 days. An "active response" is defined by the Division as one of three possible actions by staff to deal with the delinquency report (see note below). Research indicates that in order to be effective, responses to juvenile crime must be timely and appropriate to the level of the offense. The first chart above illustrates the percentage of referrals that received a response within 30 days of the date the referral was received by each office in Alaska. The statewide average percentage of referrals that received a response within 30 days was 78%, exceeding the goal of 75%. The second chart illustrates the average number of days it took to actually respond to all referrals relative to previous years' data. The average response time in FY 06 was 22.4 days. FY 06 marked the second year that the Division was able to provide response time information through a streamlined procedure in the Juvenile Offender Management Information System (JOMIS).

Note: Delinquency reports, or "referrals" included in this analysis were those received in the fiscal year that resulted in one of the following actions: Referral Screening (review of the police report and either closing the referral or it being forwarded to a community accountability program, such as

youth court), Petition Filed (resulting in an adjudication or dismissal by the court), or Intake Interview (which may result in referral being adjusted, dismissed, petitioned, or forwarded to a community accountability program).

*Referral: A request for a Division of Juvenile Justice response service following the arrest of a juvenile or submission of a police investigation report alleging the commission of a crime or violation of a court order by a juvenile offender.

A2: Strategy - Strategy 1b: Improve the satisfaction of victims of juvenile crime.

Target #1: Develop a process to track victims' satisfaction with juvenile justice services.
Measure #1: Implementation of a process and/or protocol to record and assess victims' satisfaction with juvenile justice services.

Analysis of results and challenges: The Division made significant progress this year in meeting this qualitative objective. The Division designed a victims' satisfaction survey to gauge victim satisfaction both soon after the juvenile delinquency episode and two years after their case has been processed. The department's Finance and Management IT Section linked the survey to a website and database to enhance the ability for victims to report their experience with juvenile justice services. As of November 2006, the application needs to be tested by the Division and piloted in one of our probation offices so that statewide policies and procedures can be developed to guide its use.

A3: Strategy - Improve the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ field probation policy and procedure manual.

Target #1: All field probation units will achieve an average of 95% compliance with all probation audit standards for each one-year period measured.
Measure #1: Average % of all probation audit standards met by probation officers over the course of the fiscal year.

Avg Audit Compliance Rate

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total	Target	Variance
FY 2005	95.2	95.8	94.3	94.7	95%	95%	0
FY 2006	96.0	95.0	95.0	93.0	95%	95%	0

In FY05, the division had 84 juvenile probation officer positions. Not all of those positions carry caseloads and at the time that the probation officers were audited, some of the positions were vacant. The total number of case carrying probation officers is approximately 75.

Analysis of results and challenges: The data indicates that juvenile probation officers have been successful in meeting the goal of 95% audit compliance. This measure monitors the Division's success in achieving compliance with audit guidelines for juvenile probation officers as specified in the DJJ Field Probation Policy and Procedure Manual. Supervisory audits of each probation officer's caseload are conducted on a quarterly basis. These are used as a constructive means to assess an officer's performance in carrying out the required duties of the position and to ensure the delivery of appropriate services to each client. Data was collected for each quarter of the fiscal year as demonstrated above. In the coming year, the Division will be examining the format and method used to conduct audits of probation casework to attempt to make these audits an even more useful tool in determining the quality of juvenile probation officers' work.

Public Assistance

Mission

Promote self-sufficiency and provide for basic living expenses to Alaskans in need.

Introduction

To meet this mission, the division administers programs that provide temporary economic support to needy families and individuals, financial assistance to the elderly, blind and disabled, benefits to supplement nutrition, medical assistance, and supportive services that enable and encourage welfare recipients to pursue economic independence and self-sufficiency.

Core Services

Division staff determines program eligibility for services that help Alaskans remain safe and healthy by:

- Providing temporary financial assistance to low-income Alaskan families with children working towards self-sufficiency to help meet basic needs.
- Providing employment assistance to low-income Alaskan families with children to help them become more self-sufficient and increase stability through employment.
- Providing financial assistance to low-income aged, blind, or disabled Alaskans to help meet basic needs.
- Providing food assistance to low-income Alaskans to decrease incidences of food insecurity.
- Providing home heating assistance to low-income Alaskans to reduce the burden of home heating costs.
- Providing child care subsidies to families who need child care to work or participate in approved training activities.
- Licensing child care providers to increase the safety and quality of child care in Alaska.
- Determining eligibility for medical assistance programs.

The division provides direct customer services in 17 offices statewide. To qualify for public assistance, individuals must have income near or below poverty level and also meet a number of specific eligibility requirements that vary by program.

Unemployment, illness, and other personal emergencies can threaten the well-being of any Alaskan and create the need to seek public assistance. One out of every six Alaskans requests some type of cash, food, medical, or heating assistance from the division. In the last fiscal year, the division assisted approximately 67,000 families each month. While many families and individuals are served only seasonally or for a short period of need, an estimated 115,000 persons will receive some form of assistance in the coming year.

Services Provided

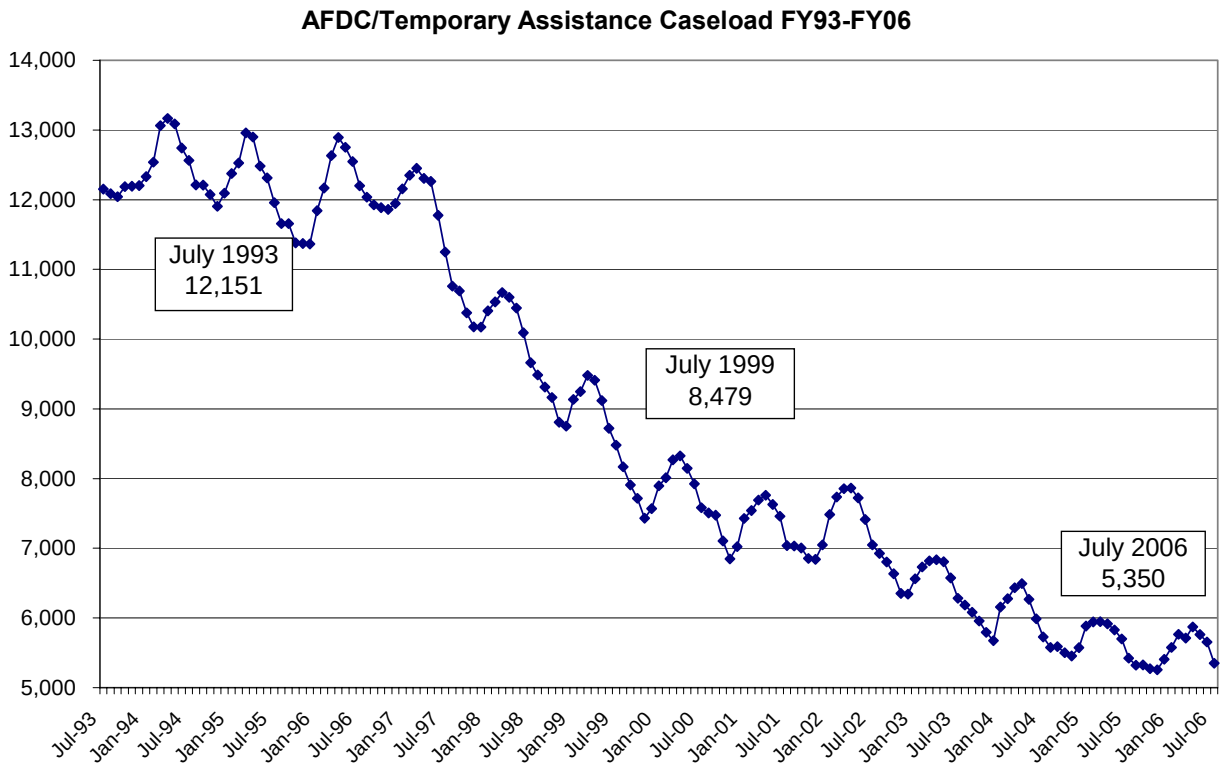
Alaska Temporary Assistance Program
The Alaska Temporary Assistance Program (ATAP) provides temporary financial assistance to needy families with children for basic living expenses while the adults prepare to become self-sufficient. ATAP was created by the state and federal welfare reform laws passed in 1996 and replaced the Aid to Families with Dependent Children (AFDC) Program. The program is funded by the federal Temporary Assistance for Needy Families (TANF) block grant and a required percentage of state expenditures, based on the amount spent in FFY1994 for the AFDC program in Alaska.

The program provides assistance to nearly 3,700 families throughout the state. This assistance is limited to 60 months and is a temporary safety net that helps families care for their children in their own homes by providing for the basic needs of shelter, clothing, transportation and food. ATAP also has a strong emphasis on work. Adults in families who receive assistance must participate in work or activities that will help them become self-sufficient and leave the program. They receive support to help them seek, secure, and retain employment. Case management and employment-related services are provided under a "work first" approach that emphasizes quick entry into the work force. These supports and services are referred to as Work Services.

Tribal Assistance Programs
Federal law allows tribes and Alaska Regional Native non-profit organizations to operate tribal Temporary Assistance for Needy Families (TANF) programs and to receive direct federal funding. State law allows the department to provide funding to Native organizations operating tribal TANF programs. These programs are known as Native Family Assistance programs. Funding for Native Family Assistance Programs comes from the federal Temporary Assistance for needy Families (TANF) block grant, and are supplemented by state funds that would otherwise be spent to serve Native families through the Alaska Temporary Assistance Program. Funds provided by the state grant are used for the purpose of providing assistance to eligible families.

While required to be comparable to the state's program, the Native Family Assistance Programs have the flexibility to be culturally relevant and regionally focused. The programs may serve both Natives and non-Natives in a region, or serve only Native families in a specific service area.

Approximately 1,900 Alaskan families now receive TANF services and benefits from one of five Native Family Assistance Programs. These programs are operated and administered by the Association of Village Council Presidents (AVCP), Central Council of Tlingit and Haida Indian Tribes of Alaska (CCTHITA), Tanana Chiefs Conference (TCC), Cook Inlet Tribal Corporation (CITC), and Bristol Bay Native Association (BBNA).



The success of the Temporary Assistance programs in Alaska are reflected in the 56% decrease in the annual monthly average State and Native Temporary Assistance caseloads between FY06 and FY94. The caseload decline has generated annual savings in welfare cash benefits of $77 million since FY97. These savings provided opportunities to reinvest in local organizations for community-based work services and child care subsidies. The caseload decline and benefit savings are a reflection of the efforts of staff, employers, partner agencies and community organizations to provide the services and support that help needy families achieve self-sufficiency.

Child Care Benefits

The Alaska Child Care Assistance Program has been in existence for 30 years. It was initially administered by the Department of Community and Regional Affairs; in 2001 it moved to the Department of Education and Early Development; in 2003 it moved to the Department of Health and Social Services.

Providing access to child care is a key component in the state's efforts to assist families to achieve employment and attain self-sufficiency. The federal Child Care Development Fund and Temporary Assistance for Needy Families block grant, along with the required state general fund match, provide funding for the child care program. The Child Care Program provides:

- child care assistance for low-to-moderate income families to allow the parents to work or participate in training activities,
- child care licensing of child care facilities across the state to promote the health and safety of children in child care, and
- Activities to promote quality care through Child Care Resource and Referral services, the Child Care Grant Program, and other special initiatives.

The state's continued commitment to improving the quality, availability, and affordability of child care helps ensure that families can move towards self-sufficiency while their children are in safe and healthy child care.

Work Services

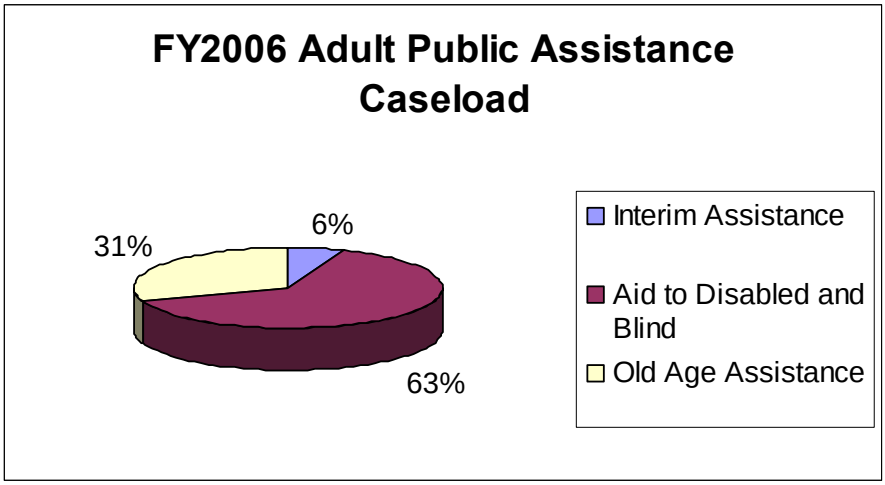
The Alaska Temporary Assistance Program's time-limited benefits and focus on moving recipients into the workforce require services that assist program participants to gain paid employment quickly. Work Services supports and promotes the efforts of Alaska Temporary Assistance recipients to attain economic self-sufficiency through employment. Additionally, employment and training services are provided to certain Food Stamp Program participants.

Work services include activities and supports that prepare clients to enter the workforce as well as to retain jobs, advance and to succeed in the workforce. Work Services also provides wage subsidies to employers who create new jobs and hire recipients into the jobs. The majority of Work Services is delivered through grants and pay for performance contracts with community-based organizations that use case managers to deliver welfare-to-work services to program participants. In state FY06 over 20 grants and contracts were issued to non-profit organizations, for-profit, private sector businesses and Native regional-non profits to assist recipients in their communities to move from welfare to work.

Adult Public Assistance

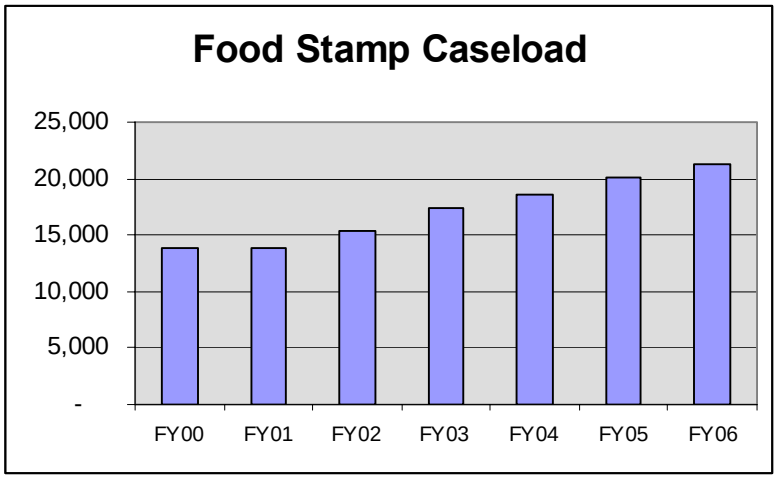
Adult Public Assistance (APA) is a state funded program that provides financial assistance to needy elderly, blind and disabled individuals. The program was created to supplement Social Security benefits and provides program recipients with the income support needed to remain as independent as possible in the community. People who receive APA are low-income individuals over 64, or at least 18 years of age and blind or diagnosed by a physician as permanently disabled or terminally ill. This year, an estimated 5,000 elderly and 11,700 disabled Alaskans will receive financial help and access to medical care from the APA Program.

The Adult Public Assistance program also includes an Interim Assistance benefit of $280 a month for individuals who appear to meet the Supplemental Security Income (SSI) disability criteria and have applied for SSI. Individuals must sign an Interim Assistance Reimbursement Agreement to receive the Interim Assistance payment, and are required to pay back the amount of Interim Assistance received while waiting for a decision on their SSI disability application from their first retroactive SSI check.



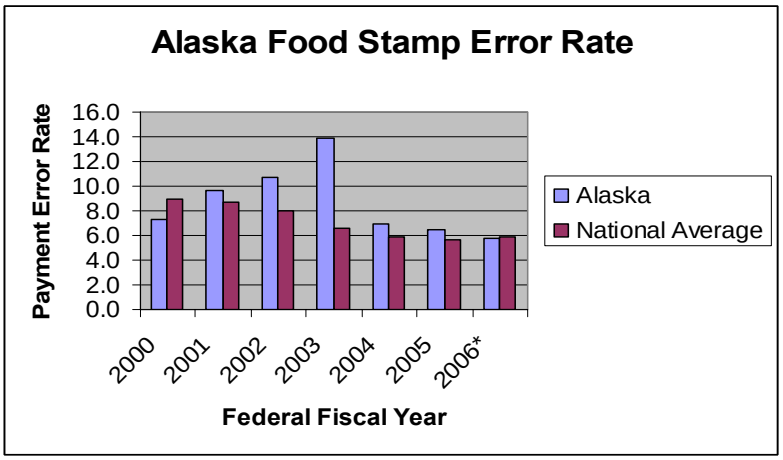
Food Stamp Program

The Food Stamp Program helps low-income households maintain adequate nutrition. Eligible participants are issued monthly food stamp benefits on the *Alaska Quest* debit card. The benefits are used to purchase food products from more than 500 authorized retail grocery stores throughout Alaska. The amount of benefits varies with household size, income, expenses and place of residence. Participants in rural communities get larger monthly benefits to compensate for higher food costs. Food stamp benefits are 100 percent federally funded by the U.S. Department of Agriculture, Food and Nutrition Service. The state and federal government equally share the administrative cost of the program. The Food Stamp caseload has been steadily growing. In FFY 2006, the program served over 21,000 low-income households with about $7 million of food stamp benefits each month.



Quality Control

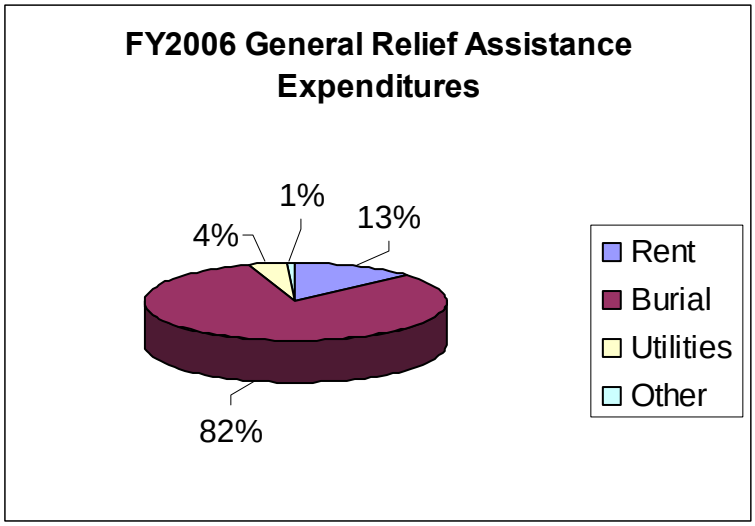
The division conducts rigorous quality control case reviews to assure the accuracy of individual eligibility and benefit payment decisions. This is a mandated activity for the Food Stamp and Medicaid programs, and the division also conducts regular reviews of Alaska Temporary Assistance Program cases. States can receive Food Stamp Program performance bonuses for superior performance and financial penalties for poor results. The quality assessment effort helps the division focus on work quality, improved performance outcomes and program accountability.



(* Preliminary Average)

Fraud Control
The division manages an active statewide welfare fraud control effort. The Fraud Control Unit investigates allegations of applicant and recipient fraud received from the staff or the public. The investigations involve most of the division's major programs. The unit's investigative staff is stationed in offices in Anchorage, Fairbanks, Wasilla, and Kenai. Individuals found to have intentionally violated program rules are disqualified from program participation and required to repay the amounts they were overpaid. The most serious cases are referred for possible criminal prosecution to the Department of Law. In SFY 2006 the unit investigated 368 applicant fraud referrals and 601 recipient fraud allegations.

General Relief Assistance
Alaska's General Relief Assistance (GRA) program is a safety net program for very low-income individuals who lack the personal income and resources to meet an emergent need and are not eligible for other state or federal assistance. It is the bottom tier in Alaska's welfare system; a last resort program designed to meet emergency food, clothing, shelter, and burial needs of low income Alaskans who have no other resources available. Nearly 80 percent of GRA program expenditures are used to pay for funeral and burial expenses of indigent deceased persons. The remainder is used to meet emergency shelter, food and clothing.



In FY2006 the program covered burial expenses for 500 deceased individuals and met emergency needs by preventing eviction and homelessness for approximately 90 households each month.

Medicaid Program
The Medicaid Program provides medical coverage for basic health and long-term care service for low-income Alaskans. The Division of Health Care Services (HCS) is responsible for managing payments to health care providers. The Division of Public Assistance (DPA) develops and administers policies for the program, ensures access, and determines eligibility of individuals and families, including eligibility for children and pregnant women under the Denali KidCare Program. The division manages the Medicaid Eligibility Program for nearly 100,000 Alaskans each month. Often, Medicaid recipients participate in other public assistance programs.

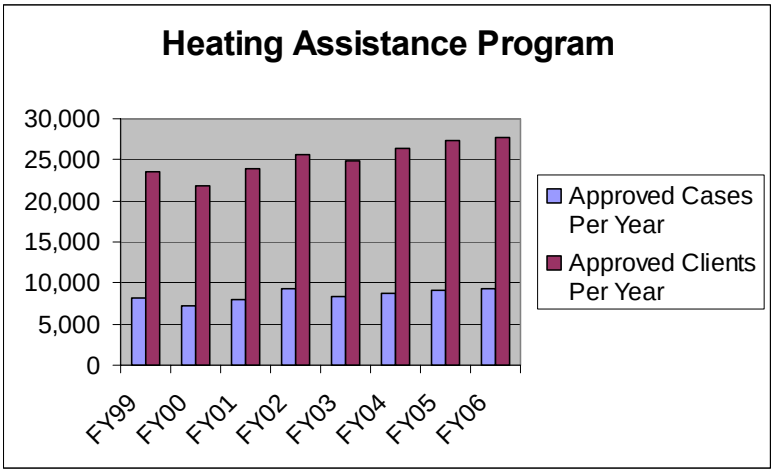
Chronic and Acute Medical Assistance Eligibility
The Chronic and Acute Medical Assistance (CAMA) program is state funded and designed to help needy Alaskans who have specific illnesses to get the medical care they need to manage those

illnesses. The program is for people who do not qualify for Medicaid, have very little income, few personal resources and have inadequate or no health care. People must also have a medical need covered by the program. These include a terminal illness, cancer requiring chemotherapy, chronic diabetes, seizure disorders, chronic mental illness or hypertension. The division develops and administers policies for the program, ensures access, and determines eligibility of individuals. The Division of Health Care Services (HCS) is responsible for authorizing care and handling payments to health care providers.

Energy Assistance Program
The Heating Assistance Program (HAP) is 100% federally funded through the Low Income Home Energy Assistance Program (LIHEAP) Block Grant. The program provides seasonal help to low-income households with home heating expenses.

Benefits are based on family income, home heating costs, housing type and geographic region. Applicant households apply once a year to receive a single heating assistance grant. Assistance is normally provided in the form of a credit with the client's home energy vendor, and covers the cost of home heating oil, natural gas, electricity, propane, wood and coal.

Last season over 9,300 households received help from the Energy Assistance Program. Eighty percent of the households included a person who is over age 65, disabled, or a child under age 6. The significant increase in the cost of home heating oil has nearly doubled over the last two years, based upon spot market prices from 10 communities around the state and have resulted in a 9% increase in applications for heating assistance since FY2004.



**Cases=Number of Households, Clients=Number of Individuals*

The Heating Assistance Program also funds weatherization projects to increase efficiency of homes with low income residents. Last year the LIHEAP program contributed $600,000 to the Alaska Housing Finance Corporation for administration of their Low Income Home Weatherization Assistance Program.

SeniorCare Program
The SeniorCare Program helps low income seniors who are at least 65 years of age remain independent in the community by providing a cash or prescription drug benefit as well as information and referral services. Program administration transferred from the Division of Alaska Pioneer Homes to the Division of Public Assistance effective January 1, 2006 without any interruption in benefits to seniors. In November 2006, 6,971 low income seniors received cash benefits and 140 received prescription drug benefits.

The SeniorCare program, which was reauthorized by the Alaska Legislature in May 2005, has a sunset date of June 2007. It must be reauthorized to continue. If the maximum income level remains fixed as provided in current law, the program will see a decline in the number of seniors served as other income sources, such as Social Security income, increase due to yearly cost of living adjustments.

Alaska Longevity Bonus Program

The Alaska Longevity Bonus program was created in 1972 to recognize Alaska's elders who lived in Alaska prior to statehood in 1959 for their contribution to the State, and to help these seniors stay in Alaska during their retirement years. To qualify, individuals must have been over age 65 and lived in Alaska for 25 consecutive years.

The bonus amount was initially $100 per month, and was later increased by legislative action to $125 in 1977, $150 in 1979, $200 in 1981 and $250 in 1982.

The residency requirements were challenged in court during the 1980's, and as a result the program became available to all Alaskans over age 65. In addition to the bonus payment, the program funds the loss of needs based Supplemental Security Income (SSI) and Adult Public Assistance benefits which, under federal law, requires the division to count longevity bonus payments as income. The replacement of the SSI and APA payments are known as Alaska Longevity Bonus Hold Harmless payments.

The annual cost of the program reached $67 million by 1993 and prompted the Legislature to enact legislation to begin phasing it out by reducing the bonus payment to seniors applying after January 1, 1994 and closing enrollment to seniors turning age 65 by December 31, 1996. The decline in the amount of bonus payments during the phase-out was as follows:

- $250, for applications submitted before January 1, 1994;
- $200, for applications submitted during 1994;
- $150, for applications submitted during 1995; and
- $100, for applications submitted during 1996.

The Palin Administration is restoring funds for the Longevity Bonus program beginning July 1, 2007. An increment of $33,709,200 in general funds is requested. The budget request is based on estimates that the program will serve approximately 13,000 seniors in FY2008.

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Comparison of Public Assistance Programs

	ATAP/TANF		Adult Public Assistance		General Relief		Food Stamps	
FY06 Cases avg. mo.	3,646		16,354		149		21,231	
# of clients avg. mo.	9,957		16,354		204		58,227	
Race Distribution	White	45%	White	49%	White	N/A	White	34%
	Alaska Native	26%	Alaska Native	29%	Alaska Native	N/A	Alaska Native	47%
	Black	9%	Asian	9%	Black	N/A	Black	5%
	Asian	8%	Black	5%			Hispanic	3%
							Asian	4%
Recipients by Location (District area)	Anch / Mat-Su	58%	Anch / Mat-Su	53%	Anch / Mat-Su	54%	Anch / Mat-Su	46%
	Northern	11%	Northern	13%	Northern	15%	Northern	14%
	Southeast	8%	Southeast	11%	Southeast	14%	Southeast	13%
	Balance of State	23%	Balance of State	23%	Balance of State	17%	Balance of State	27%
Expenditure By Category of Service	Single parent	65%	Disabled	69%	Burial service	82%	FS and ATAP	14%
	Two parent	14%	Aged	30%	Rent assistance	13%	FS only	43%
	Child only	22%	Blind	1%	Other	5%	FS and APA	17%
							FS and Med	53%
Children 0 - 18 yrs	6,887		0				29,011	
Adults 19 - 59 yrs	3,051		9,438				26,580	
Adults 60 - older	19		6,918				2,648	
Total Expenditures	$41,308,900		$57,556,200		$1,261,100		$85,024,229	
Federal	$11,033,100		$1,393,200				$85,024,229	
GF	$28,183,500		$52,300,000		$1,261,100			
Other	$2,092,300		$3,863,000					

Notes:
1) Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.
2) ATAP/TANF caseload includes the Alaska Temporary Assistance Program only. Expenditures include the Alaska Temporary Assistance Program and the Native Family Assistance Program.

Comparison of Public Assistance Programs

	Heating Assistance		Child Care (PASS I, II, III)	
FY06 Cases	9,359			
# of clients	27,806		6,388	children
Race Distribution	White	52%	N/A	
	Alaska Native	35%		
	Black	2%		
	Asian	4%		
	Unknown	7%		
Recipients by Location (District area)	Anch / Mat-Su	37%	N/A	
	Northern	14%		
	Southeast	6%		
	Balance of State	43%		
Expenditure By Category of Service	Employed, retired or temp unemployed	61%	PASS I	15%
			PASS II	8%
			PASS III	77%
	Receiving ATAP	12%	(Pass II/III)	
	Receiving APA	27%	(Pass II - 9%)	
			(Pass III - 91%)	
Total Expenditures	$10,411,326		Pass I	$5,704,355
			Pass II/III	$31,573,931
Federal	$10,411,326		$30,334,386	
GF			$6,943,900	
Other				

Notes:
1) Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.
2) Several areas of Alaska receive Heating Assistance through tribal organizations funded directly by the federal government.
3) The Child Care Subsidy information includes PASS I (child care for families also receiving ATAP), PASS II/III child care subsidy and Child Care Grant Program Expenditures.
4) Caseloads listed for Heating Assistance is an annual number, where the caseloads listed for Child Care are monthly averages.

AS 43.23.075	Eligibility for Public Assistance
AS 43.23.085	Eligibility for State Programs
AS 47.05.010-080	Public Assistance
AS 47.05.300-.390	Criminal History; Registry
AS 47.07.010-900	Medicaid
AS 47.25.001-.095	Day Care Assistance and Child Care Grants
AS 47.25.120-300	General Relief Assistance
AS 47.25.430-615	Adult Public Assistance
AS 47.25.975-990	Food Stamps
AS 47.27.005-.990	Alaska Temporary Assistance Program
AS 47.32.010-.900	Centralized Licensing and Related Administrative Procedures
AS 47.45.300-.390	SeniorCare Program
7 AAC 38	Permanent Fund Dividend Distribution
7 AAC 39	Child Care Grant Program
7 AAC 40	Adult Public Assistance
7 AAC 41	Child Care Assistance
7 AAC 44	Heating Assistance Program
7 AAC 45	Alaska Temporary Assistance Program
7 AAC 47.020-290	General Relief Assistance
7 AAC 47.800-890	SeniorCare Program
7 AAC 57	Child Care Facilities Licensing
7 CFR 273.16	Food Stamp Program
7 CFR 275.10	Food Stamp Quality Control
42 CFR 431	Medicaid Program
42 CFR 457	State Children's Health Insurance (SCHIP) Payment Error Rate Measurement (PERM)
45 CFR 235.110	Welfare Fraud
45 CFR 431.800	Medicaid Quality Control

Public Law 97-35 L.I.H.E.A.P. Act of 1981

Public Assistance	2007	2008 Proposed	07 to 08 Change
General Funds	122,312.1	159,904.6	37,592.5
Federal Funds	95,262.2	97,682.7	2,420.5
Other Funds	23,152.2	23,272.2	120.0
Total	**240,726.5**	**280,859.5**	**40,133.0**

**Alaska Longevity Bonus Program included $33,709.2 GF for 2008 Proposed.*

Adult Public Assistance

Transfer Inter Agency (I/A) Authority from Tribal Assistance Program to APA (200.0 I/A)
Transfer of Inter Agency Authority to the Adult Public Assistance Component for funds needed for the Permanent Fund Hold Harmless portion of payments.

Child Care Benefits

Child Care Program Caseload Growth (1,547.7 GF)
The number of low-income families who need help in paying for child care so they can keep working continues to grow. Child care assistance can often make the difference between obtaining and maintaining employment or being at risk of needing public assistance. While Alaska's temporary assistance (TANF) caseload decreased significantly in past years, the rate of decline has leveled off. It is especially important to adequately fund child care in order to keep families working and off TANF. This increment fully funds the projected formula growth and should prevent creation of wait lists for child care assistance.

Public Assistance Administration

Increase in Receipt Supported Services (RSS) for Increased Collections of Benefit Overpayments (120.0 RSS)
Increment of $120.0 needed in additional authority for collections of established overpayment claims owed to the state due to benefit overpayments.

Alaska Longevity Bonus Program

Establish New Alaska Longevity Bonus Grant Program (33,709.2 GF)

The Palin Administration is restoring funds for the Longevity Bonus program beginning July 1, 2007. The budget request is based on estimates that the program will serve approximately 12,631 clients in FY2008.

Alaska Longevity Bonus Program
Benefit Costs

Fiscal Year	Total Cost	# Recipients
2003	$ 55,275,500.00	18,741
2004	$ 44,777,917.00	17,252
2005	$ 41,543,333.00	16,081
2006	$ 38,344,167.00	14,917
2007	$ 35,203,333.00	13,766
2008	$ 32,130,417.00	12,631

Note: Final payment of original program was issued in August 2003. FY2004-2008 are projections.

Challenges

Alaska Temporary Assistance Program

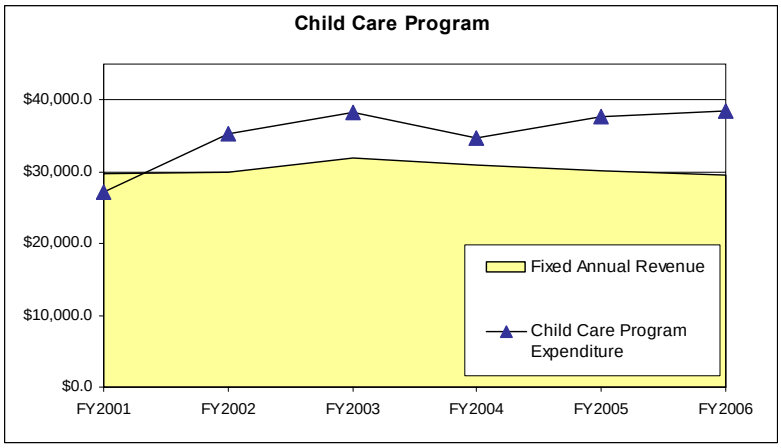
- Management of the state's TANF balance to ensure core business needs are supported and sustained while maintaining the Alaska Temporary Assistance Program's safety net services and efforts to support self-sufficiency through employment.
- The 2006 reauthorization of TANF increased performance expectations and eliminated the High Performance Bonus, a past source of revenue. Alaska earned over $12 million from the High Performance Bonus over the last 4 years, which the division used to fund new programs and strategies. Reauthorization also only ensured the continuation of supplemental grants to States with high population growth through Federal Fiscal Year 2008. Alaska's "High Pop" grant is almost $7 million.

Child Care Benefits

In FY08, the division expects the need for child care assistance to increase by 5%, or 315 children per month. The Governor's FY08 budget request includes an increment of $1,5467.7 to meet this projected formula growth.

- The funding for child care programs is primarily federal dollars, including CCDF (Child Care Development Fund) funding, TANF (Temporary Assistance for Needy Families) transfers into CCDF, and direct TANF expenditures. While the CCDF funding has remained in the range of $11.3 to $11.7 million dollars over the last five years, child care expenditures have continued to increase. TANF funding has always filled the gap between the amount of CCDF funding and child care expenditures and over half of the child care budget is funded by TANF. However, the availability of TANF is uncertain and sufficient funding is needed to maintain core child care services by adequately funding the program in order to keep families working and off of TANF.
- State rates for child care assistance have not been raised since 2001, except for the Fairbanks area, where rates were recently raised to match those in Southeast Alaska and Anchorage. State rates are not keeping up with rates that child care providers charge. As state rates decline in relation to the market rate, low income families on child care assistance are faced with an increased financial burden to pay the difference between the state rate and the amount the child care providers charge (in addition to their required co-payment) or choosing lower priced and usually lower quality child care.
- The oversight of preschools continues to be a point of discussion between the Departments of Health and Social Services and Education and Early Development. At this time, limited oversight is provided by the Department of Education and Early Development. We believe that there are many preschools that are currently out of compliance with Alaska Statutes because they are not licensed as a child care facility or certified as a preschool.
- The current funding methodology used to fund grantees for eligibility determinations for the Child Care Assistance Program is inconsistent. Funding levels for these services have essentially remained flat over the past 4 years, despite the increased costs of doing business grantees have experienced. In FY06, an effort was made to change the funding methodology, the service areas, and the actual services to be provided by grantees. There was considerable negative feedback and the division's proposal was withdrawn. The current challenge is to develop a procurement plan that is cost effective, promotes efficiency and consistency, and is community based. The division needs to issue a Request for Proposal (RFP) for child care eligibility services in early 2007 and anticipated grantees may not be interested in continuing to provide services with reduced or flat funding.

- Income eligibility guidelines for the Child Care Assistance Program have not been raised since 2002. The income ceiling for Child Care Assistance Program eligibility is currently 70% of the 2006 state median income, or $3,887 gross per month, for a family of three. The majority (97%) of families served have incomes less than 58% of the state median income or $3,184 gross per month, for a family of three. The federal government allows states to serve families with incomes up to 85% of their state's median income; raising Alaska's income limits would likely require additional resources.



SeniorCare

- The Senior Care Program, reauthorized by the Alaska Legislature in May 2005, will sunset in June 2007. The program must be reauthorized to continue to provide cash and prescription drug assistance to over 7,000 seniors per month.

Senior Care Recipients

Senior Care Recipients	7,111*
Previous Longevity Bonus Recipients Enrolled in Senior Care	2,541
Difference	4,570

**Total recipients of Senior Care Cash Payment and Drug Benefit - November 2006*

Energy Assistance Program

- The price of home heating oil has nearly doubled over the past two years, based upon Alaska spot market prices from 10 communities around the state. This is creating great difficulties for low income Alaskans, as their grants do not adequately cover their increased costs.
- Maintaining and supporting increased caseloads due to high fuel costs.
- The uncertainty of federal funding for administering the program increases the difficulty of planning and managing the program. The division projects another 9% increase in applications in FY08. Higher energy costs combined with increased eligible families results in smaller grants with lower buying power.

Public Assistance Administration

- The Division of Public Assistance's automated Eligibility Information System (EIS) is an aging, inflexible application. It is difficult to adapt to the State's and the division's diverse and ever-changing business practices. EIS was implemented in 1984 and is not keeping pace with the need for administrative efficiencies and program timeliness, accuracy and performance requirements. As its technology infrastructure ages, both the application architecture and hardware/software platform will become increasingly difficult to maintain

and enhance due to a shrinking number of available support vendors in the marketplace. An evaluation of system alternatives is needed to inform the division of ways in which the costs and effort of maintaining the out-moded system could be reduced or administrative efficiencies and performance outcomes increased by replacing the system.

- The division is continuing to experience the loss of long term knowledgeable professional staff through retirement, and turnover due to technical staff that leave for better paying jobs or more favorable and less stressful workload environments.

Work Services

- Temporary Assistance to Needy Families reauthorization requires states to meet higher work participation rate expectations in order to avoid fiscal penalties.
- Meeting the federal performance expectations requires increased focus on providing meaningful work activities and promoting employment opportunities for families living in rural, economically depressed regions of the state.
- Alaska is successful at quickly helping the job-ready to find employment. However, families with multiple or profound challenges to economic self-sufficiency are a growing percentage of the caseload. The division must develop strategies that better identify barriers, provide enhanced services to address the challenges, and build stronger collaborations that integrate services for shared customers.

Alaska Longevity Bonus Program

- The Governor's FY08 budget request includes an increment of $33,709,200 in general funds to re-establish the Alaska Longevity Bonus program, and proposes the program be administered by the Division of Public Assistance.
- The Division of Public Assistance estimates approximately 13,000 seniors who qualified for the Alaska Longevity Bonus when the program ended will participate when the program is re-established.
- A reasonable implementation period will be needed to re-establish the Alaska Longevity Bonus program, and to provide enrollment opportunities to qualifying seniors.

Contribution to Department's Mission

To provide self-sufficiency and basic living expenses to Alaskans in need.

Core Services

- Provide temporary financial assistance to low income Alaskan families with children who are capable of self-sufficiency to help them meet their basic needs.
- Provide employment assistance to low income Alaskan families with children to help them become more self-sufficient.
- Provide financial assistance to low income aged, blind, or disabled Alaskans to help them meet their basic needs.
- Provide food assistance to low income Alaskans to decrease their incidence of food insecurity.
- Provide home heating assistance to low income Alaskans to reduce their disproportionate burden of home heating costs.
- License childcare providers to increase the safety and quality of childcare in Alaska.

Department Level Measures

F: Result - Outcome Statement #6: Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10% annually.
Measure #1: Rate of change in self-sufficient families.

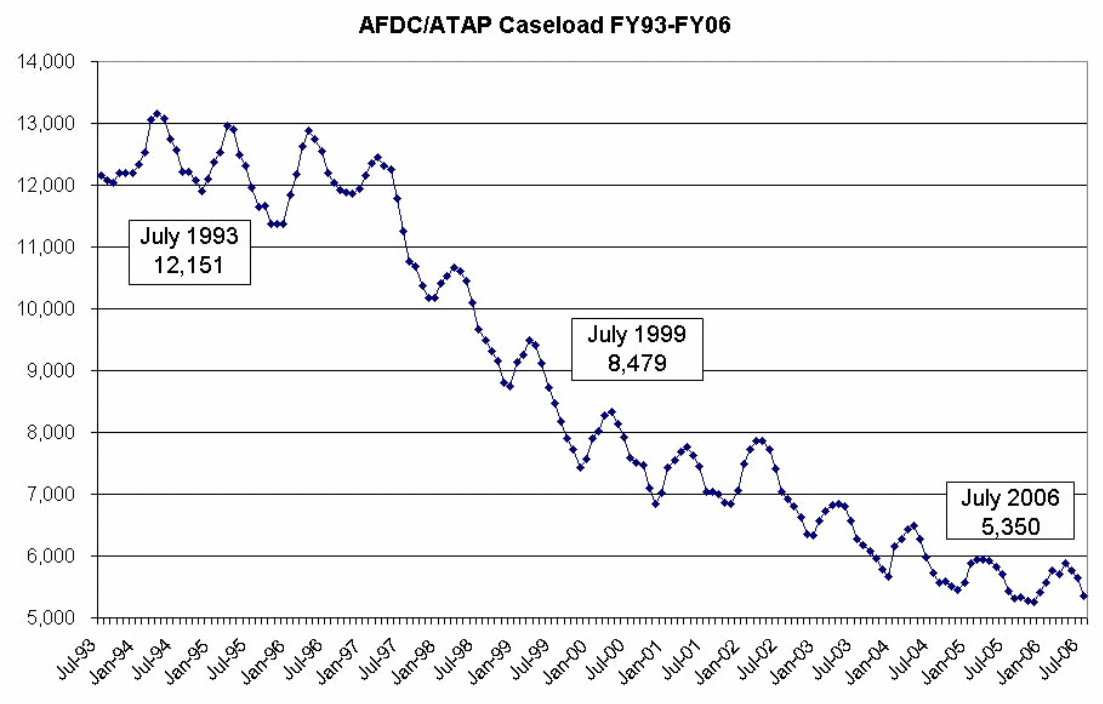


*Table includes ATAP & Native Family Assistance Programs

Changes in Self Sufficiency

Fiscal Year	September	December	March	June	YTD Total
FY 2002	-16%	6%	4%	3%	-2%
FY 2003	-1%	-11%	-14%	-13%	-9%
FY 2004	-12%	-7%	-6%	-9%	-9%
FY 2005	-6%	-7%	-8%	-6%	-7%
FY 2006	-6%	-3%	-4%	-1%	-2%
FY 2007	-5%	0	0	0	-5%

**YTD Total column represents the average annual monthly caseload rate change.*

Analysis of results and challenges: As shown in the YTD Total column, SFY2006 had a 2% decline in the number of families receiving Alaska Temporary Assistance Program benefits compared to SFY2005. The other four monthly columns show a snapshot of caseload rate change compared to the previous year's month. (Note: The YTD Total column represents the average annual monthly caseload rate change.)

The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of families becoming self-sufficient.

F1: Strategy - Use TANF high performance bonus funds for families approaching 60-month time limit.

Division Level Measures

A: Result - Low income families and individuals become economically self-sufficient.

Target #1: Increase self-sufficient individuals and families by 10%.
Measure #1: Rate of change in self-sufficient families.

Analysis of results and challenges: This target and measure is reported at the Department level. See Result F: Outcome Statement #6.

A1: Strategy - Increase the percentage of temporary assistance families who leave the program with earnings and do not return for 6 months.

Target #1: 90% temporary assistance families leave with earnings and do not return for 6 months.
Measure #1: Percentage of families that leave temporary assistance with earned income and do not return for 6 months.

Percent of Temporary Assistance Families Who Leave the Program With Earnings and Do Not Return for 6 Months

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	83%	83%	76%	81%	81%
2003	85%	87%	82%	82%	84%
2004	90%	85%	79%	80%	84%
2005	88%	85%	80%	82%	84%
2006	87%	87%	80%	84%	85%
2007	88%	0	0	0	88%

Analysis of results and challenges: The goal is for clients to move off of Temporary Assistance with more income than they received while on the program, and for those clients to stay employed with sufficient earnings to stay off the program. The measurement ties in job retention, since retaining employment is directly related to remaining off Temporary Assistance.

The Division provides childcare and supportive services to support employed families during the transition to self-sufficiency. Supportive services include case management support to continue coaching the employed client during this vulnerable period.

To calculate this measure, we divide the number of cases that closed with earnings 6 months ago by the number of cases that closed with earnings 6 months ago who are not in the current caseload. The calculation for the quarterly figures is a weighted average of the 3 months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY07 target is 90%.

A2: Strategy - Increase the percentage of temporary assistance families with earnings.

Target #1: 40% of temporary assistance families with earnings.
Measure #1: Percentage of temporary assistance families with earnings.

Percent of Temporary Assistance Adults With Earnings

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	31%	28%	27%	31%	29%
2003	30%	28%	27%	32%	29%
2004	31%	29%	29%	35%	31%
2005	34%	31%	30%	35%	33%
2006	34%	32%	32%	36%	34%
2007	36%	0	0	0	36%

Analysis of results and challenges: This is a measure of current Temporary Assistance recipients who have earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare-to-work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient.

The calculation for the quarterly figures is a weighted average of the 3 months in the quarter. The YTD total is a weighted average of all the months so far in the year.

The FY07 target is 40%.

A3: Strategy - Increase the percentage of temporary assistance families meeting federal work participation rates.

Target #1: 50% of temporary assistance families meet federal work participation rates.
Measure #1: Percentage of temporary assistance families meeting federal work participation rates.

Percentage of temporary assistance families meeting federal work participation rates.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	38%	37%	36%	36%	36%
2003	32%	33%	33%	34%	34%
2004	36%	36%	36%	37%	37%
2005	39%	37%	39%	40%	40%
2006	42%	43%	44%	44%	44%
2007	47%	0	0	0	47%

Analysis of results and challenges: Temporary Assistance (TA) is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

The quarterly figures are YTD figures. The federal participation rate calculation is a running YTD figure.

The FY07 target is 50%.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

In FY06, DPA began a family-centered services initiative to increase the self-sufficiency and self-responsibility of Alaska Temporary Assistance families with complex issues and multiple barriers to self-sufficiency.

Family Centered Services assesses the service needs of all members of a temporary assistance family, not just the adults who are required to participate in work activities. Program coordinators work with local Job Center partners and field staff from different programs, divisions, departments and community agencies to weave collective goals into integrated service plans to help families with complex challenges achieve a healthier self-sufficient family structure. This requires a much more collaborative and coordinated planning effort. Family Centered Services also uses a “customized employment” method of finding job opportunities for individuals participating in the project.

In FY06, DPA conducted Family Centered Services pilot projects in Fairbanks and the Mat-Su Valley. Results of the pilot projects show families participating have an increase in hours of participation in work and work-related activities, an increase in average monthly earnings, and an increase in the number of months of earnings.

A4: Strategy - Improve timeliness of benefit delivery.

Target #1: 95% of food stamps expedited service applications meet federal time requirements.
Measure #1: Percentage of food stamps expedited service households that meet federal time requirements.

Percentage of food stamps expedited service households that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	95.4%	94.5%	93.4%	93.4%	93.4%
2003	94.0%	90.5%	90.8%	92.1%	92.1%
2004	93.2%	93.8%	94.5%	94.7%	94.7%
2005	90.9%	92.3%	92.7%	93.5%	93.5%
2006	95.0%	95.6%	96.0%	95.7%	95.7%
2007	96.5%	0	0	0	96.5%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The quarterly data are YTD figures. The FY07 target is 95%.

Target #2: 96% of new food stamps applications meet federal time requirements.
Measure #2: Percentage of new food stamps applications that meet federal time requirements.

Percentage of new food stamps applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	93.0%	94.2%	94.3%	94.7%	94.7%
2003	95.9%	95.1%	95.1%	95.5%	95.5%
2004	96.2%	96.1%	96.3%	96.5%	96.5%
2005	95.2%	95.5%	95.7%	95.9%	95.9%
2006	95.4%	95.9%	96.1%	96.2%	96.2%
2007	97.2%	0	0	0	97.2%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 96%.

Target #3: 99.5% of food stamps recertification applications meet federal time requirements.

Measure #3: Percentage of food stamps recertification applications that meet federal time requirements.

Percentage of food stamps recertification applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	99.8%	99.8%	99.7%	99.6%	99.6%
2003	99.5%	99.5%	99.4%	99.4%	99.4%
2004	99.6%	99.6%	99.6%	99.6%	99.6%
2005	99.5%	99.5%	99.5%	99.6%	99.6%
2006	99.4%	99.5%	99.5%	99.5%	99.5%
2007	99.7%	0	0	0	99.7%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 99.5%.

Target #4: 90% of temporary assistance applications meet time requirements.
Measure #4: Percentage of temporary assistance applications that meet time requirements.

Percentage of Temporary Assistance applications that meet time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	83%	86%	85%	86%	86%
2003	90%	88%	89%	90%	90%
2004	88%	88%	88%	88%	88%
2005	85%	84%	85%	85%	85%
2006	88%	86%	86%	87%	87%
2007	85%	0	0	0	85%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 90%.

Target #5: 90% of Medicaid applications meet federal time requirements.
Measure #5: Percentage of Medicaid applications that meet federal time requirements.

Percentage of Medicaid applications that meet federal time requirements

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	89%	90%	89%	89%	89%
2003	91%	90%	90%	90%	90%
2004	88%	91%	91%	91%	91%
2005	92%	91%	91%	90%	90%
2006	89%	88%	89%	89%	89%
2007	88%	0	0	0	88%

Analysis of results and challenges: Timely benefits ensure clients have their benefits when they need them. Untimely benefits cause budget issues for clients and impact their ability to gain self-sufficiency. An issue affecting timeliness is the balance that eligibility workers must strike between timely and accurate benefit delivery.

The FY07 target is 90%.

A5: Strategy - Improve accuracy of benefit delivery.

Target #1: 93% of food stamp benefits are accurate.
Measure #1: Percentage of accurate food stamp benefits.

Percentage of accurate food stamp benefits

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	90.4%	92.4%	90.5%	89.2%	89.2%
2003	86.2%	84.7%	85.6%	86.4%	86.4%
2004	90.8%	94.2%	93.5%	93.3%	93.3%
2005	92.2%	93.2%	93.0%	93.8%	93.8%
2006	92.3%	93.5%	94.1%	0	94.1%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY06 target is 93%.

Target #2: 95% of temporary assistance benefits are accurate.
Measure #2: Percentage of accurate temporary assistance benefits.

Percentage of accurate temporary assistance benefits.

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	88.2%	93.7%	93.6%	92.0%	92.0%
2003	94.4%	93.6%	94.5%	93.6%	93.6%
2004	96.7%	97.5%	98.2%	98.1%	98.1%
2005	98.5%	95.9%	95.7%	97.1%	97.1%
2006	98.1%	96.3%	97.7%	0	97.7%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid sampling, case reviews, and home visits.

This is a cumulative measure based on the federal fiscal year (Oct-Sep) and it has about a two-month lag.

The FFY06 target is 95%.

Target #3: 93% of Medicaid eligibility determinations are accurate.
Measure #3: Percentage of accurate Medicaid eligibility determinations.

Percentage of accurate Medicaid eligibility determinations

Year	YTD Total
2002	96%
2003	99%
2004	99%
2005	93%

Analysis of results and challenges: Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. Medicaid eligibility accuracy is compiled at the end of projects designed by the state and accepted by federal authorities.

The FFY06 target is 93%.

A6: Strategy - Increase the percentage of subsidy children in licensed care.

Target #1: 76% of subsidy children are in licensed care.
Measure #1: Percentage of subsidy children in licensed care.

Percentage of subsidy children in licensed care

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	0	60%	58%	64%	64%
2003	65%	66%	68%	75%	75%
2004	75%	76%	76%	76%	76%
2005	74%	81%	77%	80%	77%
2006	80%	84%	75%		

Analysis of results and challenges: The first available data regarding this measure is the second quarter in 2002.

There is a two month lag in the data. The FY06 target is 76%.

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Public Health

Mission

Protect and promote the health of Alaskans.

Introduction

The Division of Public Health (DPH) operates programs that are primarily population-based and focused on protecting and promoting the health of all Alaskans and visitors to Alaska. DPH employees conduct disease surveillance and investigation and provide treatment consultation, case management and laboratory testing services to control outbreaks of communicable diseases and prevent epidemics. The division promotes healthy behaviors by educating citizens and supporting community actions to reduce health risks.

DPH also improves public health by encouraging, supporting and sometimes requiring the development of health services by others, and by providing services directly when unavailable from the private sector or other health organizations. Outreach activities are conducted to link high-risk and disadvantaged people to needed services. The safety of clients and residents of health care and assisted living facilities is improved through routine facility surveys and complaint investigations.

The division uses data and other scientific information and expertise to develop health recommendations and policy and deliver disease control and health promotion services. Professional personnel monitor and assess health status through the collection and analysis of vital statistics, behavioral risk factor data, and data on disease and injury, including forensic data from postmortem examinations.

Core Services

DPH provides seven core services that help achieve its mission of protecting and promoting the health of the public. The core services are:

- Prevent and control epidemics and the spread of infectious disease;
- Prevent and control injuries;
- Prevent and control chronic disease and disabilities;
- Respond to public health emergencies, disasters and terrorist attack;
- Assure access to early preventive services and quality health care;
- Protect against environmental hazards impacting human health; and
- Ensure effective and efficient management and administration of public health programs and services.

Services Provided

Infectious Disease and Epidemic Prevention & Control
The DPH Sections of Epidemiology, Nursing, and Laboratories work collaboratively as a team to monitor, prevent and protect against the spread of infectious disease. Major areas of activity include vaccine preventable diseases (e.g., measles, pertussis, hepatitis, influenza, etc.), tuberculosis, sexually transmitted diseases, gastro-intestinal diseases, botulism, rabies, paralytic shellfish poisoning, and waterborne diseases. In addition, the division is constantly vigilant for other new or unusual diseases that would constitute a public health emergency, such as SARS and pandemic influenza.

To prevent and control infectious disease, the division's medical epidemiologists conduct surveillance primarily through the receipt and analysis of disease reports from health care providers and clinical laboratories across the state. This enables identification of disease trends and rapid identification and response of outbreaks and epidemics. They travel to the site of disease outbreaks to conduct special investigations if necessary, and provide medical consultation to health care providers and information to the public on prevention and control of infectious disease. Vaccine for vaccine-preventable diseases is provided to all Alaskan children, and preventive therapies are provided for certain diseases as appropriate (e.g., tuberculosis and HIV/AIDS). Public health nurses serve as the front line workforce of public health, working at the community level to identify the presence and source of disease, provide local response to outbreaks, educate the community on how to prevent and treat disease, provide immunizations, provide partner notification and tracking for STDs, and coordinate with local health care providers. The division's public health laboratories provide analytical and technical laboratory testing necessary for the diagnosis of infectious disease, as well as training, consultation, and reference testing for clinical laboratories throughout the state.

A new investment of state dollars by the Legislature through an increment funded in FY07 is enhancing capacity for infectious disease control and emergency preparedness. These funds are being invested in staff and supplies to address the rising demands and cost of infectious disease prevention, control, intervention and treatment for Alaskans statewide. Additional information on implementation of this increment initiative is described below under "public health emergency preparedness and response."

Injury Prevention & Control
The DPH Section of Injury Prevention and Emergency Medical Services (supported by the Community Health & EMS budget component) works to prevent injuries from occurring by identifying causal factors and implementing policies and strategies for prevention. Examples of some of the specific areas of activity include poison prevention, water safety, child passenger safety, the model helmet program, fire-related injury prevention, fall prevention, and family violence prevention. This section also strives to ensure that qualified and properly equipped emergency medical services personnel are available to respond to the emergency medical needs of Alaskans and visitors to our state.

Other Sections of DPH contribute to this service as well. For example, public health nurses work within Alaska's communities to educate residents about injury prevention, and the Certification & Licensing Section's efforts to ensure quality health and residential facility care helps

protect vulnerable Alaskans in those settings from injury that may otherwise result from inadequate care.

A new investment of state dollars by the legislature through an increment funded in FY07 is helping to shore up an eroding EMS system infrastructure by providing the first increase for regional EMS activities in many years. The 20% increase has been fully awarded to Alaska's Regional EMS Councils.

Chronic Disease Prevention & Control

The DPH Section of Chronic Disease Prevention and Health Promotion seeks to improve the health and well being of all Alaskans by: monitoring behavioral risk factors and chronic diseases through the collection, interpretation, and dissemination of surveillance data; educating the public and health professionals; collaborating with communities and other partners in the planning, implementation and evaluation of evidence-based strategies and interventions; advocating for the prevention and control of chronic diseases; and promoting healthy lifestyles. Programs focus on the prevention and control of diabetes, cancer, heart disease and stroke, arthritis, obesity, and tobacco use.

Other DPH Sections contribute to this service as well. For example, public health nurses organize and staff local senior clinics to help seniors monitor and care for a variety of chronic conditions, and the Section of Women's, Children's and Family Health administers the Alaska Breast and Cervical Health Check program to provide breast and cervical cancer screening to women who do not have financial access to this service.

A new investment of state Tobacco Education/Cessation Fund dollars by the legislature through an increment funded in FY07 is currently supporting development and implementation of comprehensive urban and rural school tobacco prevention programs.

Public Health Emergency Preparedness & Response

The Division of Public Health works to ensure Alaskans are protected in the event of a public health emergency – whether natural (such as SARS and pandemic influenza) or manmade (such as the anthrax attacks of 2001). The division's efforts are focused in several key areas, including: emergency preparedness planning and readiness assessment, disease surveillance and epidemiology capacity, biological and chemical laboratory capacity, communications and information technology, public communication and health information dissemination, training and exercises, and hospital preparedness.

The emergency preparedness activities are a division-wide effort coordinated out of the DPH Director's Office (PH Administrative budget component), and conducted by the division's public health nurses who provide leadership for and participate in community disaster and bioterrorism response activities, medical epidemiologists who develop policies and plans for improved detection and control of a wide range of possible public health emergencies, laboratory scientists (microbiologists, virologists, and chemists) who have developed the analytic testing capabilities to ensure timely detection and diagnosis of epidemic, bio-terror, or chemical terror agents. The division also strives to ensure that Alaska's emergency medical system and hospitals are prepared to respond to a medical disaster or public health emergency.

A new investment of state dollars by the legislature through an increment funded in FY07 is enhancing capacity for infectious disease control and emergency preparedness. These funds are contributing to increased support for disaster preparedness for hospitals throughout the state and pandemic preparedness for Alaska's communities. Specific examples of new activities include mass vaccination clinic exercises sponsored in seven communities during the fall of 2006, community outreach visits to provide planning workshops for 15 regions of the state, the first alternate care site exercise ever held in Alaska, and purchase of ventilators and personal protective equipment for state and local first responders and hospitals. One increment specific to development of an antiviral medication stockpile for the state has been used to purchase 34,559 doses of oseltamivir and 5,181 doses of zanamivir. An FY07 capital budget appropriation supports purchase of electronic immunization and infectious disease registries as part of this initiative. The Request for Proposals for this purchase is nearing completion in January 2007, and contract award is expected to be complete before the end of FY07.

Picture Caption: Alaska's public health pharmaceutical warehouse takes delivery of the oseltamivir order for the state's antiviral stockpile on November 3, 2006.

Access to Early Preventive Services & Quality Health Care

Alaska public health nurses are the service delivery arm for essential public health services in communities and villages across the state. Direct clinical and preventive services are provided in 23 community public health centers and through itinerant visits to communities and families statewide. Examples of the types of services they provide include well child exams, tuberculosis screening, STD screening and treatment, HIV testing and prevention counseling, immunizations, family planning, pregnancy testing, prenatal monitoring, postpartum and other home visits, and school screenings. Public health nurses also link individuals to needed health care services at the local level.

The DPH Section of Women's, Children's and Family Health (WCFH) contributes to the delivery of population-based services and the building of health care system infrastructure so Alaska's women, infants, children, and families can achieve the best possible health and well-being. The programs in this section work with other health care and community support service providers to assure they are organized in ways that allow for flexibility to address the changing and varied needs of families. WCFH administers the following programs in support of access to preventive and other health care services: breast and cervical cancer screening, family planning, genetic and specialty clinics, newborn metabolic screening, newborn hearing screening, and oral health.

The DPH Section of Injury Prevention and Emergency Medical Services (supported by the Community Health & EMS budget component) works to ensure the availability and quality of the emergency medical services (EMS) in Alaska by: 1) certifying emergency medical technicians (EMTs), EMS instructors, emergency medical dispatchers, and ground and air ambulance services; 2) reviewing and approving emergency trauma technician, EMT, and mobile intensive care paramedic courses; 3) providing training and technical assistance to local EMS agencies; and, 4) administering state and federal grants that provide operational and capital equipment support for EMS systems across the state.

The DPH Section of Certification & Licensing works to ensure the safety and quality of Alaska's hospitals, nursing facilities, assisted living homes, and other residential and health care facilities through routine inspections and complaint investigations. Through criminal background checks for employees working in these facilities, this section provides additional safeguards against abuse and neglect of the state's vulnerable populations.

Environmental Hazard Protection
While the Department of Environmental Conservation (DEC) and particularly DEC's Division of Environmental Health play the primary role in environmental health protection in the state, DPH works in close partnership with them to provide the human health and medical epidemiology expertise in support of our common mission. While community-based environmental hazard identification and response is coordinated with DPH public health nurses at the local level, the DPH Section of Epidemiology operates a statewide Environmental Public Health program to evaluate the possible hazards to human health associated with the presence of hazardous substances in the environment. Activities conducted by this program include medical consultation response to hazardous substance emergency events, studies on subsistence food safety, blood lead surveillance and targeted screening, public health consultation at sites that contain hazardous substances, and public information and outreach regarding environmental health hazards.

Effective & Efficient Programs & Services
The DPH Director's Office (supported by the Public Health Administrative Services component of the budget) provides leadership and management support to ensure the efficient and effective operation of the division.

A DPH cross-cutting program that supports all core public health services described above is administered by the Bureau of Vital Statistics (BVS). BVS is responsible for the registration, certification, security, and protection of permanent records of vital events (births, deaths, marriage, divorce, and adoptions), maintaining the medical marijuana registry, and receiving reports of induced terminations of pregnancy. In addition to providing a valuable legal registration and documentation service to all Alaska residents, BVS provides research and analysis of vital events data in support of public health policy development.

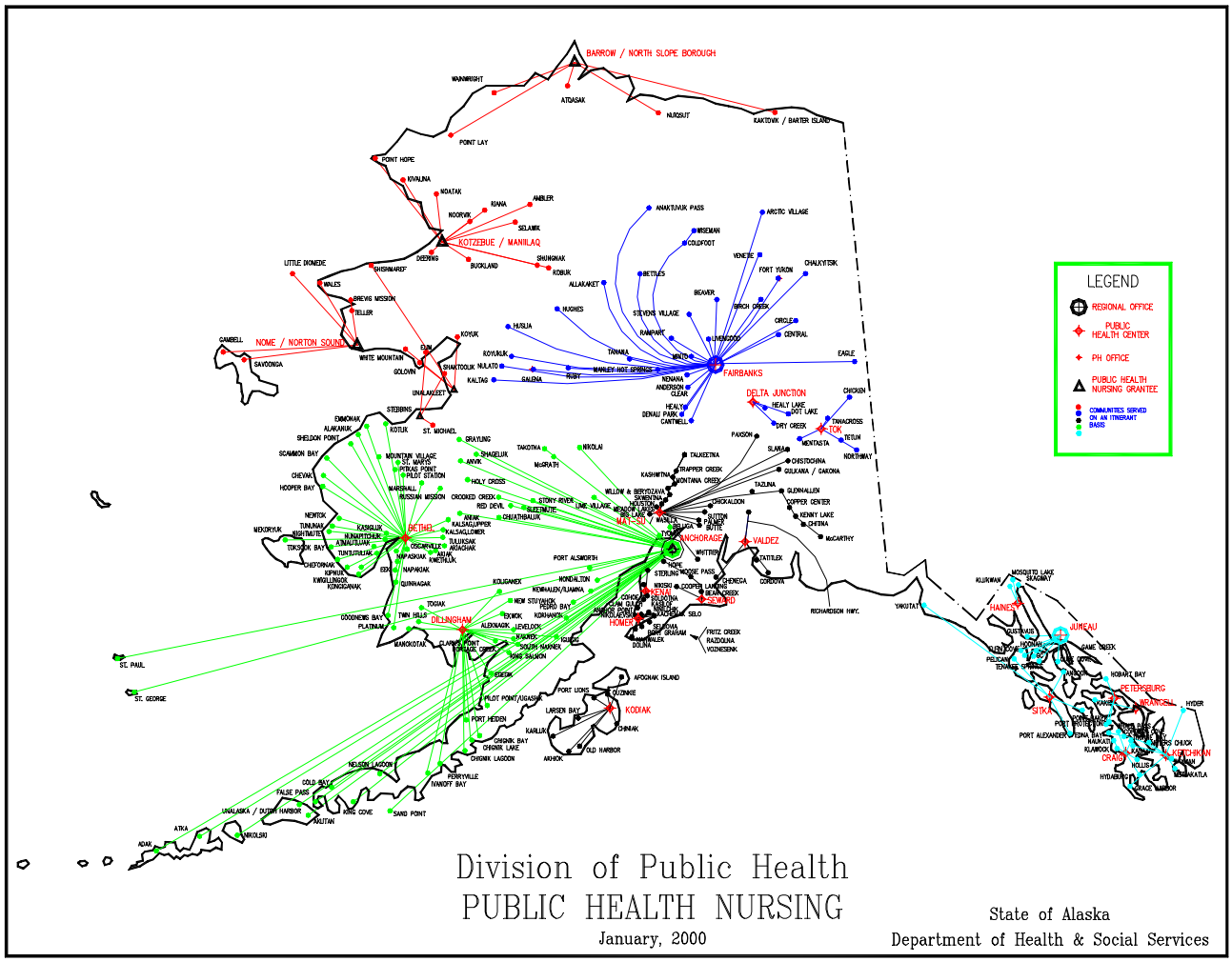
Another DPH cross-cutting program that supports all core public health services is administered by the Office of the State Medical Examiner (SME). As a key element of the public health mission to prevent injury disease and death, the SME designs and manages a statewide system of medical legal investigation of unanticipated, sudden, or violent deaths. Activities include providing accurate, legally defensible determination of the cause and manner of death, and conducting comprehensive medical legal death investigations.

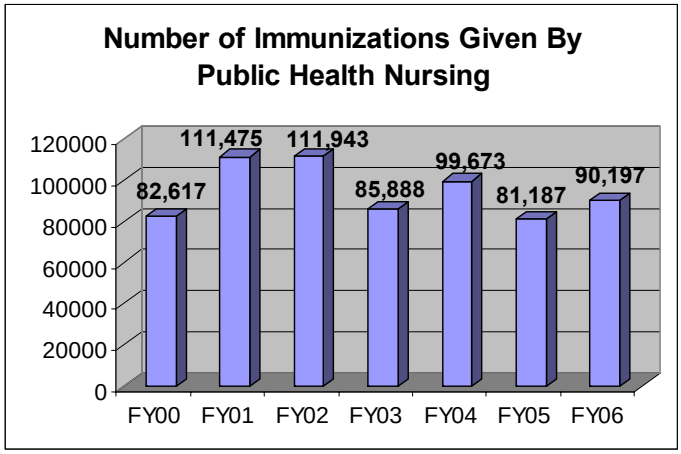
Recent incremental funding provided by the Legislature for SME improvement is allowing continued progress on a three-year plan (FY06-FY08) to improve services to the public and to receive national accreditation. State lawmakers initiated expansion of SME capacity by passing a bill requiring a Deputy Medical Examiner and by adding $100,000 to the FY06 budget to fully support the Deputy and an additional Autopsy Assistant. The SME office followed through and hired a second pathologist to serve as the Deputy Medical Examiner. In FY07, an increment of $500,000 was funded to continue improvements in safety and operations, and to provide resources for staff to perform more death investigations. An additional Autopsy Assistant position was created and an additional Investigator was hired, and the search is ongoing for a third Medical Examiner.

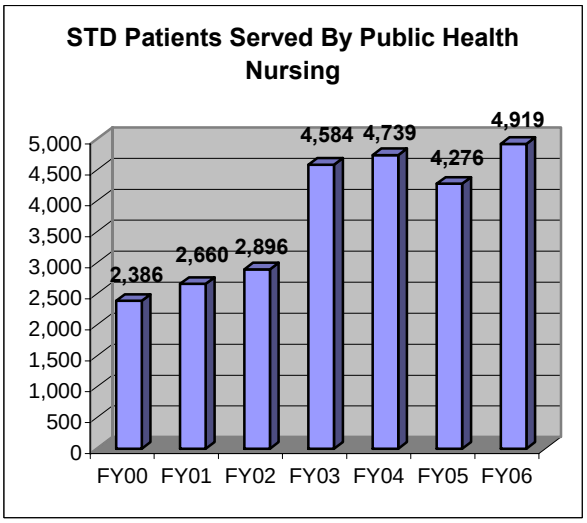
Many of the services and programs delivered by the Division of Public Health serve the population as a whole, rather than individuals, so statistics on individual services do not complete the picture of the division's work. Activities such as disease outbreak response, preparation and dissemination of epidemiology bulletins to all health practitioners in the state, planning and development of health systems, and educational campaigns such as those to influence children not to smoke are but a few examples of DPH efforts to protect, promote and improve the health of hundreds of thousands of Alaskans every day. Some of the easy to quantify results from FY06 are provided below.

Public Health Nursing

Public health nursing staff provides the division's community-based service delivery for disease prevention and protection, health promotion, and health assessments. Public health nurses are on the front lines in emergency preparedness and response mobilization. They provide the focused surge capacity to respond to infectious disease outbreaks. Essential public health services are provided or assured by the state in the absence of local governments with the necessary health powers to serve as local public health authorities.







Public health services are provided by nursing staff in public health centers in 23 communities and by itinerant public health nurses serving more than 250 communities. Grantees in four areas of Alaska – Norton Sound Health Corp., Maniilaq Association, the North Slope Borough, and the Municipality of Anchorage – are supported through grant funding and technical assistance to assure that public health nursing services are available statewide. Four expert public health nursing specialists assigned at the regional level assure the performance of staff across the state, assure or provide backup for locations with a public health nurse vacancy, and provide public health leadership at the regional and statewide levels.

Public health nurses devoted significant time in FY06 to community assessment and development activities as work continued to transition clinical client services to other health care providers wherever possible. They also delivered significant numbers of basic essential health care services to Alaskans.

In FY06, public health nurses statewide*:

- Provided 142,582 health care visits to 87,355 patients.
- Administered 90,197 doses of vaccine.
- Gave and read 25,553 tests for tuberculosis (TB).
- Served 40,463 children and youth (birth-19 years).
- Provided 1,997 Pap Smears for detection of cervical cancer in Alaska women.
- Provided 15,500 visits for family planning to 6,290 individuals.
- Provided 8,857 visits to 4,919 patients for Sexually Transmitted Diseases.
- Provided 3,963 visits for HIV/AIDS services including blood testing for 2,315 patients.

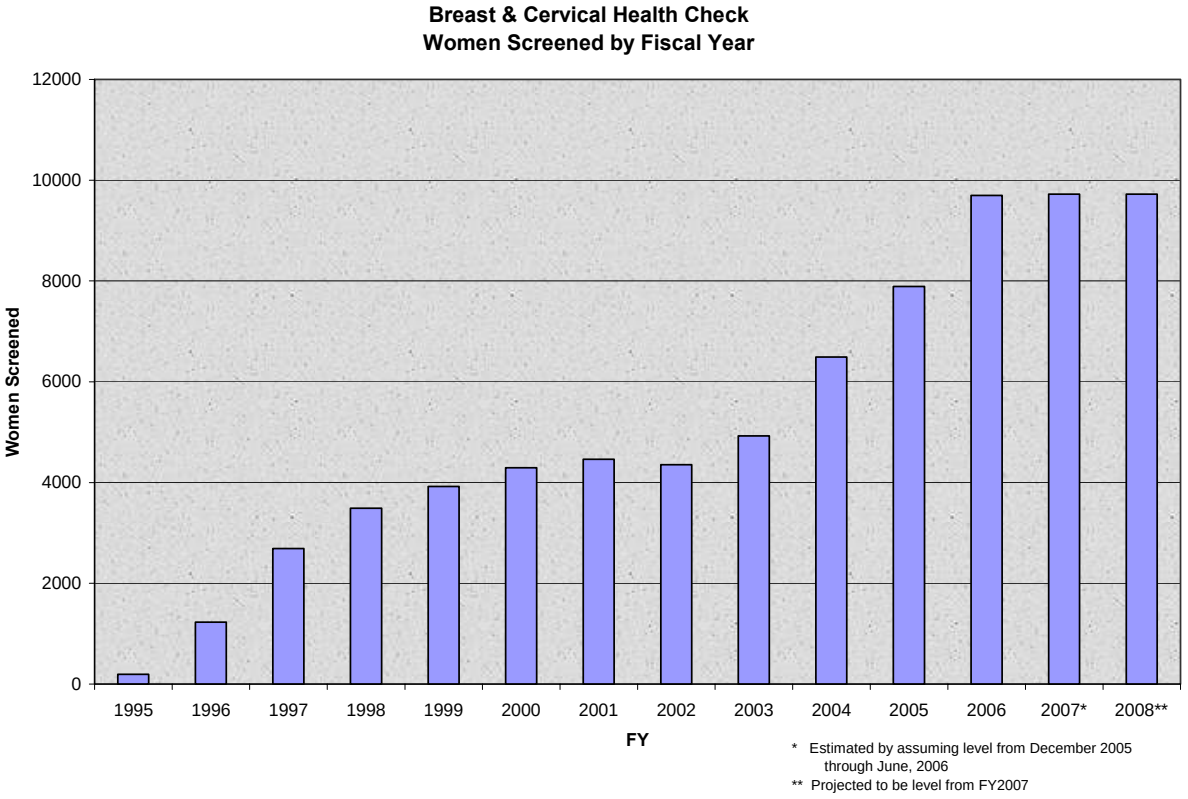
*Note: Data does not include the Municipality of Anchorage, a Public Health Nursing grantee, except for doses of vaccine given. Anchorage uses a different data system for all but immunizations.

Women's, Children's and Family Health

The Section's mission is to promote optimum health outcomes for all Alaska women, children and their families. This is accomplished by providing leadership and coordination with primary and specialty health care providers and public entities within the state's health care system to develop infrastructure and access to health services; and to deliver preventative, rehabilitative and educational services targeting women, children and families.

Services and programs delivered statewide include Breast and Cervical Health Check; Family Planning; Perinatal Health; Oral Health for Children and Adults; Newborn Metabolic Screening;

Early Hearing Detection, Treatment and Intervention Program; Pediatric Specialty Clinics; and Genetics and Metabolic clinics. In addition, the Maternal & Child Health Epidemiology Unit collects, analyzes and reports maternal and child health indicator data to provide an accurate picture of the health status of Alaska women, children and their families.



Examples of services supported or coordinated by the Section of Women's, Children's and Family Health in FY06 include:

- The Breast and Cervical Health Check Program continued its lifesaving work. Since its inception in 1995, the program has provided over 60,000 cancer screenings to nearly 25,000 individuals who are medically underserved. Of those women, 159 cases of breast cancer, 25 cases of cervical cancer and 1,227 pre-cancerous conditions have been diagnosed.
- Of all newborns, 99.9 percent were screened for metabolic conditions.
- Approximately 90 percent of newborns were screened for hearing.
- Second and third editions of the Maternal & Child Health (MCH) Data Books on Pregnancy Risk Assessment and Monitoring System (PRAMS) data and Birth Defects were published.

Certification and Licensing

The mission of the Section of Certification and Licensing is to protect the life, health and safety of vulnerable populations. Consolidation of certification and licensing functions into the Division of Public Health began in 2003; today, changes are being fully implemented. Along with centralized funding and staff came the responsibility to ensure that statutory and regulatory standards are met by assisted living homes, nursing homes and other health care facilities. The section has developed a Background Check Unit to ensure barrier crimes are defined and conditions that will disqualify someone from working in a home or facility are reviewed.

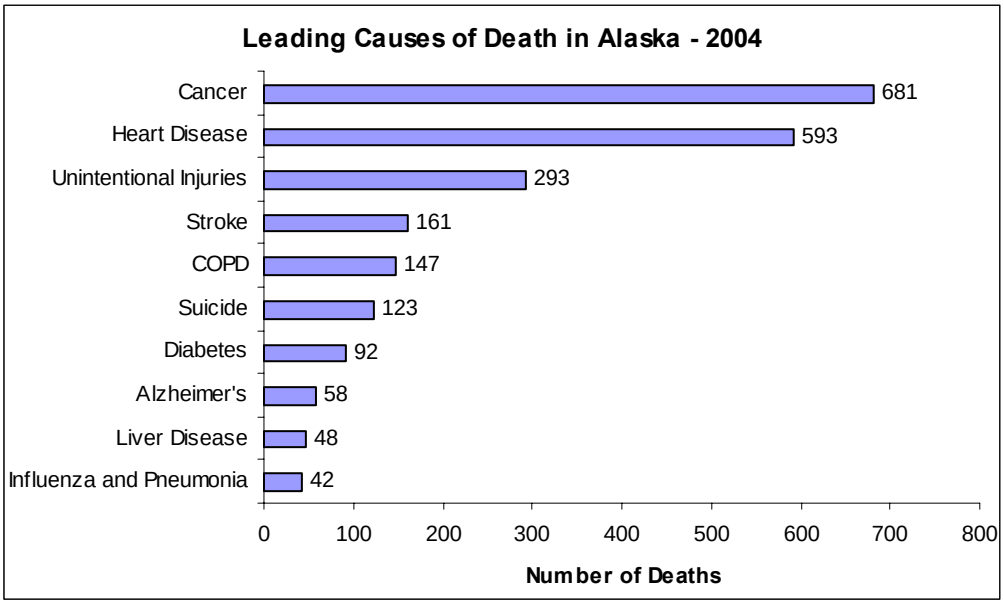
Examples of services provided in FY06:

- Licensing staff made over 900 onsite visits. These visits included but were not limited to new licensing visits, license renewals, conducting investigations and responding to complaints.
- The Background Check Program was activated and began processing background checks and making fitness determinations for programs administered by the department.
- A centralized complaint intake process involving assisted living homes and certification and licensing programs continued to improve response time and thorough follow-up with all complaints.
- Licensing of residential (24-hour facilities) child care facilities became the responsibility of Certification & Licensing (C&L), part of on-going efforts to centralize licensing functions.
- Unnecessary restraints and pressure ulcers were reduced in nursing home residents; Alaska is currently below the national average for both.
- Licensing caseloads were redistributed and the internal application process redesigned to accommodate the 12 percent growth in assisted living homes.

Chronic Disease Prevention and Health Promotion

The new Section of Chronic Disease Prevention and Health Promotion was established at the beginning of FY06 and centralized in the budget in FY07, bringing into one unified component many programs: Tobacco Prevention and Control, Health Promotion, Diabetes, Arthritis, Obesity, Heart Disease and Stroke, Cancer, School Health, and Data and Evaluation. These programs work to reduce the social, economic and health impacts of chronic disease by:

- Assessing the chronic disease burden;
- Educating the public and health professionals;
- Collaborating with communities and other partners in the planning, implementation and evaluation of science-based strategies and interventions; and
- Advocating for the prevention and control of chronic diseases.



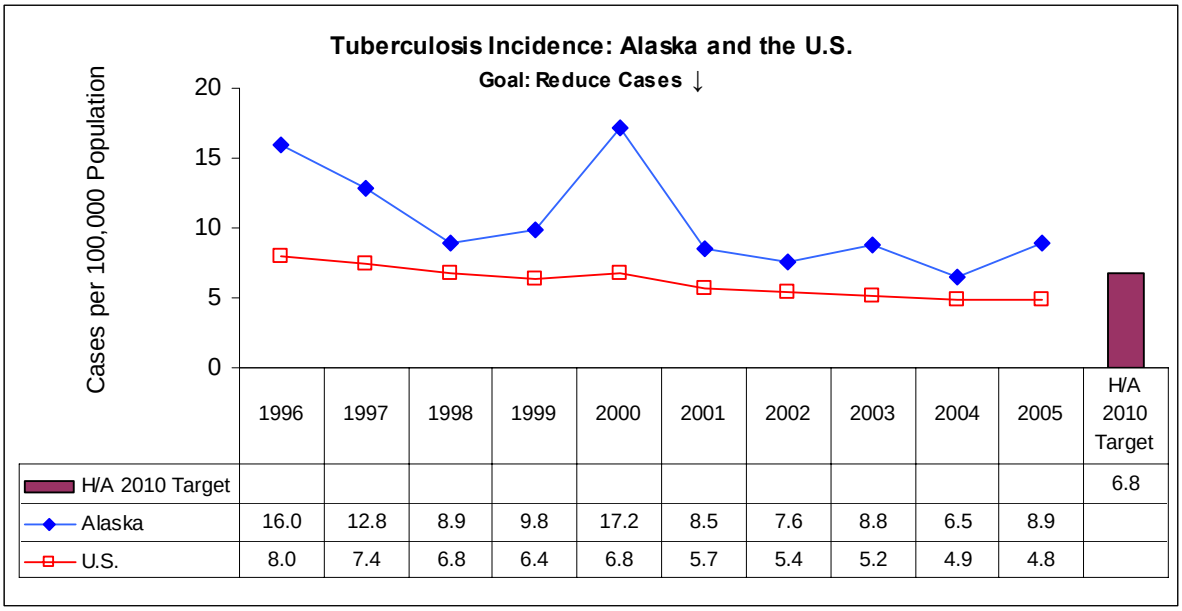
Note: Latest complete data available is still for calendar year 2004. Death records are still being updated. (COPD - Chronic Obstructive Pulmonary Disease)

Examples of services provided by Chronic Disease Prevention and Health Promotion programs in FY06 include:

- Provided technical expertise related to chronic disease prevention and control, in the areas of diabetes, cancer, arthritis, obesity, heart disease and stroke to communities, partners and Native health organizations statewide.
- Worked with communities to assess the burden of chronic diseases and their associated risk factors and develop disease intervention activities to prevent and control chronic disease.
- Successful evaluation of the Tobacco Quit Line, which demonstrated the efficacy of this cessation tool. Eighty-nine percent of participants reported they were very satisfied with Quit Line services. At three months, 41 percent of callers reported they no longer smoked cigarettes, while 30 percent reported they no longer used smokeless tobacco.
- Production and distribution of Alaska School Wellness Toolkit, which was provided to all 53 school districts. The toolkit contains information on why wellness policies are important and the role that schools can play in promoting physical activity and good nutrition among students. The toolkit is designed to serve as a resource for groups working on development of a local school wellness policy.

Epidemiology

The Section of Epidemiology provides surveillance for reportable health conditions to accurately assess the health of Alaskans, to detect disease outbreaks requiring intervention, and to assess the effectiveness of prevention strategies, such as immunization programs. Section staff also detects, investigates and controls disease outbreaks through defining causal factors, and by identifying and directing prevention and control measures. The Section provides scientific data through epidemiological studies and data interpretation to form the basis of policy development and prevention program planning and evaluation; medical and epidemiological expertise required for infectious disease control and epidemic response in disease outbreaks and following natural or manmade disasters; contact identification, education, and diagnosis and treatment support for persons exposed to tuberculosis, HIV, sexually transmitted diseases, and other infectious diseases; and risk assessment of environmental health threats to Alaskans.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	H/A 2010 Target
H/A 2010 Target											6.8
Alaska	16.0	12.8	8.9	9.8	17.2	8.5	7.6	8.8	6.5	8.9	
U.S.	8.0	7.4	6.8	6.4	6.8	5.7	5.4	5.2	4.9	4.8	

Data Source: Alaska – Morbidity Database; U.S. – National Notifiable Diseases Surveillance System
H/A = Healthy Alaskans 2010

Examples of services provided by Epidemiology in FY06 include:

- Provided medical public health expertise for major revision and two updates of the State of Alaska Pandemic Influenza Response Plan.
- Continued an aggressive immunization campaign at the state and local level to assure that Alaska's children are immunized against preventable childhood diseases.
- Began revitalization of the Rabies Control Program and the Rabies Lay Vaccinator Program, including planning of the Alaska Rabies Summit in December 2006 to gain input from partners and subject matter experts to create a science-based, efficient program for rabies control.
- In partnership with the Municipality of Anchorage, investigated an outbreak of tuberculosis (TB) in the homeless population. This outbreak began in December of 2005 and at least 20 cases have been identified. The TB Program has collaborated with the municipality to provide regular screening events at facilities that support the homeless and provided housing for homeless persons with TB during the course of treatment.
- Responded to outbreaks of Norovirus in two chronic care facilities in southeast Alaska, as well as at least five other Norovirus outbreaks. Rapid identification of the agent causing the outbreak and investigation to determine possible mode of transmission formed the basis of recommendations to prevent additional transmission.
- Conducted or coordinated HIV disease intervention activities which identified 29 percent of all HIV cases newly diagnosed in Alaska in 2005 (28 cases). These results illustrate the critical role of disease intervention (partner notification, testing, and where appropriate, treatment) in interrupting disease transmission.
- HIV/STD Program staff completed activities to implement major changes to the purchasing mechanism and contracts for the statewide AIDS Drug Assistance Program (ADAP) early in FY06. By the end of FY06, ADAP enrollment had been expanded from 37 to 65 clients (a 76 percent increase) and the ADAP waiting list had been (temporarily) eliminated.
- Interviewed and collected fish and hair samples from 214 sport fishermen to assess the risk of mercury exposure from sport-caught halibut in Cook Inlet (result pending).

Bureau of Vital Statistics

The Bureau of Vital Statistics (BVS) oversees the registration of vital events in Alaska and is responsible for the preservation and security of the records. Bureau staff work in partnership with hospitals, funeral directors, physicians, and the court system to ensure all vital events are properly recorded, that they satisfy the legal requirements of Alaskans and their families, and that the information contained in vital records meet the statistical needs of researchers or health officials at the state and national level. To help ensure vital events are properly registered and to maintain the integrity of the vital records system, the Bureau maintains a statewide program to train local officials, hospital staff, physicians, and funeral home staff on the procedures to properly complete birth, death and divorce certificates. The Bureau also maintains the state's Medical Marijuana Registry.

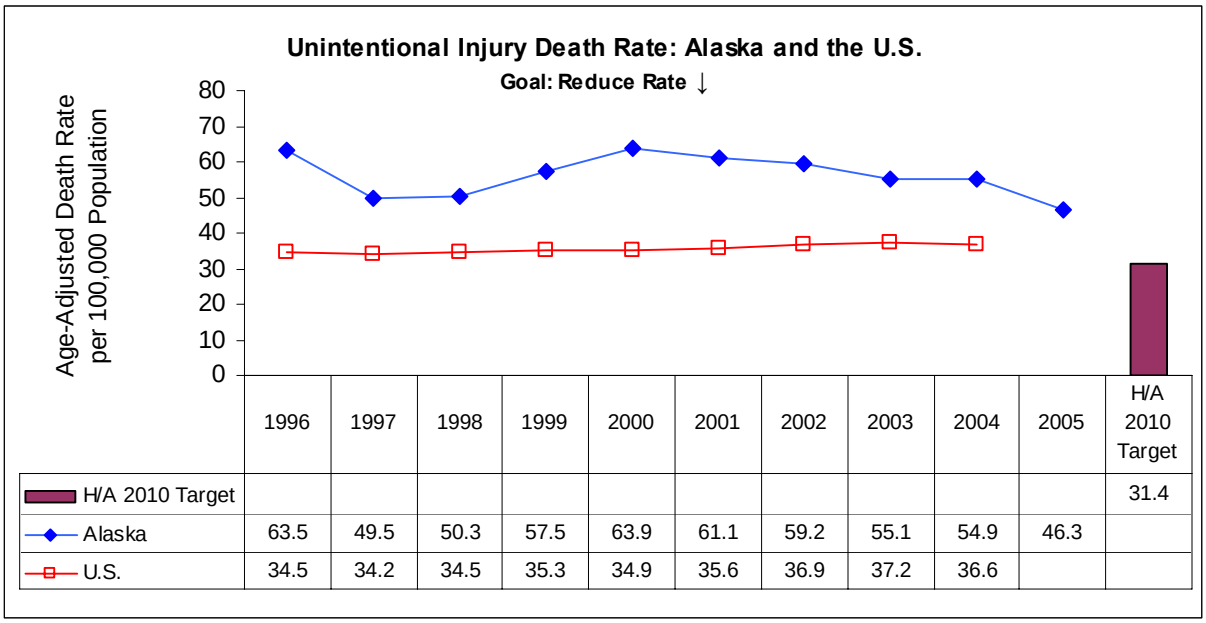
Information from vital records is used to monitor and assess the health status of Alaskans and help guide health policy issues affecting the state. The Bureau publishes an annual report of vital events in Alaska and provides public health statistics on its web site. These reports include statistics on births, fetal and infant deaths, induced terminations, adoptions, marriages and divorces, and deaths. Teen birth rates, chronic disease mortality, leading causes of death, infant mortality, pregnancy and fertility rates, local health profiles, and Healthy Alaskans 2010 statistics are examples of information published on the Bureau's web site.

Examples of BVS services provided in FY06 include:

- Processed 60,643 requests for vital records
- The Bureau recorded these events in Alaska:
    - Births: 10,459
    - Deaths: 3,138
    - Marriages: 4,792
- Adoptions of Alaska-born children processed: 704
- Establishments of paternity of Alaska-born children processed: 3,543
- Funds generated for the Alaska Children's Trust through heirloom birth and marriage certificates: $24,880
- Applications for the Medical Marijuana Registry processed: 108
- The Bureau continued its efforts to improve customer service to the public. Despite processing more than 60,000 requests for vital records, the time required for issuing certified copies of vital records has remained low. Mail requests for vital records were usually processed within 2 days of receipt and were frequently processed within one day. During the past fiscal year backlogs have been eliminated throughout the Bureau.
- The processing time for paternity actions has been reduced from one month to less than a week.
- Adoption and correction requests were usually processed within two weeks of receipt.
- By the end of FY06, BVS had nearly completed a project to enter all older births into the Bureau's information system. Before this project began, births were only available electronically from 1970 forward. The "back birth" project ensures the Bureau will meet a requirement of new federal legislation.
- The Bureau also made significant improvements to the quantity and timeliness of public health data published on the BVS website. Detailed information on injury deaths, leading causes of death, chronic disease deaths, infant mortality, teen birth rates, causes of death, birth outcomes, and health profiles is readily available at: http://www.hss.state.ak.us/dph/bvs/data/default.htm

Community Health and Emergency Medical Services (CHEMS)

The Section of Injury Prevention & EMS (supported by the CHEMS component in the budget) provides services and outreach training to reduce human suffering and economic loss to society resulting from disability and premature death due to injuries and to assure access to community-based emergency medical services. The Section is charged with increasing public awareness and promoting long-term positive behavior toward safety and health, and encouraging interventions statewide in injury prevention and control. The Section also maintains the Alaska Trauma Registry and the Alaska Violent Death Reporting System and provides detailed analyses of its injury databases to community, municipal, state, federal and private sector agencies and organizations to assess current prevention efforts and planning.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	H/A 2010 Target
H/A 2010 Target											31.4
Alaska	63.5	49.5	50.3	57.5	63.9	61.1	59.2	55.1	54.9	46.3	
U.S.	34.5	34.2	34.5	35.3	34.9	35.6	36.9	37.2	36.6		

Data Source: Bureau of Vital Statistics

Examples of services provided in FY06 include:

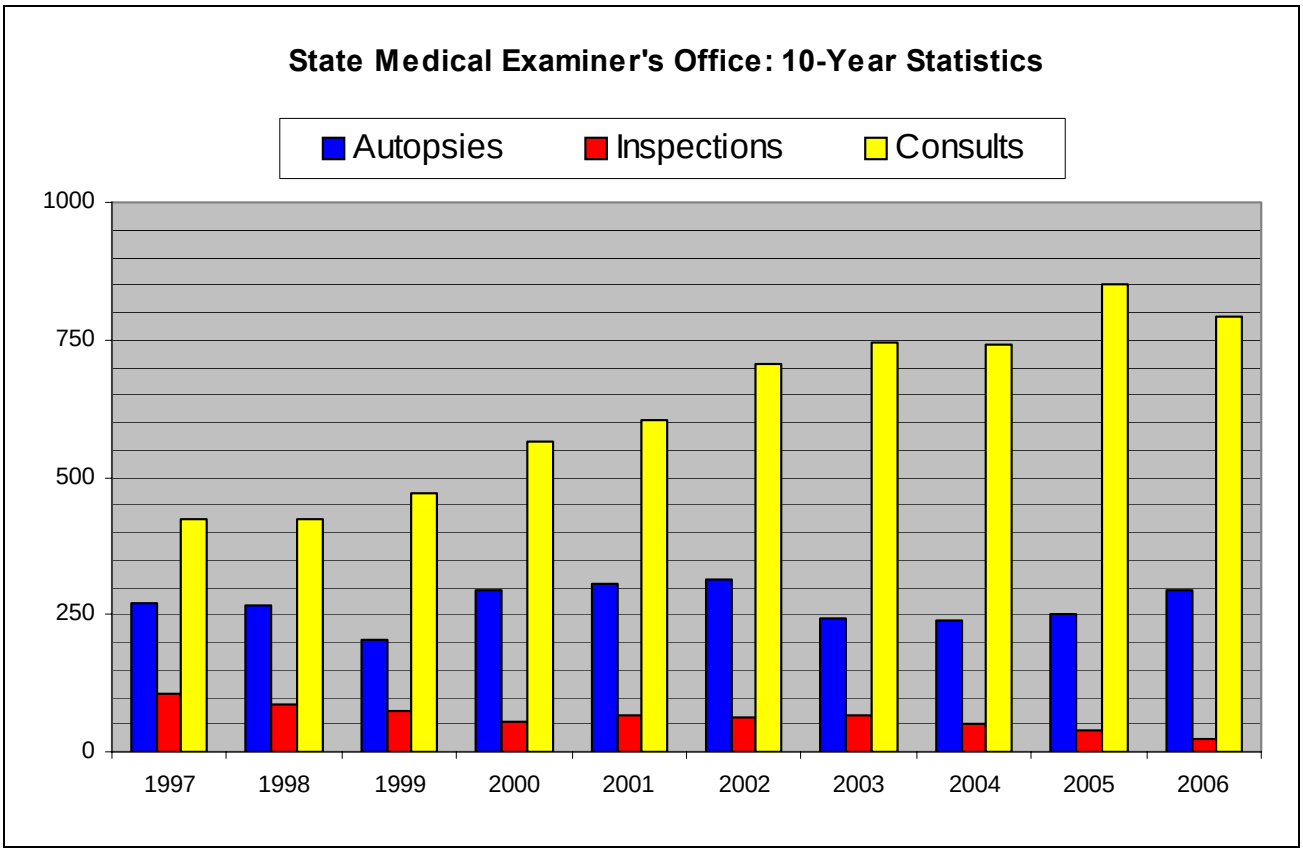
- Certification was maintained for more than 3,800 Emergency Medical Technicians (EMT), Emergency Medical Services (EMS) Instructors, Emergency Medical Dispatchers, and Defibrillator Technicians. Also certification or recertification occurred for approximately 87 ground emergency medical services, 22 air medical services, and 3 hospital trauma centers.
- More than 4,500 smoke alarms were distributed and installed in residences throughout the state to help prevent deaths from house fires; 2,977 rural and low-income households were enrolled (in at least 65 villages) in the fire prevention/smoke alarm installation program, with the potential of 43 lives saved.
- Approximately 489 "Kids Don't Float" life jacket loaner sites were maintained or newly installed in 163 communities in all regions of Alaska (some communities have multiple stations). Since 1998, this program has resulted in 12 documented cases of prevented drowning. “Kids Don’t Float” received an outstanding achievement award by the National Freshwater Fishing Hall of Fame in 2006.
- Alaska Poison Control activities were supported and continued, including a statewide triage phone hotline and educational request. The Poison Control Center received approximately 9,500 calls, of which 7,302 were human exposures resulting in 1,733 hospitalizations. The Poison Control Center provided statewide technical and educational support to caregivers on all calls.

State Medical Examiner

The State Medical Examiner’s Office is responsible for investigating and certifying all deaths that occur within the State of Alaska that are the result of violence, suspected violence, deaths due to accidental causes, deaths that occur during incarceration, deaths that are associated with conditions that pose a hazard to public safety or health, and all unattended or unexplained deaths. The medical examiner ensures appropriate follow-up on all child deaths; establishes the identity of the deceased; maintains records and evidence; provides legally defensible determinations of the cause and manner of death; presents finding of the investigation to courts, law enforcement agencies, and other parties with legitimate interests in the death.

Over the past 10 years of operations, the Medical Examiner’s Office has become increasingly involved with communities throughout Alaska. There has been an increase in cases brought in from

the villages and remote areas of the state. This provides for a more accurate tracking of cases in all manners of death. It also provides a stable environment for tracking and prevention of hazardous health problems in the state.



Examples of services provided in FY06 by the Medical Examiner's Office include:

- Total cases reported: 1,512
- Cases autopsied: 293
- Cases with consult: 793
- Cases with inspection: 23
- Cases with natural cause: 403

Also, the office:

- Successfully recruited and hired new Deputy Medical Examiner to enable the State Medical Examiner's Office to meet the expectations of increased autopsies performed and surveillance to detect new or unexpected infectious diseases.
- Began the accreditation track, as recommended by the National Association of Medical Examiners.
- Enhanced the quality of performance of the Child Fatality Review Committee.
- Continued to upgrade the database of State Medical Examiner's Office cases.

Public Health Laboratories

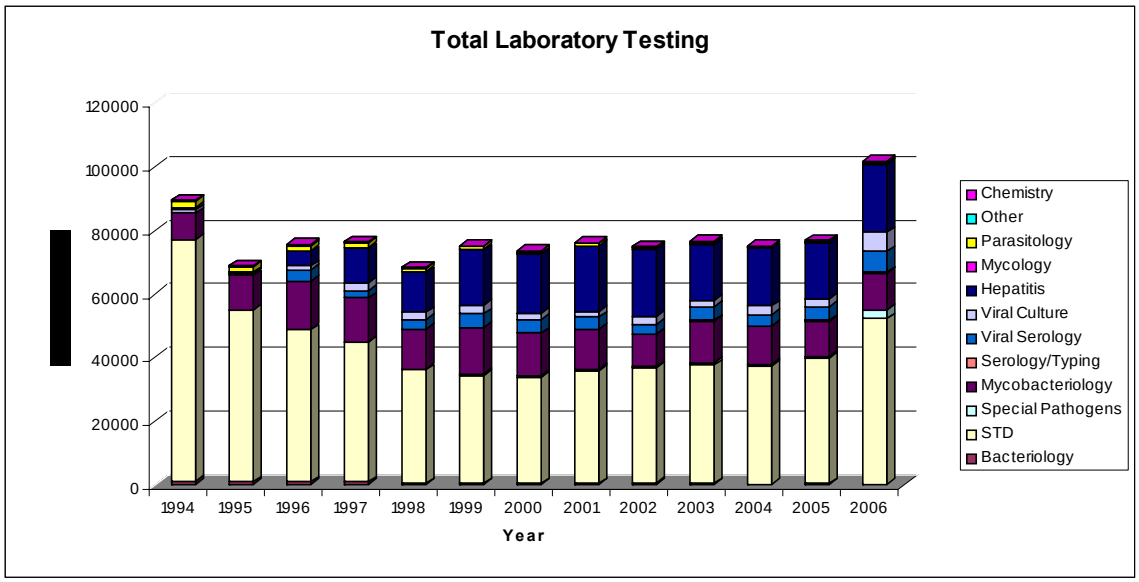
The Section of Laboratories provides analytical and technical laboratory testing and information to support disease prevention programs, services and activities. The Anchorage laboratory provides

testing for microbial, parasitic and fungal infectious agents, as well as testing for disease antibodies in the blood and for chemical and toxic agents. The Fairbanks laboratory provides virology testing.

In addition to laboratory testing, this section provides technical consultation and continuing education to clinical laboratorians throughout Alaska, and quality assurance and reference testing for Alaska's clinical laboratories to ensure the safety and efficacy of their services.

Examples of services provided in FY06 include:

- The laboratory received and processed 101,602 test requests. That number was far higher than average (75,551 test requests) and also higher than any other previous year since 1994.
- STD tests: 51,851 (+31%)
- Total number of hepatitis tests: 21,384 (+22%)
- Total number of tuberculosis tests: 11,760 (+6%)
- Total toxicology tests: 211 (new service implemented during FY06)



Preparedness for Public Health Emergencies Program (Public Health Administrative Services Component)

The goal of this program is to ensure that Alaskans are protected in the event of a public health emergency – whether natural or manmade. Efforts are focused in several key areas, including: emergency preparedness planning and readiness assessment, disease surveillance and epidemiology capacity, biological and chemical laboratory capacity, communications and information technology, public communication and health information dissemination, training and exercises, and hospital preparedness. The division coordinates extensively with such agencies as the FBI, CDC, Federal Emergency Management Agency, Alaska Division of Homeland Security and Emergency Management, Municipality of Anchorage, Alaska Native health organizations, and private health care providers to assess Alaska's public health preparedness needs, develop appropriate plans, and conduct training and exercises.

During FY06, the preparedness program:

- Supported three community mass vaccination clinic exercises, demonstrating the ability to process up to 500 patients per hour.
- Revised the Alaska Pandemic Influenza Plan based on exercise after action reports and partner agency reviews.

- Established a Multiagency Coordination Group (MAC) and Interagency Incident Management Team for Pandemic Influenza preparedness, planning and response with state, local, private and non-profit partner agencies at the direction of the Governor (Administrative Order 228). The MAC is co-chaired by DMVA and DHSS Commissioners.
- Conducted training workshops and exercises in 18 communities as part of the Pandemic Influenza Community Outreach Program.
- Conducted a statewide executive Pandemic Influenza Summit with top level representatives from local, state, federal, private and non-profit agencies in attendance. Commissioner Karleen Jackson and U.S. Department of Health and Human Services Deputy Secretary Alex Azar presided.
- Updated and exercised the DPH Emergency Operations Plan, including annexes for Biological Agent Response, Chemical Agent Response, Mass Prophylaxis, Alternate Care Site Operations, Mass Casualty Response, and Risk Communication.
- Continued partnerships with Alaska Division of Homeland Security and Emergency Management, Alaska Native Tribal Health Consortium, Municipality of Anchorage, and the Alaska State Hospital and Nursing Home Association for all planning, training and exercise activities.

AS 08.36.271	Dentist Permits for Isolated Areas
AS 08.64.369	Medicine
AS 08.68	Nursing
AS 09.55	Special Actions & Proceedings
AS 09.65.090, 095, 100	Actions, Immunities, Defenses & Duties
AS 11.81.430	Use of Force, Special Relationships
AS 12.55.155	Sentencing & Probation
AS 12.65	Death Investigations & Medical Examinations
AS 12.810	Laboratory Safety
AS 14.07	Administration of Public Schools
AS 14.30	Physical Examinations & Screening Examinations
AS 17.37	Medical Use of Marijuana
AS 18.05	Administration of Public Health & Related Laws
AS 18.08	Emergency Medical Services
AS 18.15	Disease Control & Threats to Public Health
AS 18.16	Regulation of Abortions
AS 18.20	Hospital & Nursing Facilities
AS 18.23	Health Care Services Information & Review Organizations
AS 18.25	Assistance to Hospital & Health Facilities
AS 18.28	State Assistance for Community Health Aide Programs
AS 18.50	Vital Statistics Act
AS 18.60	Health Care Protections
AS 25.05	Alaska Marriage Code
AS 25.20.025, 050(b), 055	Examination & Treatment of Minors
AS 25.23.160 - 170	Adoption
AS 37.05.146	Receipts for Fees for Business Licenses for Tobacco Products, definitions
AS 37.05.580	Tobacco Use Education & Cessation Fund
AS 40.25	Public Records
AS 43.70	Alaska Business License Act
AS 44.29	Department of Health & Social Services
AS 47.05	Criminal History & Registry
AS 47.07	Medical Assistance for Needy Persons
AS 47.08	Assistance for Catastrophic Illness & Chronic or Acute Medical Conditions
AS 47.17	Child Protection
AS 47.20	Services for Developmentally Delayed or Disabled Children
AS 47.24	Protection for Vulnerable Adults
AS 47.25	Public Records
AS 47.32	Centralized Licensing & Related Administrative Procedures
AS 47.35.010	Child Care Facilities, Child Placement Agencies, Child Treatment
4 AAC 06.055	Immunizations
7 AAC 05.110 - 990	Vital Records
7 AAC 05.976	Heirloom Marriage Certificates
7 AAC 10	Licensing, Certification & Approvals
7 AAC 12	Facilities & Local Units
7 AAC 12.650	Employee Health Program – TB Testing; Rubella Immunity

7 AAC 16.010 – 090	Do Not Resuscitate Protocol & Identification
7 AAC 26.280, 390, 710	Emergency Medical Services
7 AAC 27	Preventative Medical Services
7 AAC 35	Embalming & Other Post-Mortem Services
7 AAC 43	Medical Assistance
7 AAC 48	Chronic Illness & Chronic & Acute Medical Assistance
7 AAC 50	Health in Full Time Care Facilities
7 AAC 60.100	Pre-Elementary Schools – Immunizations Required
7 AAC 75	Assisted Living Homes
7 AAC 78.010 - 320	Grant Programs
7 AAC 80	Fees for Department Services
12 AAC 2.280	Board of Nursing
12 AAC 44	Advanced Nurse Practitioner
13 AAC 08.025	Medical Standards – School Bus Drivers' Health Screening
18 AAC 31.300	Disease Transmission
18 AAC 80	Drinking Water

Social Security Act:
Title XVIII Medicare
Title XIX Medicaid
Title XXI Children's Health Insurance Program

Public Health	2007	2008 Proposed	07 to 08 Change
General Funds	27,519.7	31,378.1	3,858.4
Federal Funds	33,028.9	34,934.7	1,905.8
Other Funds	19,926.5	20,583.4	656.9
Total	**80,475.1**	**86,896.2**	**6,421.1**

Nursing, Women, Children and Family Health (WCFH), Chronic Disease Prevention and Epidemiology

Funding for the Nurse Salary Market-Based Pay Increase the Legislature authorized $838.5 GF (Nursing $810.2; WCFH $3.5; Chronic Disease $3.5; Epidemiology $21.3)
The increase in salaries for nursing positions has had a very positive effect on both nursing staff morale and our ability to retain current nursing staff. Since the salary increase was announced in September 2006 we have had 4 public health nurses transfer or promote into different public health nurse positions; it is likely that the salary increase enticed at least some of these nurses to transfer within the State system rather seek positions elsewhere.

We look forward to this salary increase further positively affecting our ability to recruit new nurses. We have filled 6 vacant public health nurse positions since the salary increase was announced in September 2006. Though it is difficult to know how many of those hired the salary increase was a deciding factor, we believe it has had an impact and we anticipate seeing the effect of this more and more within the current year as we also work to expand our recruitment outreach efforts into new venues.

Nursing and Public Health Laboratories

Fuel/Utility Cost Increase Funding Distribution $24.6 GF (Nursing $12.8; Labs $11.8)
Authorization has been added back to the FY08 budget for fuel/utility increases which were added in the FY07 budget to help meet the operating needs of the division.

Women, Children and Family Health (WCFH), Public Health Administrative Services, Chronic Disease, Epidemiology and State Medical Examiner

Health Insurance Increase for Exempt Employees of $2.9 ($1.7 Fed, $1.2 GF)
An increase for Health Insurance rates has been added to all components within the division

Challenges

As the Division of Public Health (DPH) continues work on achieving its overall mission – to protect and promote the health of Alaskans – several major challenges face its leadership and staff. In general terms, these challenges fall into five main categories: fighting infectious disease, preventing chronic disease and promoting good health, improving birth outcomes, strengthening statewide emergency medical services system support capacity, and protecting vulnerable Alaskans in the care of health or residential facilities. In each of these categories, progress will continue through the right mix of necessary investments in the division's programs, expanded partnerships with the entire public health community and the recruitment and retention of expert, dedicated staff.

Infectious Disease Control and Emergency Preparedness

Infectious disease control is increasingly complex and challenging – with new diseases discovered all the time, the threat of pandemic influenza looming, the continuing challenges associated with controlling tuberculosis and vaccine-preventable diseases, and Alaska's growing role as a transportation and tourism hub. The Legislature made an initial investment last year for FY07; funding half of a request by the administration to modernize and strengthen an aging and under-funded infectious disease control system. The remaining portion of the request is required to provide the additional investment needed to expand public health nursing services to growing Alaskan communities, strengthen the epidemiologic outbreak team, improve tuberculosis treatment, support operation and maintenance of the infectious disease and immunization registries, continue development of the public health emergency stockpile, and improve laboratory testing capacity.

Living for a Healthier Alaska

The fight is just as important against chronic diseases, which are responsible for three of every five deaths in Alaska. The primary risk factors for chronic diseases are tobacco use, poor diet, lack of exercise and obesity. A major challenge for the division is to continue efforts to prevent chronic diseases and promote good health through better education efforts. This makes sense financially because investments in a healthier Alaska now will save healthcare dollars in the years to come. Additional funding is required to provide Alaskans with the knowledge and tools they need to make healthy choices, and to create healthy communities (through support of physical activity and nutrition programming in schools, worksites, places of worship, and other community settings).

Tobacco Prevention and Control

More work must be done to reduce the use of tobacco in Alaska. Tobacco use continues to be the number one cause of preventable death in our state. Increased revenues available through the state's Tobacco Fund must be appropriated for community-based primary and secondary prevention activities, tobacco use treatment by health care providers, and an expanded media campaign for counter-marketing of tobacco products.

Perinatal Outcomes

There are a number of alarming trends in Alaska related to birth outcomes, including a reduction in the number of health care visits pregnant women are receiving during their prenatal course of care, an increase in the number of preterm babies born, an increase in the number of low birth weight and very low birth weight babies born, an ongoing high percentage of babies dying within their first year of life, as well as an ongoing high number of babies born with fetal alcohol spectrum disorder. A new investment of state funds could improve birth outcomes by providing training and consultation

to health care providers statewide, and improving data and information so health care providers and policy makers can more effectively target limited resources.

Statewide Emergency Medical Systems
An investment begun by last year's Legislature in the state's eroding emergency medical services (EMS) infrastructure has helped shore up that system by increasing grant support to regions, but there are increasing demands on the State EMS Office to ensure EMS organizations statewide meet new training standards and medical treatment guidelines, maintain the EMT certification system, continue data collection and analysis to identify injury trends and target injury prevention resources, and cover increasing costs of the Alaska Poison Control Program.

Protecting Vulnerable Alaskans
Continued investment in the ongoing consolidation of certification and licensing functions into the division is critical to ensure that facilities are inspected in a timely manner, licensing paperwork is quickly reviewed and new state and federal safety mandates are met. The relatively new Section of Certification and Licensing was formed to ensure that Alaska's susceptible seniors and children in need will always receive safe and appropriate care. Under a law passed by the Legislature in 2005 and the implementation of accompanying regulations, Certification and Licensing staff is now responsible for safety in nearly 700 facilities statewide, from hospitals to nursing homes to children's residential facilities. Funding is needed to support the staffing capacity required to address this increased responsibility and caseload.

Monitoring for Human Exposure to Chemical Contaminants
Through chemical testing called biomonitoring, the division's Public Health Laboratories generate important data about human exposure to mercury from the consumption of Alaska fish. Biomonitoring data form the basis for recommendations emphasizing the role of fish consumption in a healthy diet. In addition, the state labs have expanded their capacity to test for chemicals from natural disasters (such as contaminated floodwaters) and potential terrorist attacks (such as gases or other poisons). Now federal funding is declining and a general fund increment is needed to retain chemists and other laboratory staff so this critical biomonitoring can continue and the capacity for rapid response is always in place.

Contribution to Department's Mission

To protect and promote the health of Alaskans.

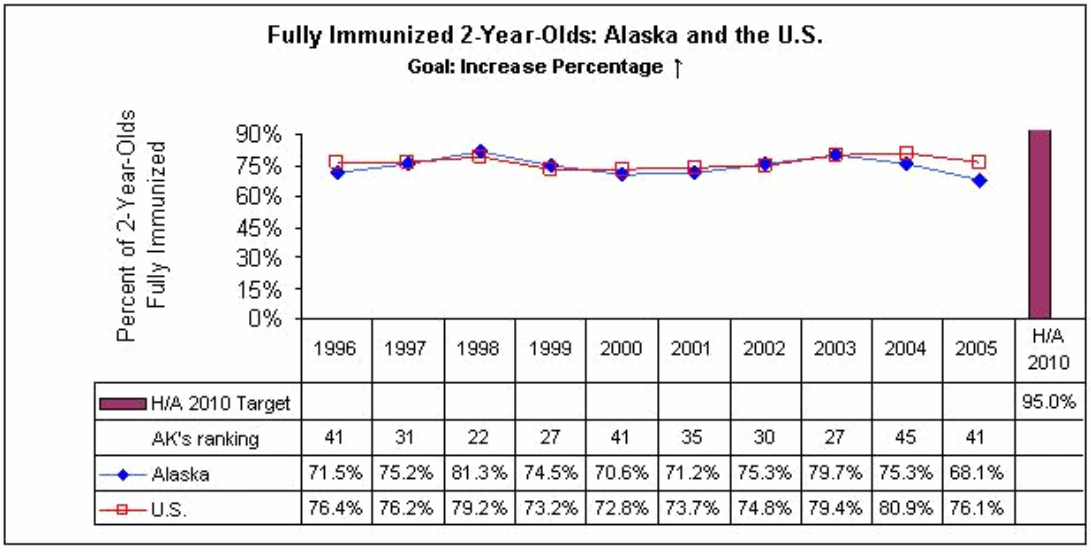
Core Services

- Prevent and control epidemics and the spread of infectious disease.
- Prevent and control injuries.
- Prevent and control chronic disease and disabilities.
- Respond to public health emergencies, disasters and terrorist attack.
- Assure access to early preventative services and quality health care.
- Protect against environmental hazards impacting human health.
- Effective and efficient management and administration of public health programs and services.

Department Level Measures

G: Result - Outcome Statement #7: Healthy people in healthy communities

Target #1: 80% of all 2 year olds are fully immunized
Measure #1: % of all Alaskan 2 year olds fully immunized



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	H/A 2010
H/A 2010 Target											95.0%
AK's ranking	41	31	22	27	41	35	30	27	45	41	
Alaska	71.5%	75.2%	81.3%	74.5%	70.6%	71.2%	75.3%	79.7%	75.3%	68.1%	
U.S.	76.4%	76.2%	79.2%	73.2%	72.8%	73.7%	74.8%	79.4%	80.9%	76.1%	

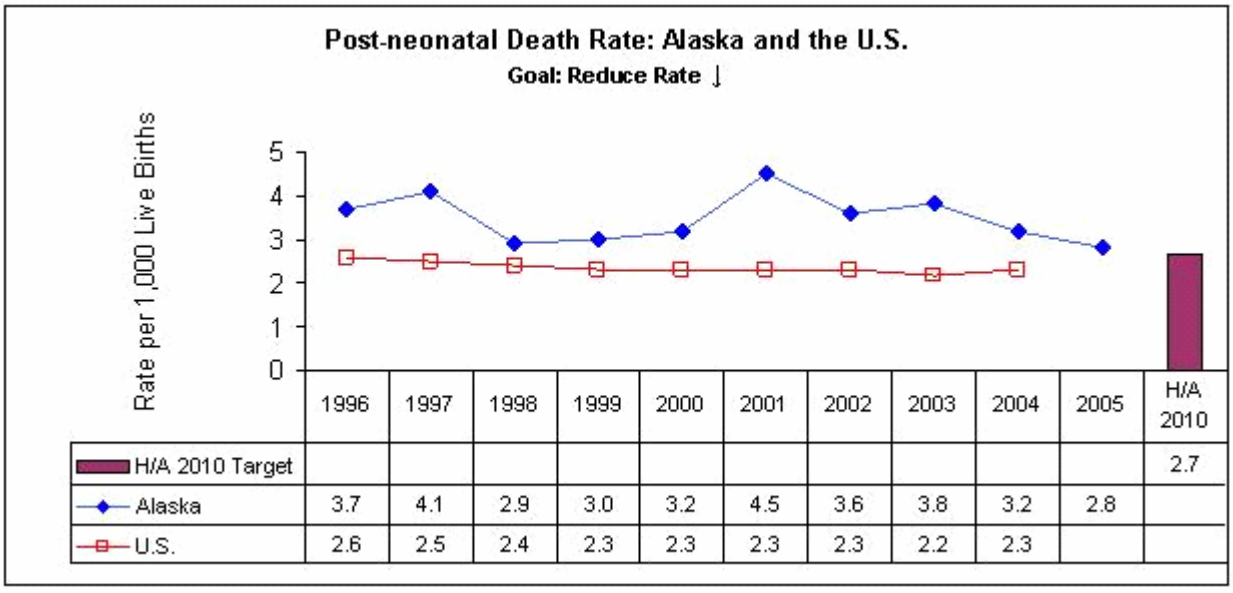
Vaccination Coverage Among Children 19-35 Months of Age, Alaska and US

Year	US %	Alaska %	AK US Rank
1999	73.2	74.5	27
2000	72.8	70.6	41
2001	73.7	71.2	35
2002	74.8	75.3	30
2003	79.4	79.7	27
2004	80.9	75.3	45
2005	76.1	68.1*	41

Analysis of results and challenges: Chart Note: Source - National Immunization Survey, Centers for Disease Control and Prevention. Annual percentages are based on CDC recommendations at the time, which have changed over the years as vaccines have been added to the "basic immunization series."

* In 2005, the CDC increased its recommendation to a new, six-dose series of vaccinations. As a result, the national rate of fully immunized two year olds dropped considerably, as did Alaska's rate. However, Alaska's ranking amongst states increased slightly, from 45th in 2004 to 41st in 2005. These results continue to illustrate the need for renewed emphasis on the importance of timely immunizations for young children.

Target #2: Reduce post-neonatal death rate to 2.7 per 1,000 live births by 2010
Measure #2: Three year average post-neonatal mortality rate (Post-neonatal is defined as 28 days to 1 year)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	H/A 2010
H/A 2010 Target											2.7
Alaska	3.7	4.1	2.9	3.0	3.2	4.5	3.6	3.8	3.2	2.8	
U.S.	2.6	2.5	2.4	2.3	2.3	2.3	2.3	2.2	2.3		

Post-Neonatal Death Rate - AK and US

Year	Alaska	US
1999	3.0	2.3
2000	3.2	2.3
2001	4.5	2.3
2002	3.6	2.3
2003	3.8	2.2
2004	3.2	2.3
2005	2.8	N/A

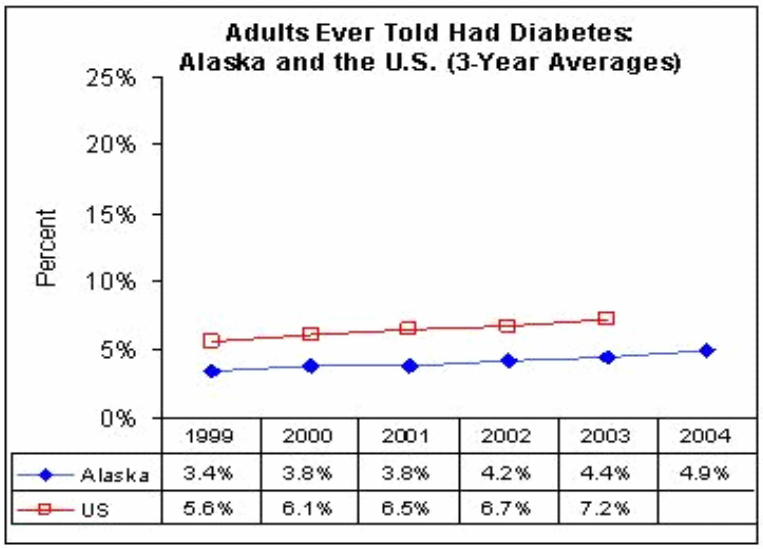
Note: The 2005 US death rate will not be available until late in 2006 or early 2007.

Analysis of results and challenges: Chart Note: Rate per 1,000 Live Births and reflects three year rate, i.e. 2003 represents 2001-2003.

Post-neonatal mortality is more often caused by environmental conditions than problems with pregnancy and childbirth. Nationally, the leading causes of death during the post-neonatal period (28 through 364 days) during 2002 were Sudden Infant Death Syndrome (SIDS), birth defects, and unintentional injuries. The post-neonatal mortality rate in Alaska is higher than the national target of 1.5 per 1,000 live births (Healthy People 2010) and has remained relatively static over time. While not shown graphically, over the last decade Alaska Native infants were 2.3 times more likely to die during the post-neonatal period than Caucasian infants.

Work by DHSS is underway with the Indian Health Service on a rural initiative to prevent Sudden Infant Death Syndrome (SIDS). Also, cessation efforts involving tobacco, alcohol and other drugs are being targeted on the pre-conception and prenatal periods. Finally, work has begun with health providers and community partners to establish a model program of early prevention and chronic disease management for prenatal patients.

Target #3: Decrease diabetes in Alaskans
Measure #3: Prevalence of Diabetes among Adults (18+) in Alaska based upon three-year averages



Est Annual Prevalence of Diabetes among Adults (18+) in Alaska Based upon Midpoints of Three-Year Averages

Year	Alaska	US
1999	3.4%	5.6%
2000	3.8%	6.1%
2001	3.8%	6.5%
2002	4.2%	6.7%
2003	4.4%	7.2%
2004	4.9%	N/A

Note: 2004 Alaska data is based on a 3 year average of 2003-2005.

Analysis of results and challenges: Data Source: BRFSS - Behavioral Risk Factor Surveillance System

Diabetes is a chronic disease characterized by high levels of blood glucose. Type 2 diabetes accounts for 90 to 95 percent of all diagnosed cases and typically occurs in adults, but is increasingly being diagnosed in children and adolescents. Type 2 diabetes usually begins as insulin resistance, a condition in which the cells do not use insulin properly. Risk factors for Type 2 diabetes include older age (40-plus years), obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

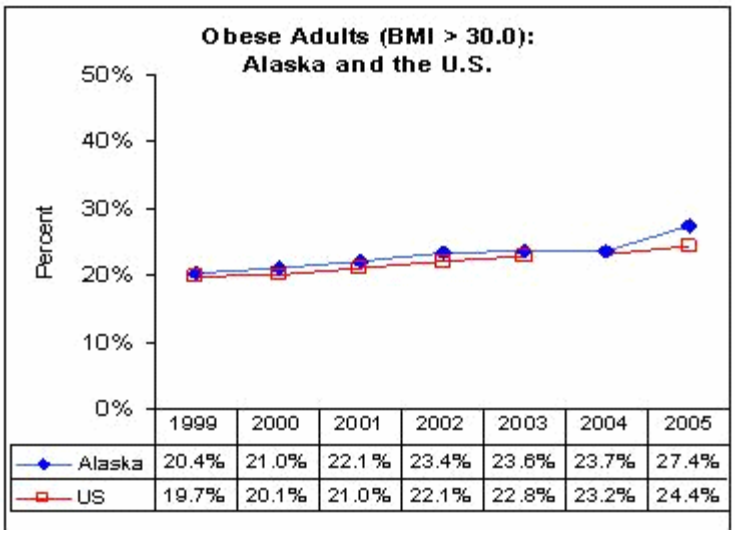
Diabetes is the leading cause of blindness and end-stage renal disease in adults. Diabetes increases the risk of heart disease, stroke, and many infectious diseases. Nerve damage from diabetes is the leading cause of lower extremity amputations. Diabetes prevalence increases with age, and the prevalence of diabetes in the United States is expected to increase as the population ages.

Over the past decade, an increasing number of Alaskan adults have reported being told by a health professional that they have diabetes. This number, plus the estimated 29% of all diabetes cases that go undiagnosed, yields the best estimate of the true prevalence of diabetes in Alaska. One limitation

of this estimate is that, with improving surveillance and detection, prevalence will continue to increase independent of any real increase in morbidity.

The department works to reduce the health burden and economic costs of diabetes in Alaska through an integrated program of prevention and disease management that supports individuals and communities. To slow or halt the upward trend of diabetes, a comprehensive approach is needed to make healthy behaviors the norm. The major risk factors contributing to chronic diseases are tobacco use, physical inactivity, unhealthy eating habits and resulting obesity. The department will address all of these factors by giving individuals the knowledge and tools they need to make healthier choices, while also assuring that healthy behaviors are reinforced in schools, worksites and other community settings.

Target #4: Decrease Alaska's adult obesity rate to less than 18%
Measure #4: Obesity rate of Alaskans



Prevalence of Obesity: Alaska & US

Year	Alaska	US
1999	20.4%	19.7%
2000	21.0%	20.1%
2001	22.1%	21%
2002	23.4%	22.1%
2003	23.6%	22.8%
2004	23.7%	23.2%
2005	27.4%	24.4%

Analysis of results and challenges: The trends in Alaska continue to show growing numbers of overweight and obese adults, with a significant increase in obesity in 2005, to 27.4%. By comparison, the Healthy Alaskans 2010 target for obesity is 18%.

Premature death and disability, increased health care costs, and lost productivity are all associated with overweight and obesity. Unhealthy dietary habits combined with sedentary behavior are primary factors in increasing body fat levels. Overweight and obesity are estimated to be responsible for approximately 300,000 deaths per year in the United States.

National studies show an association of overweight and obesity with certain types of cancers (endometrial, colon, post menopausal breast, and prostate), as well as heart disease, stroke, diabetes and arthritis. Overweight and obesity are directly associated with at least four of the top ten leading causes of death. Mortality due to unintentional injury, suicide, chronic obstructive pulmonary disease (COPD), pneumonia, and liver disease may also be influenced by obesity to some extent.

Through educational, programmatic, policy and environmental strategies, the department works to reduce the percentage of Alaskans classified as overweight, obese or at-risk for being overweight, and to promote healthy food choices and exercise. A comprehensive approach is needed to reduce the trend of increasing obesity in Alaska. Along with tobacco use, physical inactivity and unhealthy eating habits, obesity contributes greatly to the prevalence of chronic disease. The department is working to address all of these factors by giving individuals the knowledge and tools they need to make healthier choices. Strategies also are targeted to promote healthy behaviors in communities - the workplace, schools and other settings.

G1: Strategy - Strengthen public health in strategic areas.

Division Level Measures

A: Result - Outcome Statement: Healthy people in healthy communities

Target #1: Alaska's TB rate is less than 6.8/100,000 population.
Measure #1: TB rate.

Annual TB Rate per 100,000 population

Year	US	Alaska
2000	5.8	17.2
2001	5.6 -3.45%	8.5 -50.58%
2002	5.2 -7.14%	7.6 -10.59%
2003	5.1 -1.92%	8.8 +15.79%
2004	4.9 -3.92%	6.6 -25%
2005	4.8 -2.04%	8.9 +34.85%

Analysis of results and challenges: Tuberculosis has been a longstanding problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, utilizing 10% of the entire 1946 state budget and additional federal resources, led to one of the state's most visible public health successes - major reductions in TB. Tremendous inroads have been made to control TB in Alaska, although periodic outbreaks, usually in rural Alaska, have taxed both local and state resources. In 2000, Alaska had the highest rate of TB of any state in the country and additional funding was needed to effectively control two large outbreaks. In 2004, a multi-village outbreak involving Bethel and several surrounding Yukon-Kuskokwim villages again required additional public health resources and enhanced local response efforts. Unrelated to that outbreak, four Alaskans died with TB in 2004 because of delayed diagnosis and treatment - three Alaska Native elders and a Laotian. On an on-going basis, even when there are no outbreaks, significant resources are needed to do the TB case finding, diagnostic tests and treatment follow-up necessary to keep this

disease in check. In addition, for every person with TB, there are, on average, 16 people who were exposed and must also be found, evaluated, and often treated as well.

Despite the outbreak and deaths in 2004, Alaska had the lowest rate of TB ever recorded for the state. Alaska's population is small, so only a few cases can dramatically affect the statewide rate. For instance, the latest increase is a difference of just 16 cases – 43 in 2004 up to 59 in 2005. There was no specific outbreak that caused the 2005 increase, and it is important to note that the overall trend of TB incidence in Alaska continues to head downward.

However, because of latent TB infection among residents and Alaska's location as a global crossroads that attracts travelers, seasonal workers and new families, infection rates are expected to fluctuate and remain higher than the national average over the next generation. TB remains deeply entrenched in many regions of Alaska, while the homeless and foreign-born residents also suffer disproportionate rates of the disease.

To control the on-going challenge of TB, the department needs a strong and multi-pronged public health team of professionals knowledgeable about current issues of TB control. Such expertise will always be necessary if the disease once called the "Scourge of Alaska" is to be controlled and eventually eliminated.

Target #2: Alaska's Chlamydia rate is less than 590/100,000 population.
Measure #2: Chlamydia rate.

Chlamydia rate per 100,000 of population

Year	Alaska	U.S.
1999	303	247
2000	410 +35.31%	251 +1.62%
2001	433 +5.61%	275 +9.56%
2002	593 +36.95%	289 +5.09%
2003	602 +1.52%	304 +5.19%
2004	604 +0.33%	320 +5.26%
2005	656.5 +8.69%	N/A

Analysis of results and challenges: Sexually transmitted infections remain major causes of illness in Alaska and may have serious health consequences. New infectious agents and diseases are being detected, and some diseases once under control have reemerged in recent years. In addition, antimicrobial resistance is evolving over time.

Many challenges remain. Targeted screening with more sensitive technologies, as well as increased disease investigation activities, has actually increased the total numbers of STD cases diagnosed. These activities effectively identify infected individuals with no symptoms and also allow identification and treatment of other exposed individuals before they develop symptoms or further transmit infection. Case numbers are expected to decline over time as these activities reduce the reservoir of infected individuals in the population.

Identification, notification, testing, and treatment of sexual contacts of STD cases are time-tested, effective strategies for the HIV/STD Program. In combination with targeted screening and treatment activities, these strategies are effective in containing Chlamydia and many other sexually transmitted infections. The basic public health infrastructure for STD and HIV prevention and control is in place: public health laboratory services, public health capacity for patient and partner follow up, and capacity to provide epidemiologic support, data analysis, and data dissemination. Some elements of this infrastructure (e.g., partner notification services) currently need additional resources to strengthen and expand them to respond to increased needs; all elements require on-going maintenance and monitoring. Most of the financial resources currently identified to support STD prevention and control are federal, and funding has declined over time.

Target #3: Alaska's coronary heart disease death rate is less than 120/100,000 population.
Measure #3: Heart disease death rate.

Coronary Heart disease death rate per 100,000

Year	Alaska	US
1999	131.5	194.6
2000	137.7 +4.71%	186.7 -4.06%
2001	136.6 -0.8%	177.8 -4.77%
2002	118 -13.62%	170.9 -3.88%
2003	126.6 +7.29%	162.9 -4.68%
2004	94.9 -25.04%	150.5 -7.61%
2005	87.1 -8.22%	N/A

Analysis of results and challenges: Nationally, heart disease is the leading cause of death for all Americans. An estimated 12 million men and women have a history of coronary heart disease (the most common form of heart disease). In 1998, almost 460,000 people died of coronary heart disease (44% of these deaths were from heart attacks). Although death rates from coronary heart disease have declined since the late 1960s, the decline has slowed since 1990. The lifetime risk for developing this disease is very high in the United States. One of every two males and one of every three females aged 40 years and under will develop it sometime in their life.

Heart disease is the second leading cause of death in Alaska, and cerebrovascular disease (most commonly referred to as stroke) is the fourth leading cause of death in Alaska. Over the past decade, Alaska's age-adjusted mortality rate for coronary heart disease has continued to decline. This mirrors the national trend, although Alaska's rates fall consistently below those found in the U.S. overall. In 2002, 2004 and 2005, Alaska's coronary heart disease death rates fell below the Healthy Alaskans 2010 target, which is 120 deaths per 100,000 population.

While there are no hard data to explain the downward trend in coronary heart disease deaths, it is likely that improvements in medical care are prolonging life, even for patients with advanced heart disease. In addition, Alaskans diagnosed with heart disease sometimes move south to receive treatment; their eventual deaths are not recorded in this state.

Target #4: Alaska's overall cancer death rate is less than 180/100,000 population.
Measure #4: Cancer death rate.

Cancer death rate per 100,000 of population

Year	Alaska	US
1999	192.5	200.8
2000	209.6 +8.88%	199.6 -0.6%
2001	192.2 -8.3%	196.0 -1.8%
2002	189.4 -1.46%	193.5 -1.28%
2003	187.7 -0.9%	190.1 -1.76%
2004	183.9 -2.02%	184.6 -2.89%
2005	160.5 -12.72%	N/A

Analysis of results and challenges: Cancer is not a single disease, but rather a constellation of more than 100 related diseases. Everyone is at risk of cancer. In the United States, half of all men and one-third of all women will develop cancer during their lifetimes. Of the approximately 491,000 Americans who are diagnosed with cancer in any given year, four of every ten are expected to still be living five years after diagnosis. Cancer was rarely seen in Alaska during the 1950s, but in the 1990s cancer was the leading cause of death in Alaska.

Over the past 10 years, the overall cancer death rate in Alaska has declined, closely mirroring the decline seen in U.S. cancer mortality rates for the same period. The Healthy Alaskans 2010 target is 162 deaths per 100,000 population.

The leading types of cancer deaths in Alaska for women are, in order, lung, breast and colorectal cancers. For men, the leading types of cancer deaths are lung, colorectal and prostate.

Target #5: Reduce Alaska's unintentional injury death rate to 50/100,000 population.
Measure #5: Unintentional injury death rate.

Unintentional injury death rate per 100,000 population

Year	Alaska	US
1999	57.5	35.3
2000	63.9 +11.13%	34.9 -1.13%
2001	61.1 -4.38%	35.6 +2.01%
2002	59.2 -3.11%	36.9 +3.65%
2003	55.1 -6.93%	37.2 +0.81%
2004	54.9 -0.36%	36.6 -1.61%
2005	46.3 -15.66%	N/A

Analysis of results and challenges: Injuries are a significant public health and social services problem because of the prevalence of injuries, the toll of injuries on the young, and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries. Unintentional injuries were the third leading cause of death in Alaska in 1998. Unlike heart disease and cancer, which are the leading causes of death among the elderly, injuries are the leading cause of death in children and young adults.

The Division of Public Health along with its many partners continues to see the benefits of actions related to injury control and prevention. The Safe Boating Act and Kids Don't Float are only two examples of the activities that contribute to success in reaching and maintaining this target. The Division of Public Health's Injury Control Program will continue to partner with others and to use surveillance and prevention strategies to understand and target interventions.

A1: Strategy - Reduce the risk of epidemics and the spread of infectious disease.

Target #1: 95% of persons with TB will complete adequate treatment within one year of beginning treatment.
Measure #1: Percent of persons with TB completing treatment regimen.

% of Persons with TB Completing Treatment Regimen

Year	Annual
2002	95%
2003	93%
2004	86%
2005	59%*

**TB treatment requires 6-9 months for completion. 2005 completion data are still being collected.*

Analysis of results and challenges: The highest priority for TB control is to ensure that persons with the disease are diagnosed early and complete curative therapy. If treatment is not continued for a sufficient length of time, people with TB become ill and contagious again, sometimes with resistant TB the second time. Completion of therapy is essential to prevent transmission of the disease as well as to prevent the development of drug-resistant TB. The measurement of completion of therapy is an important indicator of the effectiveness of community TB control efforts.

Target #2: At least 98% of Chlamydia cases will be prescribed adequate treatment, as defined by CDC's STD Treatment Guidelines.
Measure #2: Percent of persons with Chlamydia prescribed adequate treatment regimen.

% of Chlamydia cases prescribed adequate treatment

Year	Annual
2003	99.5%
2004	99.6%
2005	99.8%

Analysis of results and challenges: HIV/STD Program staff follow-up to assure treatment for all reported cases. Given such follow-up, very few cases are identified that are not treated consistent with the current national recommendations. Challenges include maintaining resources necessary to assure identified infections are appropriately treated, and carefully evaluating recommended treatment modalities to assure they are efficacious.

In calendar year 2005, 99.8% of the 4,357 reported cases of Chlamydia infection were prescribed adequate treatment.

A2: Strategy - Reduce suffering, death and disability due to chronic disease.

Target #1: Less than 19% of high school youth in Alaska use tobacco products.
Measure #1: Prevalence of tobacco use in Alaskan youth.

Prevalence of tobacco use in Alaska youth in past 30 days (per YRBS survey)

Year	Alaska	US
1999		34.8
2001		28.5 -18.1%
2003	19.3	21.9 -23.16%

Analysis of results and challenges: Many Alaskans are currently at risk for developing cardiovascular disease due to such risk factors as smoking, overweight, poor diet, sedentary lifestyle, high blood pressure and cholesterol, and lack of preventive health screening. Smokers' risk of heart attack is more than twice that of nonsmokers. Chronic exposure to environmental tobacco smoke (second-hand smoke) also increases the risk of heart disease. Cigarette smoking is also an important risk factor for stroke.

Tobacco is a leading cause of preventable disease and death in the United States. The majority of Alaska smokers (almost 80%) began smoking between the ages of 10 and 20 years. Alaskans have been working to decrease youth tobacco use through increasing the tax on tobacco products, education of young people, enforcement of laws restricting sales to minors, and a statewide ban on self-service tobacco displays.

In 1995, 37% of Alaska youth reported smoking at least once in the last thirty days, compared with 19.3% in 2003. Data is available from the Youth Risk Behavior Survey when enough Alaska schools participate to give results that can be generalized to the high school population as a whole in the State. This was the case in 1995 and 2003. Surveys occurred in other years, however, they did not have enough participants to provide statewide results, including 2005. It is the goal of the Division of Public Health to continue to work with schools to collect a representative sample every other year.

Healthy Alaskans 2010 target is 19.0%.

A3: Strategy - Reduce suffering, death and disability due to injuries.

Target #1: Increase seatbelt use to 80%.
Measure #1: Percent of properly restrained occupants in a motor vehicle.

Seat Belt Use by Drivers and Passengers

Year	Alaska	US
1999	60.6	67.0
2000	61.3 +1.16%	71.0 +5.97%
2001	62.6 +2.12%	73.0 +2.82%
2002	65.8 +5.11%	73.0 0%
2003	78.9 +19.91%	79.0 +8.22%
2004	77.0 -2.41%	80.0 +1.27%
2005	78.4%	82%

Analysis of results and challenges: Injuries are a significant public health and social services problem because of their prevalence, the toll of injuries on the young and the high cost in terms of resources and suffering. Alaska has one of the highest injury rates in the nation. Both the intrinsic hazards of the Alaska environment and low rates of protective behavior contribute to injuries and death. Unintentional injuries are the third leading cause of death in Alaska.

Studies have shown that a primary seatbelt enforcement law that allows police to stop and cite motorists for failing to comply with the seatbelt law is most effective in reaching a higher level of seatbelt use compliance. The Alaska Legislature began its 2006 session by finally passing such a law. Meanwhile, efforts are on-going to increase seatbelt use through public information messages and other targeted activities.

The Healthy Alaskans 2010 target is 80 percent seatbelt usage.

A4: Strategy - Assure access to early preventative services and quality health care.

Target #1: More than 60% of women of childbearing age will report knowledge that taking folic acid during pregnancy can reduce the risk of birth defects.

Measure #1: Percent of women reporting knowledge of folic acid benefits.

Knowledge of Folic Acid Benefits, Alaska

Year	Overall	Alaska Native
1999	77.5	60.9
2000	80.8 +4.26%	62.3 +2.3%
2001	80.5 -0.37%	63.1 +1.28%
2002	80.8 +0.37%	63.5 +0.63%
2003	82.0 +1.49%	65.3 +2.83%

Analysis of results and challenges: Folic acid knowledge among Alaskan mothers is increasing. The proportion of women who indicated that they knew about the benefits of folic acid increased from 63.0% in 1996 to 82.0% in 2003.

The proportion of Alaska Native mothers who knew about the benefits of folic acid increased by 65% between 1996 and 2003. While the prevalence of folic acid knowledge among Alaska Native mothers of newborns was still substantially lower than overall levels, the gap in knowledge between Alaska Natives and Alaskan mothers overall appears to be closing.

Starting in 2000, the proportion of mothers of newborns who are knowledgeable about the benefits of folic acid appears to have plateaued around 80%.

For women of childbearing age, increasing folic acid use by taking multivitamins before and during pregnancy can reduce the risk of neural tube birth defects. Numerous public education campaigns have sought to increase women's knowledge of the benefits of folic acid supplementation and educate them especially about the importance of the timing (pre-pregnancy supplementation is ideal). Efforts should focus on increasing the overall knowledge prevalence to 90% and minimize racial disparities.

Target #2: 100% of Alaska's licensed and certified long-term care facilities are surveyed and recertified annually.

Measure #2: Percent of licensed and certified long-term care facilities surveyed and recertified annually.

% of licensed and certified long-term care facilities surveyed and re-certified annually

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
2002	42.86	21.43	21.43	14.29	100%
2003	21.43	42.86	14.29	21.43	100%
2004	35.71	21.43	21.43	14.29	92.86%
2005	26.67	33.33	13.33	20	93.33%
2006	20	26.7	40	20	106.7%

Analysis of results and challenges: The annual required schedule for nursing home surveys is driven in large part by federal certification requirements. Surveys are to be completed within a 9- to 15-month period. Certification and Licensing (C & L) may not appear to meet the licensing and certification goal within a given calendar or fiscal year, or sometimes it may be over 100%. However, C & L will consistently meet federal and state certification and licensing survey requirements. The Section's scheduling is affected by significant increases or decreases in complaints or reports of harm, and by significant changes in staff resources.

A5: Strategy - Minimize loss of life and suffering from natural disasters and terrorist attack.

Target #1: 25% of the Division of Public Health staff is trained in disaster response techniques and procedures.
Measure #1: Percent of DPH staff trained.

 # and % of Division of Public Health staff trained in disaster preparedness

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2005			70	103	27%
FY 2006				144*	28%

**144 Division of Public Health staff received disaster preparedness training in FY2006. Quarterly numbers are not available.*

Analysis of results and challenges: Disaster response training for Division of Public Health (DPH) staff is enabling DPH to carry out its role in disaster response operations. Training is the critical link between planning and action and permits all concerned to maintain a common knowledge base.

The FY06 percentage above reflects the following: 520 total DPH positions, with 144 receiving disaster preparedness training - for a total of 28 percent trained. This slightly exceeds the Division goal of 25 percent. However, when only filled positions are considered (415 at the end of FY06), then the total of DPH-trained staff increases to 35 percent.

A6: Strategy - Reduce Alaskans' exposure to environmental human health hazards.

Target #1: State lab has validated methods to test people for 100% of the important PCBs, pesticides and trace heavy metals.
Measure #1: Each new testing method validated as required by CLIA.

% testing methods for PCBs, pesticides and heavy metals validated by CLIA

Year	Target	Actual
2006	75%	50%
2005	75%	50%
2004	10%	10%

Analysis of results and challenges: PCBs, pesticides and trace heavy metals can affect human health, especially that of the developing fetus. The chief concern in Alaska centers on the presence of contaminants in traditional foods. Generally these foods are very nutritious and offer a number of health benefits. This testing measures human exposure to contaminants and verifies the safety of traditional foods. For years, the federal government, through the Clinical Laboratory Improvement Amendments (CLIA) process, has certified the state lab. However, no chemical testing (for PCBs, etc.) was offered at the lab until 2004. Now the lab conducts CLIA-certified testing of inorganics, and testing for Persistent Organic Pollutants (POPs) is expected to begin in FY07.

Senior and Disabilities Services

Mission

Promote the independence of Alaskan seniors and persons
with physical and developmental disabilities.

Introduction

The Division of Senior and Disabilities Services provides community grants and home and community-based services for older Alaskans and persons with disabilities as well as protection of vulnerable adults. The division administers four Medicaid Waiver programs and Senior Services and Community Developmental Disabilities Grants programs.

Core Services

Institutional and community based services for older Alaskans and persons with disabilities.
Protection of vulnerable adults

Services Provided

Medicaid Services:

Home and Community Based Waiver Medicaid Services Programs
In response to the high costs of nursing facility care, Medicaid has evolved into a program that allows the state to provide long-term care in less restrictive, more cost effective services that enable people to live in home and community settings. If determined eligible by meeting specific target population criteria, level of care, and financial guidelines, a person may apply to receive services under one of the 4 Medicaid waiver programs described below. Reimbursable waiver services include care coordination, chore services, adult day care, day habilitation, environmental modifications, meals, respite care, residential care in alternatives such as Assisted Living or Group Homes, specialized equipment, specialized private duty nursing, supported employment, and transportation to waiver services. The Division manages 4 Medicaid waivers as shown below:

The Adults with Physical Disabilities (APD) Waiver
APD provides services to those consumers who meet nursing home level of care but wish to remain in their own homes and communities. The consumer must (1) be at the level of need provided to a client in a nursing home and (2) be financially eligible for Medicaid to access the program. The program serves clients between the ages of 21 and 64 years of age.

The Children with Complex Medical Conditions (CCMC) Waiver
CCMC is for children, (1) birth through age 21, (2) having a severe chronic physical condition that is expected to continue for more than 30 days. The condition is (3) life threatening and needs (4) careful all day everyday monitoring. The child is (5) dependent upon medical care or technology and (6) requires the same sort of care usually found in a hospital or nursing home.

The Mental Retardation/Developmental Disability (MRDD) Waiver
MRDD is specifically for (1) individuals with mental retardation, autism, cerebral palsy, a seizure disorder, or a condition that means the person functions as if having mental retardation. In addition to these diagnoses, the individual (2) must have a serious limitation on how they function in everyday life. For example, it might be difficult for the person to make safe decisions or take care of personal needs without supervision. And, (3) the person requires the same level of care provided in an Intermediate Care Facility for the Mentally Retarded.

The Older Alaskan (OA) Waiver
OA provides services to those consumers who meet nursing home level of care but wish to remain in their own homes and communities. The consumer must (1) be at the level of need provided to a client in a nursing home and (2) be financially eligible for Medicaid to access the program. The program serves clients who are 65 years and older.

Additional Medicaid Services:

In addition to the 4 Medicaid waivers above, the Division operates the Personal Care Assistance and Nursing Home Authorization Medicaid programs:

Personal Care Assistance
Services are provided statewide in Alaska through the Personal Care Assistant (PCA) Program. Through Division oversight, the level of need for services is determined by assessment, to evaluate functional limitations in the performance of activities of daily living which may include bathing, dressing, grooming and problems with instrumental activities of daily living such as shopping and cleaning. The Division certifies qualified agencies as PCA providers. Per a legislative mandate to contain costs in the PCA program, new regulations became law on 4/1/2006 requiring that all recipients of PCA services receive an assessment and prior authorization of services to ensure they are receiving only the services they are eligible to receive. Preliminary expenditure detail and budget projections show that programmatic growth for PCA services has increased while programmatic expenditures have been reduced. The Division will continue to monitor this program carefully and make changes as necessary to reduce costs without reducing necessary services.

PCA services are typically provided in a consumer's home by health care paraprofessionals called personal care assistants. These services enable functionally disabled Alaskans of all ages, and frail elderly Alaskans, to live in their own home, instead of being placed in a more costly and restrictive long-term care setting. Recipients have a choice between two (2) different options of PCA services. The Agency-Based PCA model allows consumers to use one of the qualified agencies that oversee, manage and supervise their care. Or, consumers may choose the Consumer Directed PCA model that allows them to select, train, supervise, and discharge their PCA.

Nursing Home Authorizations
The Division is responsible for the initial admitting authorizations of Medicaid eligible consumers to Skilled Nursing Facilities. Reauthorizations are completed every three to six months for those consumers staying in these facilities (depending on level of care) throughout the state of Alaska and in other states if the appropriate care is not available in this state. The Division is also responsible for authorizing Await & Swing beds for hospitals, in state and out of state, while Medicaid clients are waiting for admittance to a skilled nursing facility or if a skilled nursing facility is not available in the community. There are 14 skilled nursing facilities around the state. The average yearly cost for a patient in a nursing home in FY06 was approximately $168,993.

Non-Medicaid Services:

Adult Protective Services (APS) / General Relief
The Adult Protective Services Unit protects adults over the age of 18 from abuse, neglect and exploitation. APS staff investigates reports of harm and takes appropriate action (up to and including removal from the client's home) to ensure that vulnerable adults are safe. The APS Unit also administers the General Relief Program which pays for temporary assisted living home costs for clients who need "emergency placement" and may qualify for but are not currently approved to receive services under a Medicaid waiver. The APS Unit had a caseload intake of 1,666 new cases in FY06. Currently in FY07, there has been an intake caseload of 1,000 cases. (7/1/06 – 12/31/06) If this intake rate continues through the rest of FY07, we project a total caseload intake of 2,000 cases for the year. This represents an approximate increase of 20% in one year!

Nutrition, Transportation, and Support Services Grants for Seniors
The U.S. Department of Health and Human Services, Administration on Aging grants federal funds to the Division each year to provide for Nutrition, Transportation and Support services for Alaskan Seniors.
These grants provide funding for the following services:

- Congregate Meals
- Home Delivered Meals
- Nutrition Services Incentive Program (NSIP)
- Assisted and Unassisted Transportation
- Homemaker Service
- Information and Assistance
- Outreach
- Nutrition Education and Counseling
- Health Education and Counseling
- Health Promotion / Medication Management
- Foster Grandparent / Elder Mentor Program
- Senior Companion Program
- Retired Senior Volunteer Program
- Legal Assistance
- Media Services (provides partial funding for the Senior Voice)

These services are selected through the State Plan process from a menu of services available under Title III of the Older Americans Act. These services are available to Alaskan seniors that are over age 60 and targets populations with the greatest social and economic need. This includes seniors that live in rural areas, are members of minority groups and are physically frail.

Home and Community Based Care Grants for Seniors
Home and Community based services provide a safety net for seniors and their caregivers who wish to remain in their homes and would not otherwise qualify for services under the Older Alaskans Medicaid Waiver program. Grants for these services are provided by State general fund / mental health funds, the AOA Title III federal grant for National Family Caregiver services and MHTAAR funds authorized by the Alaska Mental Health Trust Authority.

Services provided under this grant include:

- Adult Day Services
- National Family Caregiver Support
- Alzheimer's Disease and Related Dementias (ADRD) Education, Support and Mini-Grants
- Senior In-Home Services (Care Coordination, Chore, Respite and Extended Respite Services)
- Geriatric Education Treatment for Seniors with Co-Occurring Substance Abuse and Mental Health Disorders

Senior Residential Services - Through designated funding from the Alaska State Legislature, the Division of Senior and Disabilities Services oversees grants that support assisted living facilities for elders in Tanana and Kotzebue. By definition, assisted living facilities provide meals and assistance with daily activities to enable seniors to remain in or near their community of choice.

Community Developmental Disabilities Grants (CDDG)
The Community Developmental Disabilities Grant Program minimizes institutionalization and provides care for people with developmental disabilities (DD). In FY06 developmental disabilities grants provided services to nearly 2,913 recipients in 90 communities across the state with conditions such as mental retardation, autism, or cerebral palsy. Services funded by these grants result in the acquisition or maintenance of skills to live with independence and improved capacity and reduce the need for long-term residential care.
Services include but are not limited to:

- Care Coordination
- Chore Services
- Day Habilitation
- Independent Living Support
- In-Home Supports
- Behavioral Training
- Intensive Active Treatment
- Residential Services
- Respite Care
- Specialized Adaptive Equipment
- Vocational Services

For those beneficiaries that meet the diagnostic and income limits, one of the Division's 4 Home and Community Based Waiver Programs may provide similar services. However, not everyone having a developmental disability qualifies for Medicaid under a Waiver Program or meets the threshold for long-term residential care that the MRDD Waiver is designed to provide.

Other grant programs in the CDDG component include:

Core Services- Offered to individuals on the Waitlist who receive no other services from the Division. Core Services grants are limited to an annual amount of $3,000 of services per recipient and are used to alleviate crisis and delay the need for long-term care. About 500 people receive Core Services each year.
Short Term Assistance and Referral Program (STAR). In FY 06, 16 organizations were awarded funds to operate a STAR program to assist people with developmental disabilities and their families address short-term needs before a crisis occurs and to defer the need for more expensive residential services or long-term care. Many people who are on the DD Waiting List access STAR services.

Mini-grants for beneficiaries with developmental disabilities. With funds from the Mental Health Trust Authority, mini-grants are a one-time award made to individuals not to exceed $2,500 per recipient for health and safety needs not covered by grants or other programs to help beneficiaries attain and maintain healthy and productive lifestyles. Adult dental care is the most frequently requested service by those who receive mini-grants.
Specific grants that address the severe statewide shortage of qualified direct care staff and assure that critical expertise is available in the state to deliver services required in AS 47.80.130.

Behavioral Risk Management Services address difficult behaviors by providing technical assistance and training for the personnel working in community DD programs, or family members and guardians. Additionally, funds are used for personal safety training for women with DD.

The **ARC of Anchorage Student Living Center for the Deaf** provides students who are deaf living in rural areas of Alaska with residential services and daily support while they attend the Alaska State School for Deaf and Hard-of-Hearing in Anchorage.

Dental Training is an MHTAAR project to train direct service staff employed by developmental disabilities providers in techniques of oral hygiene for people with DD. Many adults with developmental disabilities have never learned good oral hygiene techniques and the majority of direct service providers have never had any training in how to teach people to care for their teeth. Oral Hygiene is a major issue in the overall health status of people with DD.

Under the Federal DD Act, the state must have a system of **protection and advocacy** that has the capacity to provide administrative and legal remedies to civil rights concerns for people with developmental disabilities. Priority services for this program, administered through the **Disability Law Center**, is to provide people with developmental disabilities and their families training and assistance in methods to resolve grievances they may have with providers of developmental disability community services.

Miscellaneous Grants: Grants under the Nursing Facilities Transition Program which help keep seniors in their homes and communities at a cost which is typically far less than paying for a residential nursing home.

Senior and Disabilities Medicaid Services

In SFY06 Senior and Disabilities Medicaid provided services to more than 7,700 Alaskans, nearly 6% of the 132,000 enrolled.

Senior and Disabilities Medicaid expenditures grew 9% from SFY05 to SFY06. Growth is due mostly to increases in utilization of home and community based waiver services and to a lesser extent increases in the number of beneficiaries for HCB services and nursing facilities.

Growth in Personal Care Attendant services slowed dramatically to 5% between SFY05-06 from its peak of 187% between SFY02-03.

Over half (56%) of the claim payments were for benefits provided to disabled adults and children. The elderly accounted for 44% of the benefit costs.

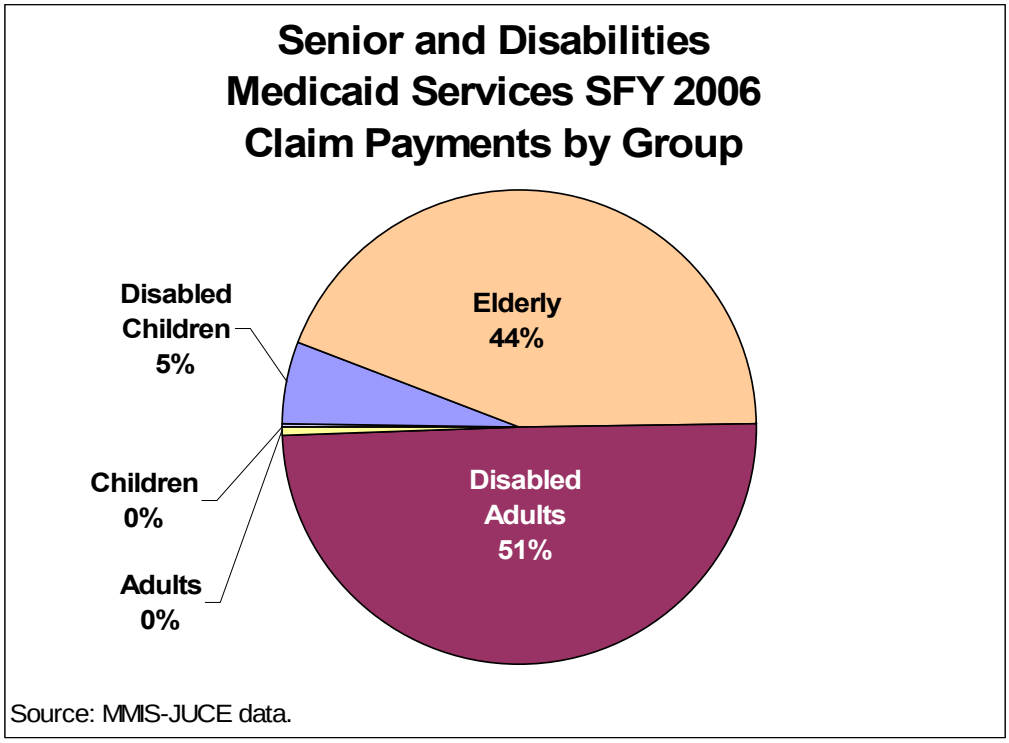
The majority of expenditures are for Home and Community Based Waiver services which comprised 42% of the Senior and Disabilities Medicaid Services component in SFY06. The Mental Retardation/Developmental Disabilities waiver is the largest subcategory with 25% of all HCB services. Personal Care Attendant services represent 29% and Nursing Homes are 26% of the remaining costs.

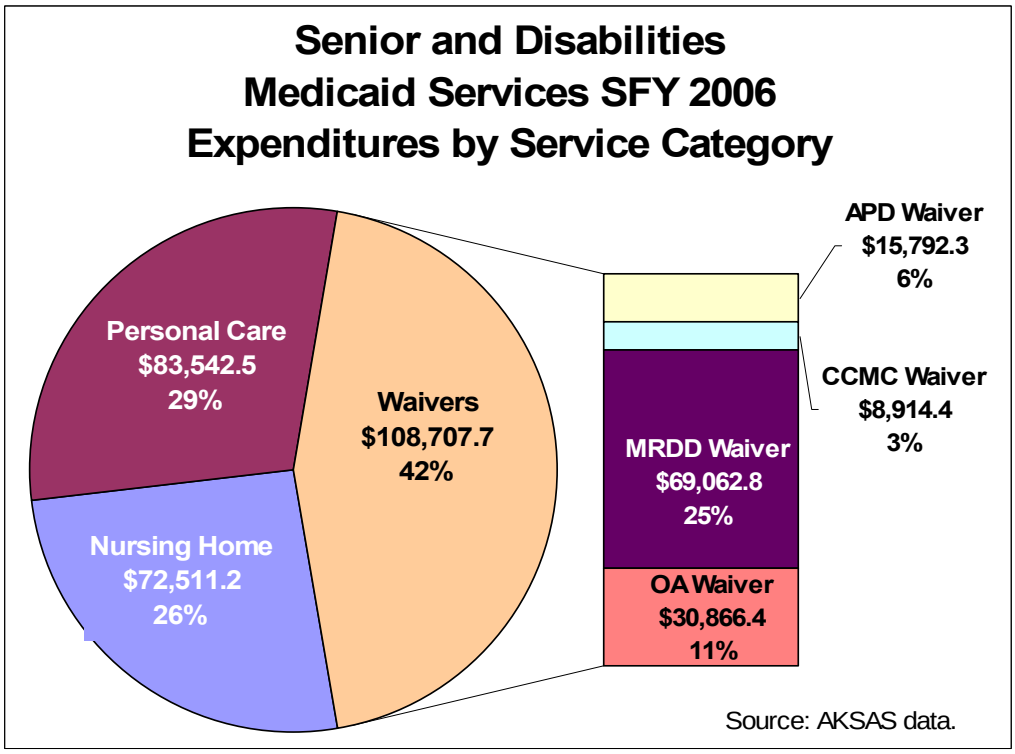
Number of Medicaid Beneficiaries in SFY 2006

	Nursing Homes	Home and Community Based Waivers	Personal Care Attendants	Total (sum)	Unduplicated by Benefit Group
Children	3	35	30	68	96
Adults	11	10	104	125	119
Elderly	814	1,563	1,980	4,357	3507
Disabled Children	0	399	90	489	774
Disabled Adults	368	1,932	1,926	4,226	3418
Total (sum)	1,196	3,939	4,130	9,265	
Unduplicated by Service	1,179	3,683	4,039		7,703

Source: MMIS-JUCE.

*The sum of the groups may not equal the total for the category because benefic


Senior and Disabilities
Medicaid Services SFY 2006
Claim Payments by Group
Disabled Children 5%
Elderly 44%
Children 0%
Disabled Adults 51%
Adults 0%
Source: MMIS-JUCE data.


Senior and Disabilities
Medicaid Services SFY 2006
Expenditures by Service Category
Personal Care $83,542.5 29%
Waivers $108,707.7 42%
Nursing Home $72,511.2 26%
APD Waiver $15,792.3 6%
CCMC Waiver $8,914.4 3%
MRDD Waiver $69,062.8 25%
OA Waiver $30,866.4 11%
Source: AKSAS data.

SFY 2006 DIVISION LEVEL SUMMARY: Senior and Disabilities Services Medicaid	DSDS MEDICAID CLAIMS (DIRECT SERVICES ONLY)						
	RECIPIENTS		PAYMENTS		COST per RECIPIENT per YEAR	Division, Percent of Department Medicaid	
	Percent of Category	Annual Count	Annual Total	Annual Total		Recipients *	Payments
Medicaid, Unduplicated Annual		**7,703**		**$280,164,440**	**$36,371**	**6.3%**	**28.6%**
Gender							
Female	60.2%	4,635	57.9%	$162,221,043	$34,999	6.6%	29.1%
Male	39.8%	3,070	42.1%	$117,943,397	$38,418	5.8%	27.9%
Unknown						0.0%	0.0%
Race							
Alaska Native	22.6%	1,747	23.8%	$66,653,369	$38,153	3.8%	18.1%
American Indian	1.2%	91	1.3%	$3,706,560	$40,731	5.1%	27.9%
Asian	10.6%	816	8.3%	$23,136,671	$28,354	12.6%	51.4%
Pacific Islander	3.3%	257	2.6%	$7,298,181	$28,398	8.0%	39.5%
Black	4.4%	340	4.1%	$11,600,181	$34,118	5.3%	26.1%
Hispanic	2.4%	188	2.1%	$5,803,689	$30,871	4.3%	26.1%
White	51.8%	3,998	54.4%	$152,421,587	$38,124	7.7%	34.8%
Unknown	3.6%	277	3.4%	$9,544,203	$34,456	6.5%	33.0%
Native	23.8%	1,837	25.1%	$70,359,929	$38,302	3.8%	18.4%
Non-Native	76.2%	5,871	74.9%	$209,804,511	$35,736	7.8%	35.1%
Age							
under 1	0.4%	29	0.0%	$31,592	$1,089	0.2%	0.0%
1 through 12	6.7%	545	2.8%	$7,869,866	$14,440	1.1%	5.4%
13 through 18	4.4%	357	3.8%	$10,731,134	$30,059	1.6%	6.5%
19 through 20	1.7%	137	1.7%	$4,706,876	$34,357	3.2%	18.4%
21 through 30	5.7%	467	9.7%	$27,117,507	$58,067	3.5%	26.8%
31 through 54	20.6%	1,688	24.1%	$67,650,580	$40,077	9.1%	31.9%
55 through 64	13.5%	1,102	11.4%	$31,999,002	$29,037	24.8%	41.0%
65 through 84	36.5%	2,987	34.1%	$95,500,068	$31,972	41.1%	73.7%
85 or older	10.7%	872	12.3%	$34,557,815	$39,631	71.0%	89.6%
Benefit Group							
Children	1.2%	96	0.4%	$1,035,593	$10,787	0.1%	0.3%
Adults	1.5%	119	0.5%	$1,288,635	$10,829	0.5%	1.1%
Disabled Children	9.8%	774	5.4%	$14,992,018	$19,370	40.2%	27.4%
Disabled Adults	43.2%	3,418	49.8%	$139,388,044	$40,781	24.4%	46.3%
Elderly	44.3%	3,507	44.1%	$123,460,149	$35,204	46.8%	78.7%

Payments: Net amount of paid claims. Amounts do not reflect payments for Medicaid services made outside of the Medicaid management information system such as lump-sum payments, recoveries, or accounting adjustments. Therefore, these amounts will not tie to AKSAS or ABS.

Enrollment: Number of persons eligibile for Medicaid and enrolled at some time during state fiscal year 2006. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,benefit group, and region categories). Some duplications may occur in subgroup counts. For example, a child might be counted in the under 1 subgroup but also in the 1 through 12 subgroup after their first birthday.

Recipients: Number of persons having Medicaid claims paid or adjusted during state fiscal year 2006. Service may have been incurred in a prior year. Counts are unduplicated on the Medicaid recipient identifier at the department and group level (gender, race, age,benefit group, and region categories). Some duplications may occur in subgroup counts.

Participation: Recipients as a percent of eligible persons (as a percent of enrollment). The percent of eligible persons having claims paid or adjusted during the fiscal year. The number of persons with claims paid in this fiscal year for services incurred in a prior fiscal cycle may cause the calculated %participation to exceed 100%.

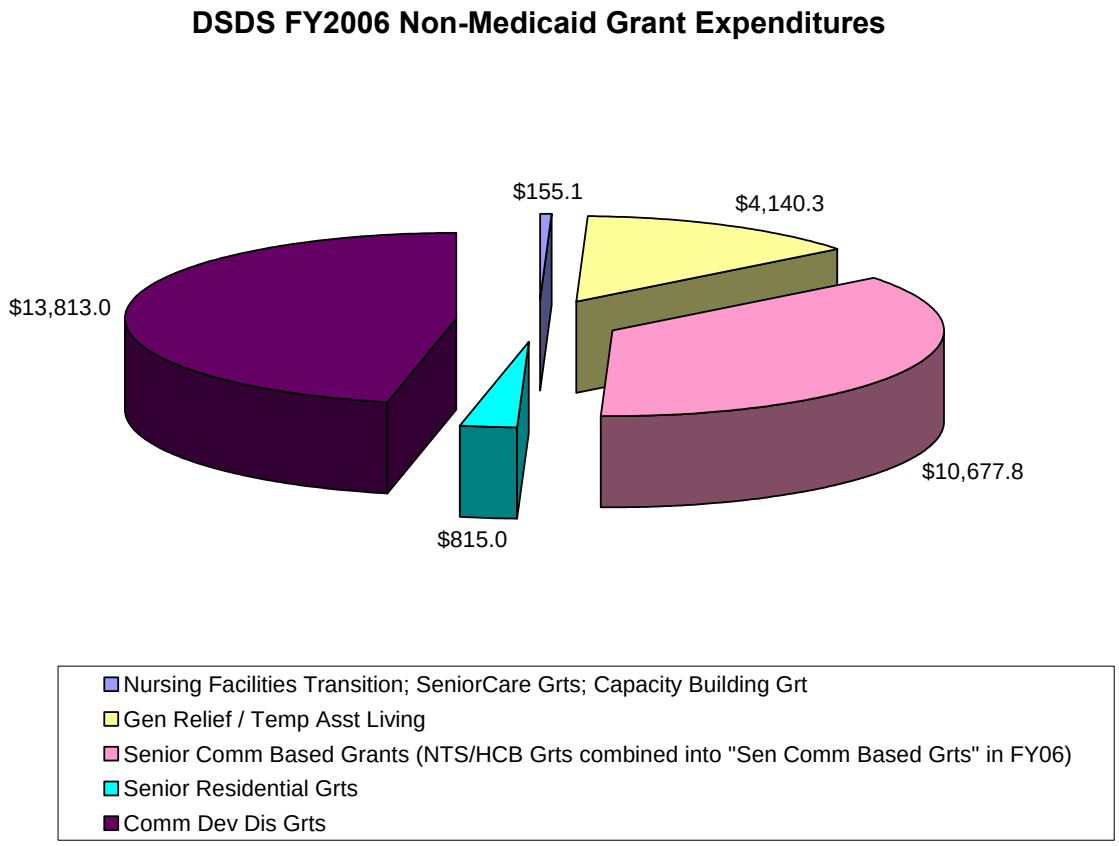
Department-wide recipient counts are unduplicated across divisions.

Source: HSS, Finance and Management Services, Medicaid Budget Group.

Non-Medicaid Grants/Services

The table below shows how funds were spent in FY06 for non-Medicaid SDS grant services:

Grant Name	Primary Service	# of Clients Served	Client Population	Total Exp:
Nursing Facilities Transition ($123.5); SeniorCare Grts ($15.1); Capacity Building Grt ($16.5)	Nursing Facilities Transition	42	Seniors	$155.1
Gen Relief / Temp Asst Living	Temp Asst Living	4,040	Adults 18+	$4,140.3
Senior Community Based Grants (NTS/HCB Grts combined into "Sen Comm Based Grts" in FY06)	Senior Grants	23,597	Seniors	$10,677.8
Senior Residential Grts	Elder Residential	20	Tribal Elders/Seniors	$815.0
Comm Dev Dis Grts	Dev Disabilities	2,913	Dev Disabled	$13,813.0
	Total Clients Served:	**30,570**	**Total Expenditures:**	**$29,601.1**



AS 44.29	Department of Health and Social Services
AS 47.05	Administration of Welfare, Social Services and Institutions
AS 47.07	Medical Assistance for Needy Persons
AS 47.24	Protection of Vulnerable Adults
AS 47.25	Public Assistance
AS 47.33	Assisted Living Homes
AS 47.65	Service Programs for Older Alaskans and Other Adults
AS 47.80.010 - 900	Persons with Disabilities
PL89-73	Title III Older Americans Act, as Amended
PL 98-459	Public Law, Title III Older Americans Act, as Amended
PL 100 - 203	Omnibus Budget Reconciliation Act of 1987
Title XVIII	Medicare
Title XIX	Medicaid
7 AAC 43	Medicaid
7 AAC 43.170	Conditions for Payment
7 AAC 43.1010 – 1990	Eligibility for the Home and Community-Based Waiver Services Program
7 AAC 72.010 - 900	Civil Commitment
7 AAC 78.010 - 320	Grant Programs
42 CFR, Part 400 to End	
42 CFR, Part 440	Code of Federal Regulations, Services: General Provisions
45 CFR, Part 1321	Code of Federal Regulations

Senior & Disabilities Services	2007	2008 Proposed	07 to 08 Change
General Funds	148,991.3	158,497.2	9,505.9
Federal Funds	196,070.0	210,572.5	14,502.5
Other Funds	3,060.6	4,151.3	1,090.7
Total	**348,121.9**	**373,221.0**	**25,099.1**

Senior and Disabilities Medicaid Services

Medicaid Facility Rates Rebased - Nursing Homes - $3,081.0 ($1,639.7 Federal / $1,441.3 GF)
Alaska nursing home facilities currently serve about 1,563 Medicaid clients per year. Most of these persons are elderly (69%) or disabled (30%). Twenty percent are over 84 years of age and 16% are under age 55.

This increment is necessary to maintain nursing home services at their current level and to prevent loss of provider participation. By regulation, payment rates for most facilities must be re-based at least every four years [7 AAC 43.685(a)(6)(B)]. Hospital, nursing home, and inpatient psych hospital facilities were last re-based in FY04.

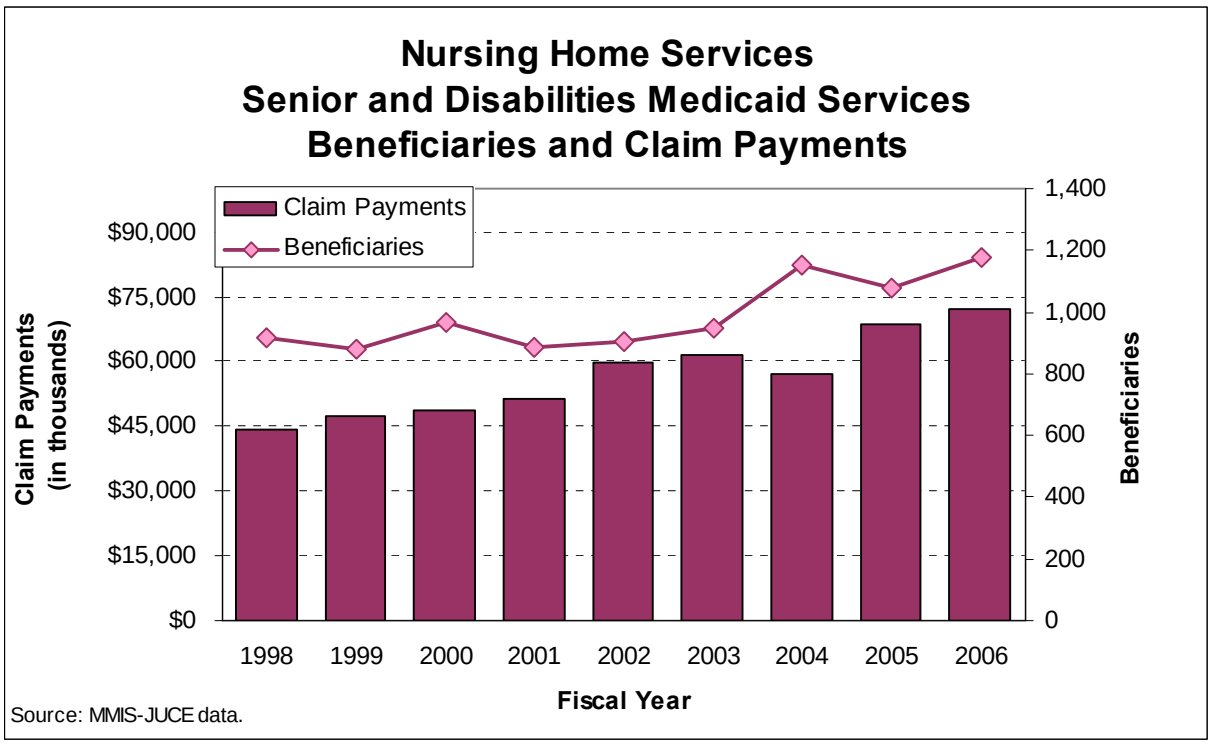
Nursing home payment rates for FY08 will be adjusted based on review of FY06 operating expenses and Medicaid billing activity for each facility. The new rate for each facility will become effective at the start of its 2008 fiscal cycle. The department estimates that rates will be adjusted by an average of 8%. Long Term Care (nursing home) facilities that will bill under re-based rates for the full 12 months of FY08 include collocated nursing facilities in Petersburg Medical Center, Sitka Community Hospital, South Peninsula Hospital, and Providence Valdez Medical Center, and the Providence Seward Medical Center/Wesley Care Center. Fairbanks Memorial Hospital/Denali Center, Providence Extended Care, Mary Conrad Center, Wildflower Court, and nursing home facilities at Providence Kodiak Island Medical Center will bill under rebased rates for the last six months of the fiscal year. Remaining in-state nursing facilities subject to review under 7ACC 43.685 will re-base effective FY09.

Not all nursing home facilities providing services to Alaska Medicaid patients will be subject to the re-basing addressed by this increment. Payment rates for any smaller in-state facilities (acute care, specialty, or psychiatric hospital or combined acute care hospital-nursing facilities billing 4,000 or fewer acute care patient days, or freestanding nursing home facilities billing 15,000 or fewer nursing facility days) are determined using a different methodology, established under a separate regulatory authority [7 ACC 43.689]. This analysis assumes no significant rate changes for small Alaskan facilities. There are currently no out-of-state nursing home facilities billing for services to Alaska Medicaid enrollees.

Data for Indian Health Service (IHS) facilities has been excluded from this analysis. The only IHS nursing home facility currently subject to re-basing by the department under 7 ACC 43.685 is Quyanna Care Center (Norton Sound Regional Hospital). It will rebase effective July 1, 2008 (FY09) so its rate adjustment will not affect the requested increment. Payment rates for most other IHS facilities are determined annually by the federal government.

Alaska Pioneer Homes are assisted living facilities, not nursing homes, and are not considered here.

To calculate the increment required to cover nursing home rate increases in FY08, the percent of FY06 non-IHS nursing home payments made to nursing facilities scheduled to re-base for the full 2008 fiscal year and the percent made to non-IHS nursing homes scheduled to re-base for only the last six months were determined, based on Medicaid claims payments for all non-IHS nursing home services in FY06. Re-based rates will impact 52.3% of payments for non-IHS nursing home services in FY08.



FY08 Projected Medicaid Growth - $21,746.9 ($12,904.7 Federal / $7,642.2 GF / $1,200.0 SDPR)
For FY08, Senior and Disabilities' Medicaid costs are projected to grow 7% over the authorized amount of $312,795.9. This increment request is necessary to maintain the current level of long term health services in Medicaid. The Senior and Disabilities Medicaid Services component funds three types of services: nursing homes, personal care attendants, and home and community based services.

In FY06 Senior and Disabilities Medicaid provided services to approximately 7,700 beneficiaries at an average cost of $3,031 per person per month. Senior and Disabilities Medicaid claims grew 10% from FY04 to FY05, and 9% from FY05 to FY06. The projection for FY08 is for the growth rate to decrease slightly. This is due to changes in the personal care attendant program that have curtailed growth.

Most of the increase can be attributed to home and community based waiver services which experienced a 14% increase from FY05 to FY06. This figure is somewhat skewed, however, as billing delays in FY05 artificially lowered that year's claim payments. The true growth rate was closer to 5% averaged over two years. Personal care attendant services, which grew 23% between FY04 and FY05, grew only 4.8% in the prior year. Nursing homes increased 5.1%.

The fund source projection is based on the actual amount of federal revenue collected in FY06 in this component, 59%, and assumes that the proportion of expenditures eligible for each type of federal reimbursement remains the same. It also assumes that the FY08 average federal medical assistance percentage remains at 57.58% for regular Medicaid and 70.31% for SCHIP.

This increment also provides $1,200.0 authority for statutory designated program receipts (SDPR) in the Behavioral Health Medicaid Services component for recoveries of overpayments to Medicaid providers discovered through audits.

Per AS 47.05.200 the department is required to audit Medicaid provider payments. Overpayments to the providers must be returned by the provider to the state. The overpayment includes both the federal and state match portion of the original claim. The amount actually recovered can include only the federal funds or the state matching funds, too. This increment provides budget authority to collect the state matching fund portion of the audit recovery.

Year 2 Fiscal Note (HB426) Medical Assistance Eligibility & Insurance Coverage One-Time Item – ($331.9) ($173.1 Federal / $158.8 GF/Match)
HB 426-This bill contains provisions that bring Alaska Statute into line with the Deficit Reduction Act of 2005 including many mandatory rule changes related to determining financial eligibility for long-term care related Medicaid.

This decrement is for Year 2 of the fiscal note (#3 of 5) and represents a full year's cost reduction.

Senior and Disabilities Services Administration

Transfer Disability Determination RSA to the Div of Public Assistance
-$100.0 General Fund; -$100.0 Federal
The Division of Public Assistance (DPA) is responsible for determining Medicaid eligibility for the Department of Health and Social Services. The DPA relies on the Department of Labor and Workforce Development, Division of Vocational Rehabilitation to determine the disability of blindness for Medicaid applicants, as a qualifying condition for determining Medicaid eligibility. During the departmental reorganization in FY04, funding for this RSA was transferred from the Division of Health Care Services to the Division of Senior and Disabilities Services (DSDS). As a result, the DSDS has been acting as a pass-through agency between the DPA and the Division of Vocational Rehabilitation. This change record transfer funding to the DPA so they can more effectively and efficiently oversee and manage this important function for determining Medicaid eligibility.

Transfer to Fund Positions and Support Costs Necessary for Developmental Disabilities Care Coordination - $330.7 (From Line 73000 to line 71000)
Transfer authorization from contractual services (73000) line to personal services (71000) line to fund newly budgeted positions.

Legislative intent language for DSDS in the FY07 budget narrative states that the Division must eliminate the Developmental Disabilities Waitlist. To that end, DSDS needs to establish care coordinator positions to help align applicants for services with the appropriate types and levels of services and the appropriate provider agency. Establishing these positions in the Division will help ensure equitable and consistent care coordination for all beneficiaries.

Increase to Authorized MHTAAR Funds- $20.7 for Rural Long Term Care Development
The Alaska Mental Health Trust Authority increased the MHTAAR funds available to support the Rural Long Term Care Coordination project. The goal of this project is to assist with the development of sufficient long-term care services so Trust beneficiaries and other elders do not have to leave their community when they have extensive care needs that their families cannot provide. The rural long term care coordinator works with rural communities to analyze long-term care needs and assists in locating resources to meet the needs of people with Alzheimer's Disease or Related Dementia. This increment provides additional needed personal services funding.

Decrease MHTAAR Funding
-80.0 Senior Community Based Grants - Discontinue Elders with Co-Occurring Disorders Project
-50.0 Community Developmental Disabilities Grants – Dental Training Program

Challenges

Elimination of the Developmental Disabilities Waitlist

The Division of Senior and Disabilities Services faces many new and on-going challenges in FY08. Under legislative mandate, the Division continues to work towards elimination of the Developmental Disabilities Waitlist. DSDS has developed methodology to remove 25 consumers from the DD Waitlist each quarter and place them into permanent services under a Medicaid Waiver. The Division process of removing consumers from the waitlist is relatively simple. Finding *capacity* to serve these individuals in the provider community has been and continues to be a problem. Many remote areas of Alaska where consumer needs exist do not have provider agencies that can provide services. Many of the consumers on the Waitlist are located in these geographic locations. Families of these individuals are faced with the option of moving from their homes and communities to somewhere they can receive services or remaining on the Waitlist until services become available. Provider agencies may not currently have the capacity to provide services to the 1,000 consumers currently on the DD Waitlist as quickly as the Division can remove them from the list. DSDS will have to work closely with providers to help them establish greater capacity to accommodate consumers coming off the DD Waitlist.

Care Coordination

Part of the Division's plan to eliminate the DD Waitlist involved a "pilot" to create and recruit staff to act as care coordinators for consumers being removed from the DD Waitlist. Two (2) care coordinator positions were established and filled in early FY2007. DSDS has received a positive response to these new "State Care Coordinators" from DSDS consumers. DSDS has quickly realized that without additional care coordinator positions, staff could quickly become overwhelmed by the volume of cases assigned to them. DSDS is working on a plan to create new positions and transition the care coordination function for all of DSDS Medicaid services to Division staff. DSDS estimates that approximately $7.8 mil is currently billed to the Medicaid program by provider agencies to perform care coordination activities for Medicaid recipients. Shifting this activity to Division staff will give DSDS greater ability to standardize care coordination activities throughout the State.

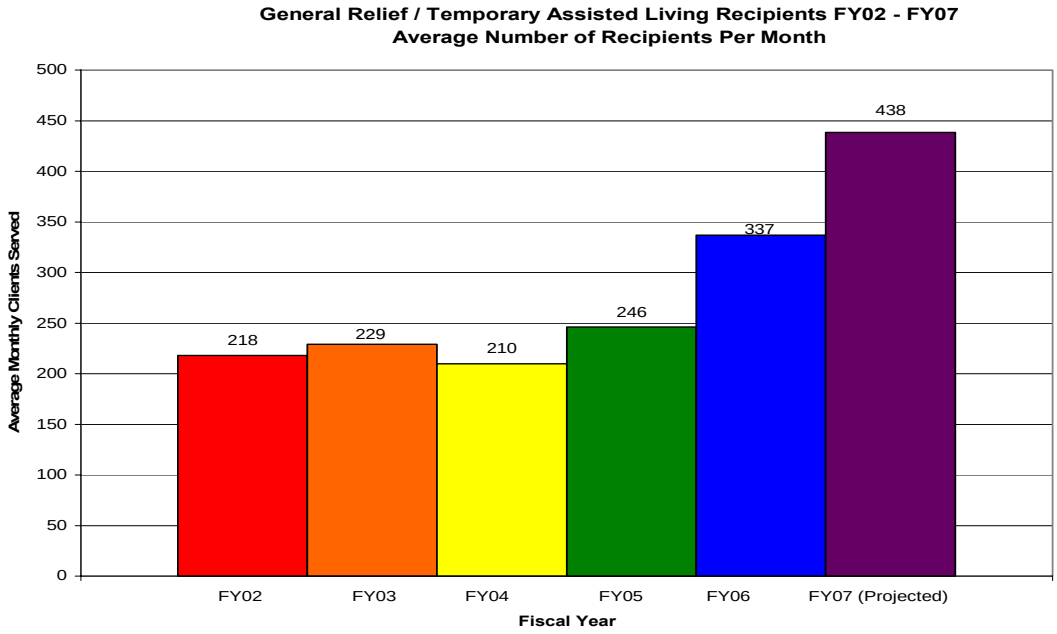
Medicaid Assessments

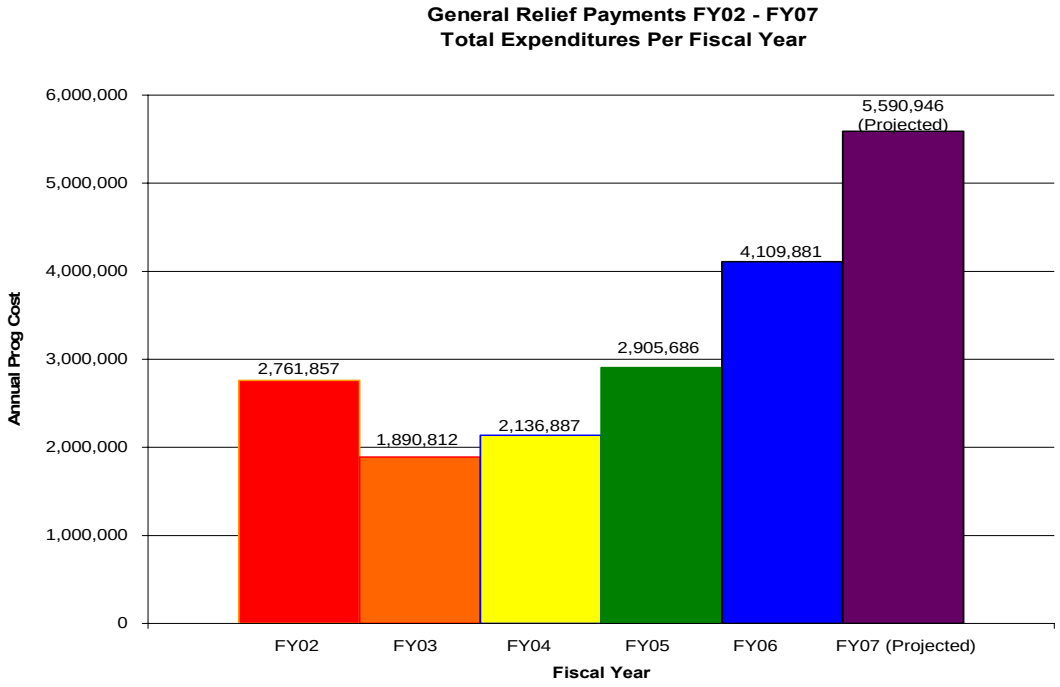
All Medicaid programs administered by DSDS require consumers to receive a medical assessment to determine the services they are eligible to receive and prior authorization of those services by DSDS Division staff. DSDS has been contracting for the medical assessment portion of this process. The Division and the current contractor are struggling to meet regulatory mandates to perform these assessments and prior authorizations for services in a timely fashion, due to a shortage of personnel that can do this work. The Division is in the process of implementing a long-range plan to create new staff positions and hire enough staff to perform these medical assessments "in-house." This will allow the Division the ability to assign staff based on current needs and DSDS would no longer be dependent on a contractor to help meet this regulatory requirement. Overcoming this challenge will be largely dependent on obtaining adequate funding to create new staff positions.

General Relief / Temporary Assisted Living

Program costs to sustain this program have been steadily increasing in recent years, while requests to increase funding have been denied. Since FY2004, when the DSDS was created and inherited this program, the number of clients served and the cost to maintain this program has more than doubled. In FY2004, $2,136.8 was spent for this program, with an average of 210 clients served each month. In FY2007, DSDS estimates spending $5,590.9 with an average monthly client base of 438. (Client counts for FY07 are projected until final payments are made in July of 2007) The Division can

attribute some of these program cost increases to the rising demographic of older Alaskans. Recent public feedback for this program is that the current Adult Protective Services Unit is more responsive than it has been for many years and is more readily accessible and able to respond to reports of harm. More reports of harm means that more vulnerable adults are placed in temporary assisted living homes. The Division has begun tracking the types of clients that come into this program to determine whether or not they might be more appropriately served by the Division of Behavioral Health or the Department of Corrections. The Division has begun a comprehensive review of this program to better understand why program costs have increased so dramatically in recent years and it will be making programmatic changes (including changes to the current regulations) to contain costs and to help ensure that future sustainability of this program will be possible without exponentially increased costs.





Data Integration

The Division has long struggled because of the lack of an integrated data system to track beneficiaries that receive services from more than one program in the division or department. Each program within DSDS has created spreadsheets and data bases to track their clients, but accessibility to these tracking "systems" within the division is not complete and many of these tracking systems have exceeded their current ability to perform and are failing. DSDS Recently hired a Research Analyst to help integrate data systems within the division. This has helped the division immensely but it represents a "baby step" in the right direction. Continued efforts and dedicated funding will be required to sustain these efforts and acquire an overall integrated data system compatible intra-divisionally and intra-departmentally.

Contribution to the Department's Mission

To promote independence of Alaskan Seniors and people with physical and developmental disabilities.

Core Services

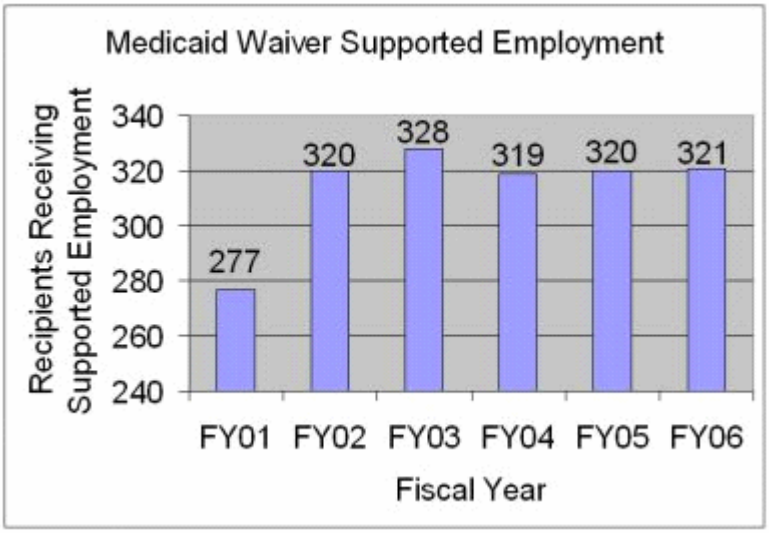
- Institutional and community based services for older Alaskans and persons with disabilities.
- Protection of vulnerable adults

Department Level Measures

H: Result - Outcome Statement #8: Senior and physically and/or developmentally disabled Alaskans live independently as long as possible.

Target #1: Increase the number of DD waiver recipients receiving Supported Employment Services.

Measure #1: % change of beneficiaries receiving supported employment services under Developmental Disabilities Waiver.



% Change in Recipients Receiving Supported Employment

Fiscal Year	% Change
FY 2002	15.5%
FY 2003	2.5%
FY 2004	-2.7%
FY 2005	0.3%
FY 2006	0.3%

Analysis of results and challenges: Supported Employment Services is one of the best resources available to developmentally disabled beneficiaries to help them live independently by providing them with the opportunity to work. The Division of Senior and Disabilities Services has determined

that the reason the number of DD waiver beneficiaries receiving supported employment has reached a plateau in recent years is because only the highest-functioning clients without behavioral issues can be easily employed. In FY07 and beyond, the Division will be working with the Governor's Council on Disabilities and Special Education to increase participation in supported employment as outlined in the Alaska Works Initiative 2006-2010 Strategic Plan.

H1: Strategy - Promote independent living and provide preadmission screening to nursing homes.

Division Level Measures

A: Result - Improve and enhance the quality of life for seniors and persons with disabilities through cost-effective delivery of services.

Target #1: Reduce % of Medicaid recipient not receiving medical assessments to less than 5%.
Measure #1: % of clients not receiving medical review.

DSDS Outstanding Medicaid Assessments (FY05-FY07)

Fiscal Year	% Not Reviewed
FY 2005	30.9%
FY 2006	23.18%
FY 2007	0.00%

This chart shows the percentage of DSDS Medicaid recipients that have not been assessed using a standardized assessment tool by an objective assessor from FY05-FY07 (projected).

Analysis of results and challenges: The Personal Care Attendant Program is the only Medicaid program that has not required a state-approved medical assessment to receive services. Implementation of new regulations in early 2006 began requiring a state-approved medical assessment and prior authorization of Medicaid benefits ensuring that beneficiaries are only receiving the services they are eligible to receive. This table shows the percentage of outstanding Medicaid assessments from 2005-2007 (projected.) DSDS anticipates that all back-logged Medicaid Waiver assessments will be caught up by the end of FY2007.

A1: Strategy - Arrange for beneficiaries to receive a medical assessment to determine what services they are eligible for and at what level. Through prior authorization process, ensure beneficiaries only receive the services they are eligible to receive.

B: Result - Promote improved service and compliance with federal/state regulations through provider agencies.

B1: Strategy - Develop, implement and maintain an on-going system of review and improvement through Technical Assistance Plans for each grantee and provider agency. Provide 8 care coordination training sessions each year in Alaskan communities.

Target #1: Reduce incidence and severity of errors resulting in audit findings by 10% by providing adequate training to provider agencies.

Measure #1: Show an overall reduction in error rates from audit findings for current rate by 10%.

Myers and Stauffer Error Rates (FY05-FY06)

Summary of Myers and Stauffers FY05 & FY06	Error Rate Fiscal Year 2005	Error Rate Fiscal Year 2006
Skilled Nursing	8.55%	0.00%
Home &Community Services	18.53%	6.33%
Assisted Living	26.28%	16.14%
Care Coordination	16.23%	1.61%
Personal Care	14.42%	4.75%
DSDS Total	**15.83%**	**6.43%**

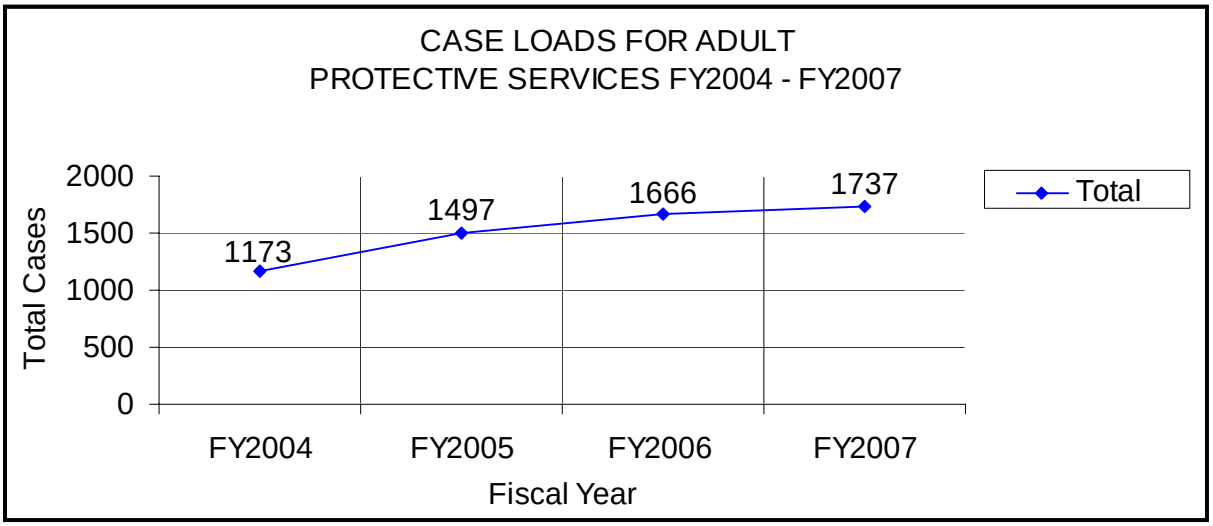
This chart shows FY05 and FY06 initial payment error rates as determined by Myers and Stauffer, an independent auditing firm hired by the Department of Health and Social Services.

Analysis of results and challenges: The chart shows DSDS Medicaid programs that have been audited by Myers & Stauffer and the percentage of audit exceptions that have been assigned to each program. These audit numbers are preliminary until the provider agencies have had a chance to respond, so these numbers should decrease as providers respond to the findings. However, it does show that significant improvement was made in the error rates across DSDS programs from FY05 to FY06.

C: Result - Ensure manageable caseload number in Adult Protective Services and Quality Assurance Units to provide timely investigations.

Target #1: Reduce APS staff assigned case loads by 10% and length of time a case is "open" by 10%.

Measure #1: Average length of time required to close a case in days per worker.



*FY2007 - Projected Caseload

Annual Adult Protective Services Caseloads

Fiscal Year	Total Investigations	# Full-time Workers	Annual Cases per Worker
FY 2004	1173	7	168
FY 2005	1497 +27.62%	7 0%	214 +27.38%
FY 2006	1666 +11.29%	7 0%	240 +12.15%
FY 2007	1737 +4.26%	9 +28.57%	193 -19.58%

** FY07 reflects estimates only.*

Analysis of results and challenges: The annual caseload for an Adult Protective Services (APS) case worker has been steadily on the rise since FY2004. From FY04 to FY05, the average caseload increased by more than 27%. From FY05 to FY06, the average caseload increased again, this time by more than 12%. Based on this unexpected growth, the Division requested and was given permission to establish two (2) new case worker positions in the FY07 budget. Because of these new positions, the Division anticipates being better able to keep up with estimated increases to reports of harm, abuse and neglect of vulnerable adults. The average length of time it took to investigate a new case was approximately 6 days in FY06, when there were only 7 case workers. Now DSDS has 9 case workers to perform investigations and the current trend shows there may be a decrease to the growth in the number of reported cases by more than 8%. If this trend continues, average caseload per case worker will be approximately 193 cases per year in FY07. With new staff numbers, it takes approximately 2.6 days to investigate a new report of harm. This represents a decrease in the number of days it takes to investigate a report of harm by approximately 56.7%! The division anticipates that if 2 new positions are approved in the FY08 budget that the number of days it takes to investigate a new case could drop to less than two (2) days!

Department Support Services

Mission

To provide quality administrative services that supports the department's programs.

Introduction

To meet the mission and goals of the department, the division serves both external and internal customers by administering all of the departments' budgetary, grants, contracts, planning, financial and management needs. Our goal is to assist all of the Department of Health and Social Services in meeting its fiduciary responsibilities.

Core Services

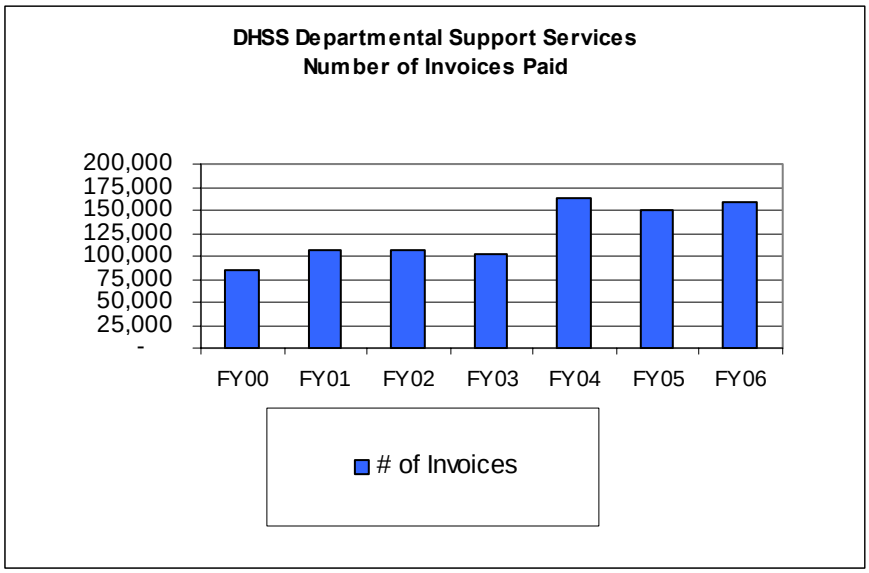
The Departmental Support Services division is one of thirteen results delivery units within the Department of Health & Social Services. Departmental Support Services is responsible for providing a full range of services to the department. These include, but are not limited to accounting, human resources liaison, payroll, budgeting, information systems support, grants and contracts administration, audit, planning, and facilities acquisition and management, support for the six Boards and Commissions and the Human Services Community Matching Grant. Departmental Support Services consists of the following components:

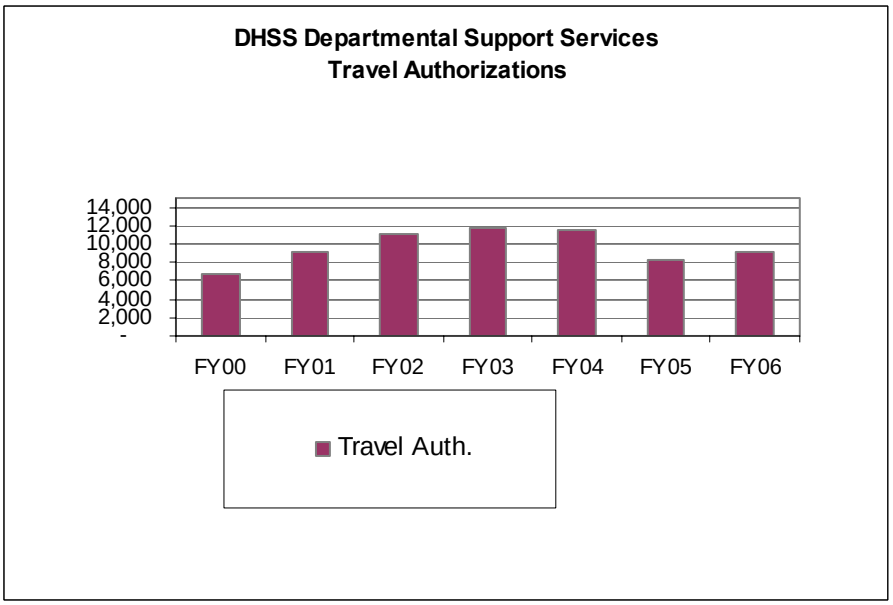
- Commissioner's Office
- Office of Program Review
- Office of Faith Based and Community Initiatives
- Rate Review
- Assessment and Planning
- Administrative Support Services
- Hearings and Appeals
- Medicaid School Based Administrative Claims
- Facilities Management
- Health Planning Infrastructure
- Information Technology Group
- Facilities Maintenance
- Pioneer Homes Facilities Maintenance
- HSS State Facilities Rent.

Services Provided

Finance Section

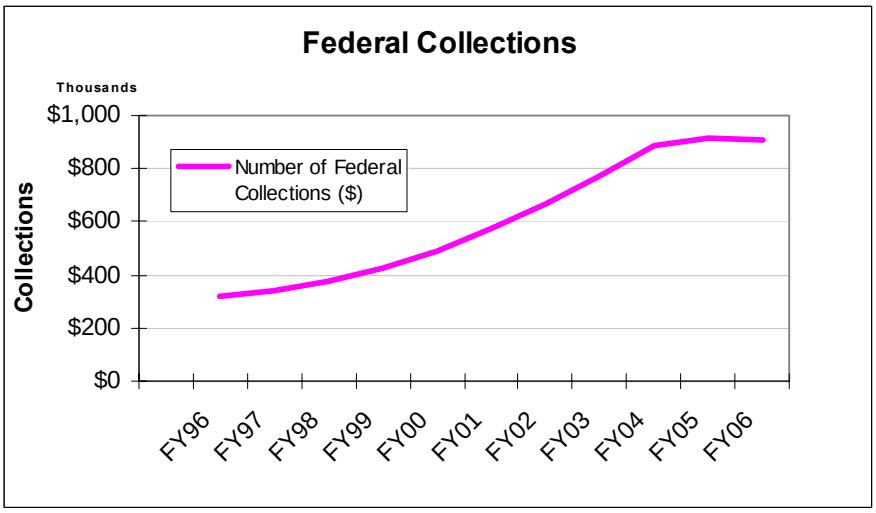
The Finance Section within the Administrative Support Services division supports all divisions and programs within the department. The Finance Section is responsible for the financial accounting and related support services. Following is the Finance Section activity from FY2000 to FY2006:





Revenue Section

The Revenue Section is responsible for all federal reporting and revenue collections for the department. The following chart shows the level of activity for the Revenue Section for collection of federal funds.



The amount of federal collections has tripled since FY1996 from $318 million to $905 million.

Budget Section
The Budget Section is responsible for analyzing, monitoring, and controlling the department's annual operating budget, budget amendments, revised programs, supplemental budgets, fiscal notes and legislative requests for information.

Chart 1 below shows the level of activity within the Budget Section for RSA and total RP's processed for FY1999 through FY2006.

Chart 1

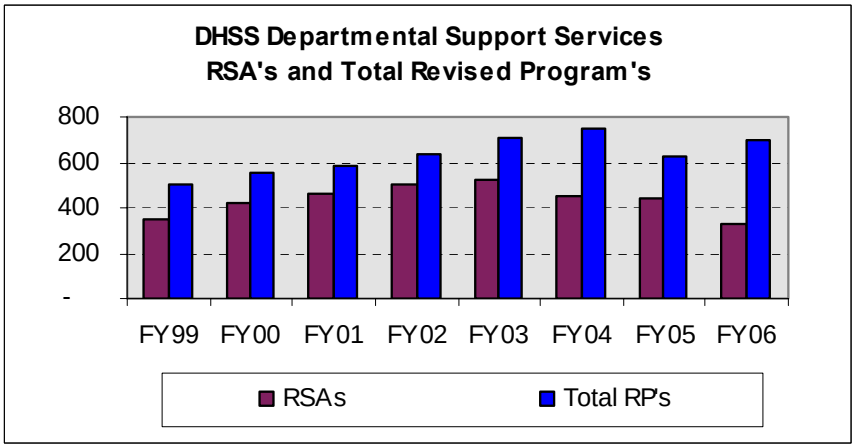
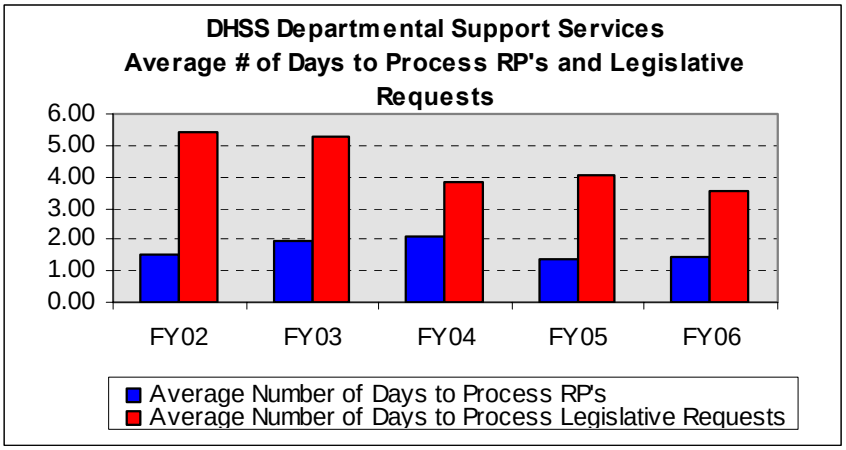


Chart 2 below shows that while the level of activity (number processed) has remained steady, the Budget Section has been able to improve response time and has dropped the number of days to respond to legislative requests from 5 to 3 days, a decline of 40% and that the number of days to process all RP's shows a decline since FY04 although Chart 1 shows an increase in the number being processed.

Chart 2



Grant and Contracts Section

The Grants and Contracts support team manages all aspects of procurement for the Department of Health and Social Services. It is comprised of three units, Purchasing and Leasing, Grants and Contracts and Accounting Services.

The Purchasing and Leasing Unit is responsible for commodities and non-professional services purchases, construction contracting, mail service, property control, space allocation and leasing.

The Grants and Contracts and Accounting Services perform the administrative tasks associated with the procurement of professional services whether it is through contract, grant or reimbursable service agreements for the department. These groups provide a single point of contact for grantees, contractors, consultants and program staff for questions, payments and interpretation of rules and regulations on the procurement of professional services.

One of Grants and Contracts goals is to reduce the number of grants and consolidate where possible. The following table demonstrates the success of reducing the number of grants by 21%.

Division:	Actual Number of Grant Awards in FY 04	Actual Number of Grant Awards in FY 05	Actual Number of Grant Awards in FY 06	Number of Grant Awards Reduced between FY04 and FY05	Number of Grant Awards Reduced between FY05 and FY06	Percentage of Grant Awards Reduced FY04 to FY05	Percentage of Grant Awards Reduced FY05 to FY06
DPH	112	88	77	-24	-11	-21%	-13%
DBH	289	248	184	-41	-64	-14%	-26%
OCS	181	208	147	27	-61	15%	-29%
DPA	34	44	48	10	4	29%	9%
FMS	9	12	14	3	2	33%	17%
HCS	7	0	0	-7	0	-100%	0%
DSDS	193	153	113	-40	-40	-21%	-26%
DJJ	45	25	29	-20	4	-44%	16%
Totals	**870**	**778**	**612**	**-92**	**-166**	**-11%**	**-21%**

Information Systems Section

The Information Technology (IT) Section provides support, development and maintenance of the department's computer and network infrastructure. It is comprised of four units: Network Services, Customer Services, Business Applications and Public Information & Publications. The IT section supports all aspects of the computational needs of the department's 3,400 employees and specific computational needs for some of the department's grantees. IT provides representation with other organizations and interfaces with other State organizational units in relation to technology issues. The section also provides strategic planning and project management support for the department's IT projects.

The Network Services unit is responsible for developing and maintaining the wide area and local area network infrastructure for the department. The Customer Services unit is responsible for providing total computer desktop support for the department's staff across the state as well as providing desktop support to nearly 200 staff working for external grantee agencies. The Business Applications unit is responsible for developing and maintaining the specialized computer software used by department staff and grantees. The Public Information and Publications unit oversees department public relations and communication functions to manage and coordinate communications to internal and external audiences.

DHSS Computing Environment:	
Number of Desktops:	3025
Number of Servers:	385
Number of Networks Statewide:	161
Number of Facilities Networks are Housed:	118
Industry Standard is 125 customers to 1 Technician DHSS Ratio: 137.5 Customers to 1 Technician Total Help Calls FY06: 22,295 Average of 98 calls per day in FY06	
Number of Communities where IT Infrastructure is Located:	36
Number of Business Applications	249
Number of DHSS Publications Produced in FY06	201

IT Success - Rural Access Enhancement – Netscaler DHSS IT Project

One of the major projects for the division was to replace an antiquated case management system (Prober) with an updated, automated web based system that allowed users to access a centralized system across the state. The new web based system (Online Resource for the Children of Alaska (ORCA)) was developed and put into production over 3 years ago. One of the lingering issues was providing quick, real time access for case workers in rural Alaska. Providing connectivity to rural communities continues to be a challenge and certainly impacts the delivery of applications to these areas. Telecommunication services provisioned to these remote communities are done with slow, low bandwidth satellite links. Information Technology experts worked to enhance data links, upgrade hardware infrastructure and optimize the application software. However, with the fundamental rural access limitations, these efforts provided minimal improvements to many of the locations. As staff continued to pursue solutions, a web based streamlining technology developed by Citrix became available. The department began testing this technology and found that rural access was improved by 60 to 80 percent. Application screens that were in some cases taking one or two minutes to appear are now being presented in a matter of seconds. This unique technology has greatly improved the ability for workers to respond and track family and children's issues across rural Alaska. Staff working in remote areas; have been reporting that the case management system (ORCA) will assist them in managing cases rather than a being a cumbersome application process that must be followed.

Some user comments received:

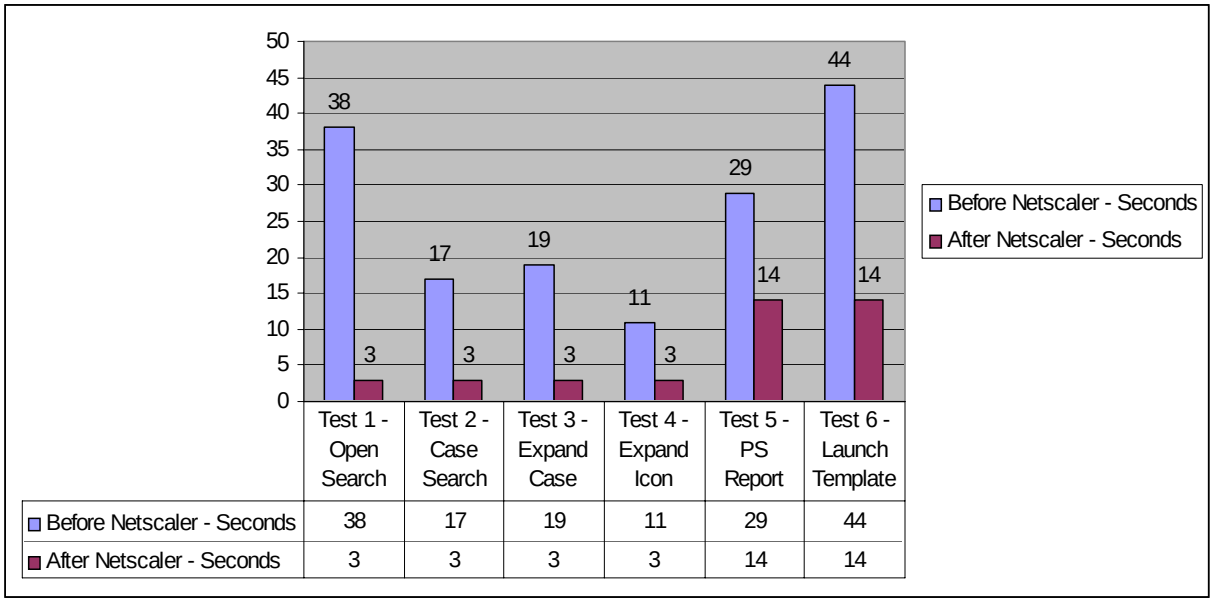
Kotzebue: "Good Job Came in to get some work done and used ORCA WOW ! What a difference in speed your new "fix" makes out here in Kotzebue."

Nome: "I can hardly contain myself – what a difference!"

Bethel: "We are chomping at the bit to get this working for all our users"

Anchorage: "rural access is now as fast as Anchorage speeds!"

Rural Alaska Application Test Table

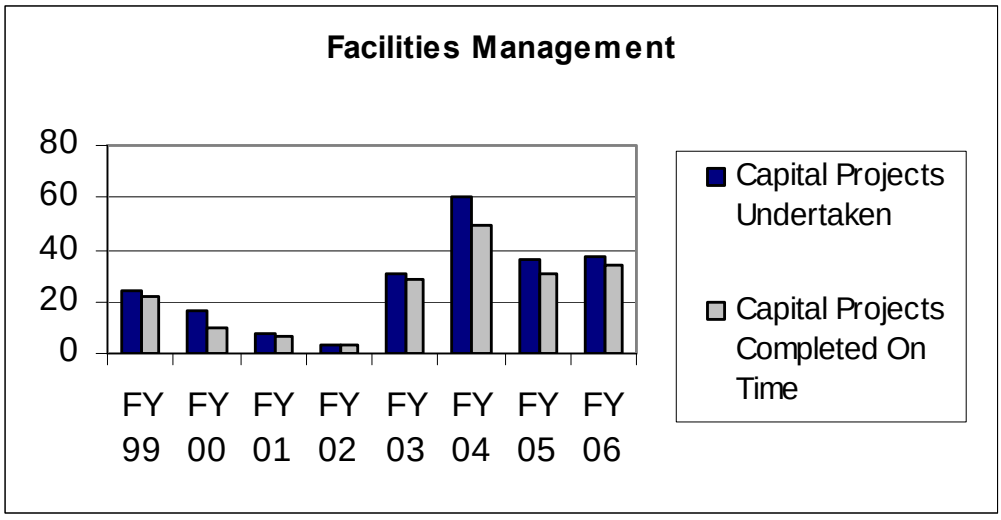


	Test 1 - Open Search	Test 2 - Case Search	Test 3 - Expand Case	Test 4 - Expand Icon	Test 5 - PS Report	Test 6 - Launch Template
Before Netscaler - Seconds	38	17	19	11	29	44
After Netscaler - Seconds	3	3	3	3	14	14

Facilities Management Section

The Facilities Management Section is responsible for research, planning and oversight of capital projects for the department. This includes managing all renovation and repair, deferred maintenance and major capital construction projects. The department operates 43 state owned buildings with an estimated 903,000 square feet throughout Alaska, at a replacement value of $224.3 million.

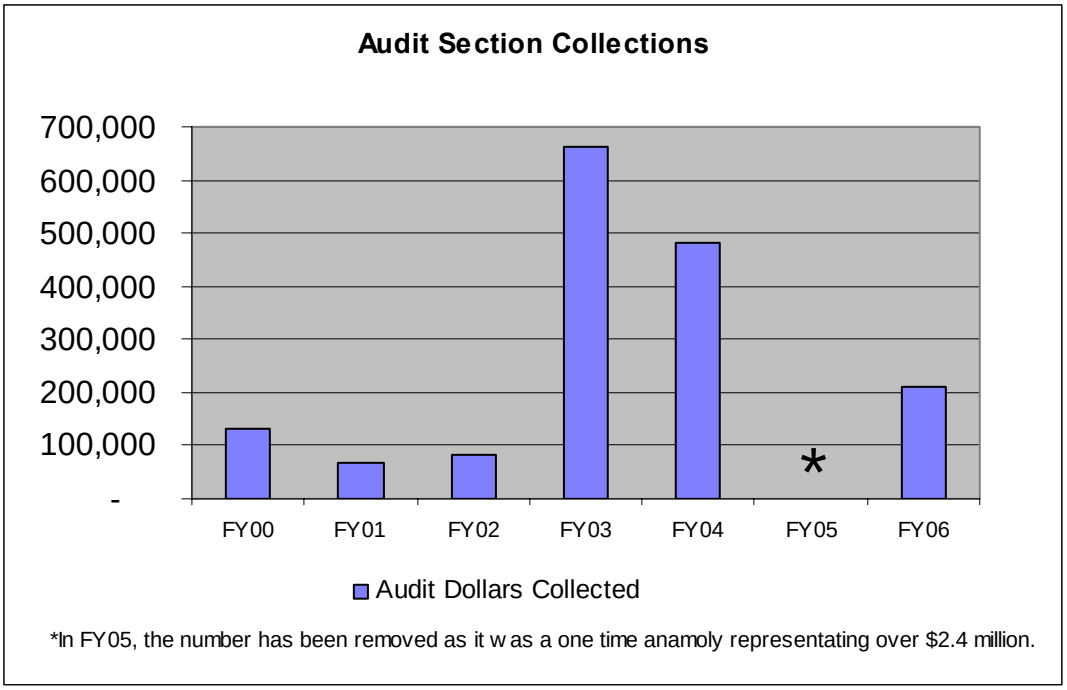
The following chart shows the capital projects undertaken and completed within the Facilities Management Section from FY1999 through FY2006:



Audit Section

The Audit Section is responsible for performing single audit reconciliations of Department of Health and Social Services grantees, federal sub-recipient monitoring and special reviews of department grantees upon request.

The following chart shows the level of Audit Section collections for FY2000 through FY2006.



*In FY05, the number has been removed as it was a one time anamoly representating over $2.4 million.

AS 18.05	Health, Safety and Housing
AS 18.07	Health, Safety and Housing, Certificate of Need Program
AS 18.08.080	Emergency Medical Services
AS 18.20	Health, Safety and Housing, Hospitals
AS 18.28.010	Community Health Aide Grants
AS 18.28.020	State Assistance for Community Health Aide Programs
AS 18.28.040	State Assistance for Community Health Aide Programs, Qualifications
AS 18.28.050	State Assistance for Community Health Aide Programs, Regulations
AS 18.28.100	State Assistance for Community Health Aide Programs, Definitions
AS 29.60.600	Human Services Community Matching Grants
AS 35	Public Buildings, Works and Improvements
AS 36.30	Public Contracts, State Procurement Code
AS 37.05	Public Finance, Fiscal Procedures Act
AS 37.05.318	Public Finance, Fiscal Procedures Act, Further Regulations Prohibited
AS 37.07	Public Finance, Executive Budget Act
AS 37.07.062	Public Finance, Executive Budget Act, Capital Budget
AS 37.10	Public Finance, Public Funds
AS 47.05	Welfare, Social Services and Institutions
AS 47.05.200	Annual audits
AS 47.07	Medical Assistance for Needy Persons
AS 47.08	Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25.001-.095	Day Care Assistance and Child Care Grants
AS 47.25.120 -.300	General Relief Assistance
AS 47.25.430 -.615	Adult Public Assistance
AS 47.25.975 - .990	Food Stamp Program
AS 47.27	Alaska Temporary Assistance Program
AS 47.30.660	DHSS and AMHTA for Comprehensive Integrated Mental Health Plan Social
AS 47.30.660	Welfare, Social Services and Institutions, Mental Health, Alaska Mental Health Board
AS 47.55	Pioneers' Homes
Security Act:	Title XVII Medicare, Title XIX Medicaid, Title XXI Children's Health Insurance Program
7 AAC 9/12	Health & Social Services, Design and Construction of Health Facilities
7 AAC 07.010	Health and Social Services Certificate of Need Aide Training and Supervision Grants
7 AAC 13	Health & Social Services, Assistance for Community Health Facilities
7 AAC 26.950-960	Emergency Medical Services
7 AAC 43	Medical Assistance
7 AAC 43.670-709	Medical Assistance, Health & Social Services
7 AAC 48	Chronic and Acute Medical Assistance

Title 7 CFR Part 270 to End
Title 7 CFR Part 273.15-16

Title 42 CFR Part 400 to End
Title 45 CFR Part 200 to End

Admin Order #221 Governor's Advisory Council on Faith Based & Community Initiatives

State of Alaska, Department of Health and Social Services Information Technology Plan

Department Support Services	2007	2008 Proposed	07 to 08 Change
General Funds	23,698.9	26,140.0	2,441.1
Federal Funds	27,423.3	29,212.0	1,788.7
Other Funds	9,268.9	9,411.8	142.9
Total	**60,391.1**	**64,763.8**	**4,372.7**

**Includes Human Services Community Matching Grants $1,485.3*

Office of Faith-Based and Community Initiatives

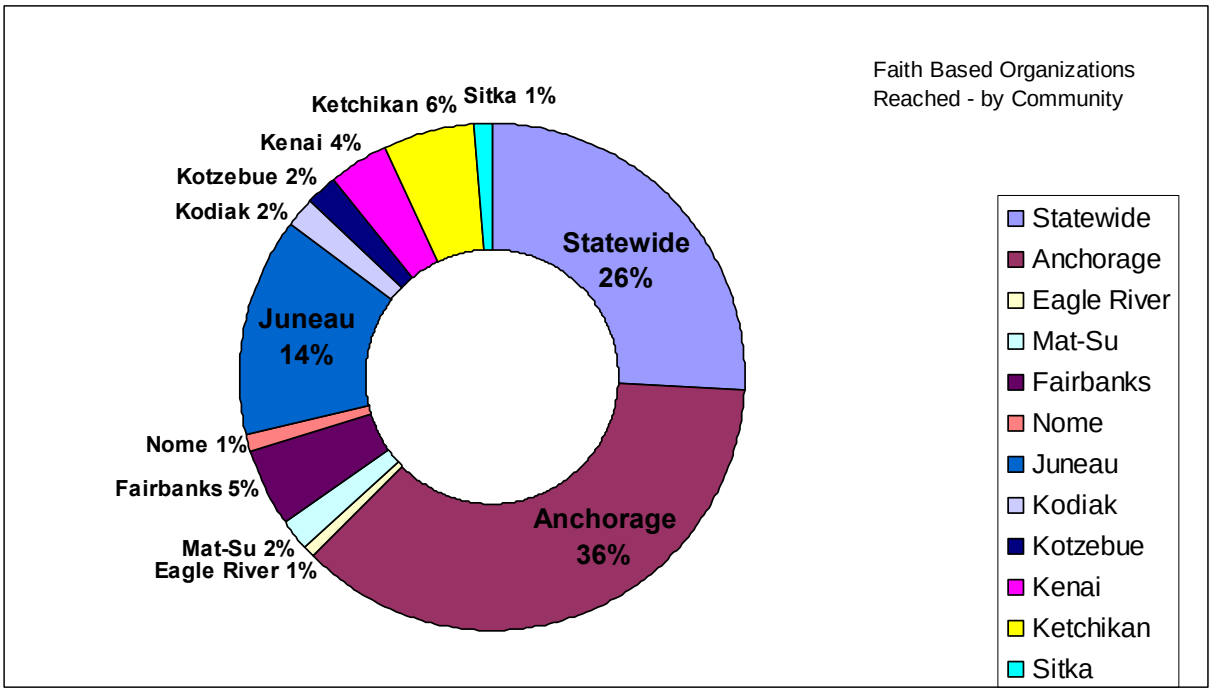
Federal Grant Award Office of Faith-Based and Community Initiatives $500.0 Fed
Re-establish Faith Based Council $414.3 GF
These two increments are for a federal grant award received in FY2007 and the general funds to match the federal grant. The federal funds are from the federal Health and Human Services Compassion Capital Fund for a demonstration project to help local faith-based, grassroots and community organizations strengthen their outreach.

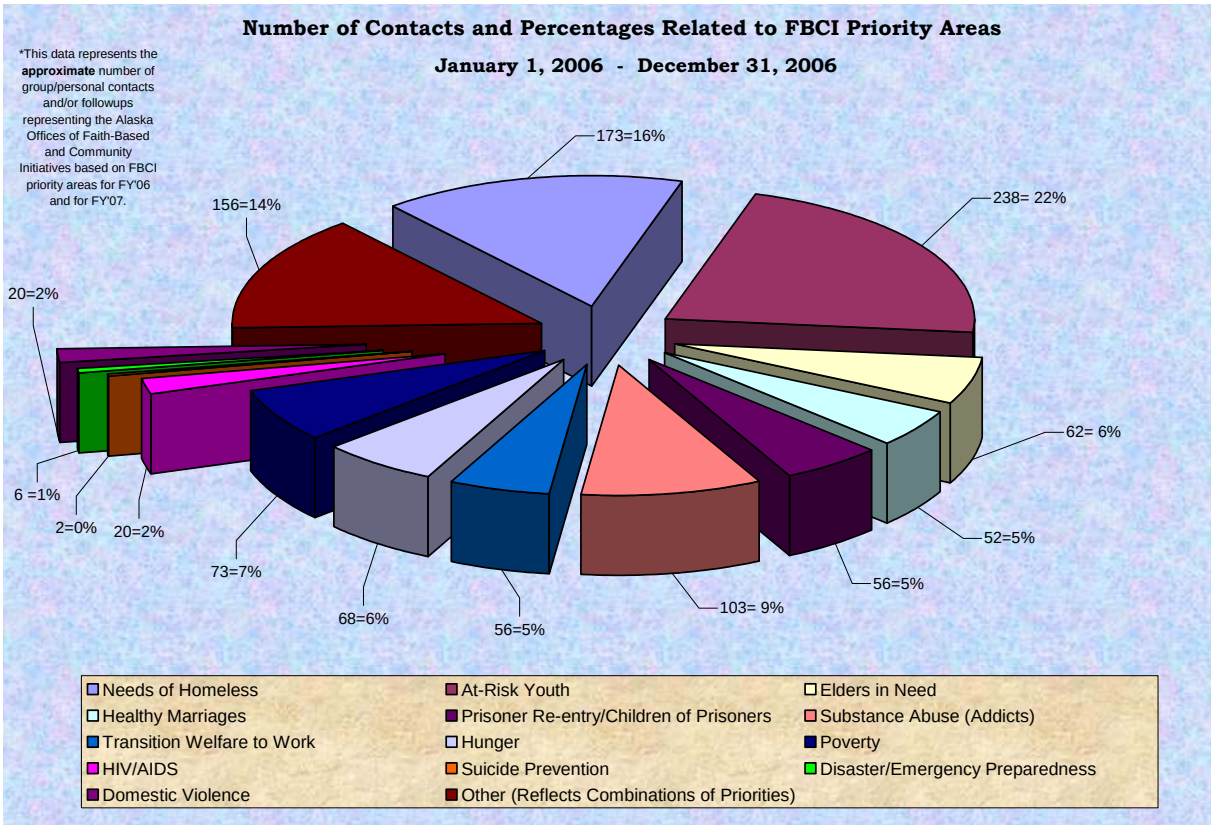
The Alaska Office of Faith-Based and Community Initiatives (AOFBCI) was created through an Administrative Order 221, signed by the Governor. The AOFBCI's mission is to enhance the health and well-being of Alaskans by strengthening and expanding human and social service partnerships between faith-based, non-profit and government organizations. The AOFBCI is supported by a state-wide Advisory Council. Core services of the AOFBCI are to provide a single point of contact for faith-based and community organizations to receive information, assistance and referrals; provide guidance and support for increased collaboration among faith-based and community organizations; and provide grant writing training, organizational development and other technical assistance to help faith-based and community organizations develop increased capacity to provide programs to those in need.

The proposed (state-wide) project will help grass roots organizations improve and increase the "back office" skills and abilities in order to meet service missions, build community partnerships and become more successful in efforts to obtain funding to expand programs and services.

Project objectives include: expanding the knowledge of Alaska's faith-based and community organizations; providing training and technical assistance to faith-based and community organizations whose mission align with FBCI priorities; and provide financial assistance in the form of sub-awards to faith-based and community organizations for the purpose of capacity building.

AOFBCI staff experienced in program development, administration, management and evaluation will manage the project. Cooperating partners will include private consultants and organizations specializing in capacity building training and technical assistance (to be determined through a Request for Proposal process), local tribal service entities, community volunteers, an AmeriCorp member and a student intern from the University of Alaska - Human Service program.


Faith Based Organizations
Reached - by Community
Ketchikan 6%
Sitka 1%
Kenai 4%
Kotzebue 2%
Kodiak 2%
Statewide 26%
Juneau 14%
Nome 1%
Fairbanks 5%
Mat-Su 2%
Eagle River 1%
Anchorage 36%
Statewide
Anchorage
Eagle River
Mat-Su
Fairbanks
Nome
Juneau
Kodiak
Kotzebue
Kenai
Ketchikan
Sitka

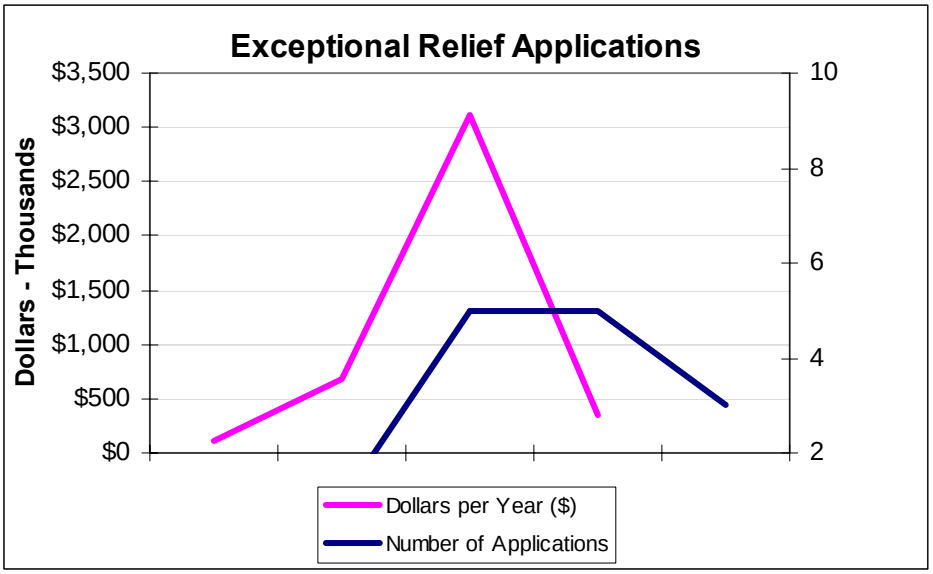

Number of Contacts and Percentages Related to FBCI Priority Areas
January 1, 2006 - December 31, 2006
*This data represents the approximate number of group/personal contacts and/or followups representing the Alaska Offices of Faith-Based and Community Initiatives based on FBCI priority areas for FY'06 and for FY'07.
173=16%
156=14%
238= 22%
20=2%
62= 6%
6 =1%
2=0%
20=2%
73=7%
52=5%
56=5%
68=6%
103= 9%
56=5%
Needs of Homeless
At-Risk Youth
Elders in Need
Healthy Marriages
Prisoner Re-entry/Children of Prisoners
Substance Abuse (Addicts)
Transition Welfare to Work
Hunger
Poverty
HIV/AIDS
Suicide Prevention
Disaster/Emergency Preparedness
Domestic Violence
Other (Reflects Combinations of Priorities)

Rate Review

Transfer funds from Medicaid Services to Support Rate Review Medicaid Activities
$142.0 Fed; $142.5 GF
In FY 2007, Rate Review managed critical functions for Medicaid Services. In FY2008 we are transferring funds from Medicaid Services to the Rate Review component to continue managing those critical Medicaid items:

Independent Certified Audits for Disproportionate Share Hospital Payments: By federal law, beginning with FY2005 each state must submit an independent certified audit of its Medicaid disproportionate share hospital (DSH) program to the federal Centers for Medicare and Medicaid (CMS) Services to receive Federal disproportionate share hospital payments. The department relies almost exclusively on the DSH program for operational expenses at the Alaska Psychiatric Institute. Annual DSH expenditures of over $15 million generate almost $8 million in federal funds for Alaska.

Efficiency Audits of Facilities for Exceptional Relief: Alaska's Medicaid Rate Setting Regulations and State Plan provide for additional payments to hospitals, nursing facilities, federally qualified health centers and rural health clinics under the exceptional relief program. Efficiency auditors are needed to justify exceptional relief by analyzing the facilities staffing models, staffing levels and employee compensation, patient census, length of stay and acuity, physical plant, purchasing and the market within which the facility operates for opportunities to reduce costs. Efficiency audits will allow the department to pay the minimum required in exceptional relief circumstances.



Administrative Support Services and Information Technology Components

Deficit Reduction Act for Title IV E $149.0 GF (Administrative Support Services)
Deficit Reduction Act for Title IV E $102.0 GF (Information Technology Services)
The department expects to lose federal funds based on the Deficit Reduction Act for Title IV-E and the Rosales Act for indirect costs charged to federal programs for the Commissioner's Office and Finance and Management Services.

The Department of Health and Social Services, Administrative Support Services and Information Technology components requests $251.0 of general funds for anticipated reduced federal receipts as

a result of the Federal Deficit Reduction Act of 2005 reversal of Rosales v. Thompson and the ability to claim for IV-E eligible children placed in unlicensed relative homes.

Rosales and Unlicensed Relative Placements
The Ninth Circuit Court ruling in Rosales provided the State of Alaska the opportunity to broadly apply Aid to Families with Dependent Children (AFDC) income and resource requirements to determine IV-E eligibility that did not need to be based on the same home from which a child was removed. This meant that a child's eligibility could be established using the home of any relative with whom the child resided within six months of the month in which eligibility was determined. Alaska became eligible to claim reimbursement for administrative costs under this ruling on July 1, 2003; the date Alaska's IV-E state plan amendment became effective.

The Federal Deficit Reduction Act of 2005 (DRA) reverses that ruling and limits the state's ability to claim IV-E maintenance and administrative costs by requiring all Title IV-E agencies determine eligibility for federal foster care assistance on the specified relatives home from which the child is removed.

The Federal Deficit Act of 2005 also changed Title IV-E administrative claiming allowances pertaining to unlicensed foster care. Previously the State of Alaska was reimbursed for its Title IV-E administrative expenditures for children in both relative and non-relative unlicensed foster care placements. The new law prohibits claiming federal fund participation for not-fully licensed non-relative foster care placements and restricts reimbursement to less than 12 months for any relative foster care placement in the process of getting licensed.

The Administrative Support Services component estimates the reduced ability to claim federal funds for services provided to Office of Children's Services IV-E eligible children through the Administrative Support Services component, Division Support Unit to be $149.0 and the Information Technology Component $102.0 for a total of $251.0. Rosales accounts for about 15% of the foster care population resulting in a parallel drop in the foster care administrative penetration rate. The penetration rate determines the percent of state administrative expenditures that will be considered reimbursable at 50%.

HSS State Facilities Rent

Add Back Authorization for First FY2007 Fuel/Utility Cost Increase Funding Distribution $198.5 GF
In FY2008, authorization is being added back to the budget for fuel/utility increases which were added in the FY2007 budget as follows:

Pursuant to sec. 21(b) and (d), ch. 33, SLA 2006, pg 69, $12,000,000 is distributed to state agencies from the Office of the Governor to offset the increased costs for fuel and utilities. The fiscal year-to-date average price of Alaska North Slope crude for the period July 1 - Sept. 30, 2006 was $69.00/barrel per the Department of Revenue, $15.40 (28.7%) above the Spring Forecast amount of $53.60.

Statewide

Retirement System Rate Increases $33,238.0 ($24,511.3 GF/$7,457.5 Federal/$1,269.8 Other)
An increase for retirement system rates has been added to all divisions within the Department of Health and Social Services. These increases totaled $33,238.0 for the department and are broken out below:

RDU	GF	FED	Other	Total
Alaska Pioneer Homes	4,131.2	0.0	319.7	4,450.9
Behavioral Health	3,054.2	7.2	90.8	3,152.2
Boards and Commissions	119.1	96.6	6.0	221.7
Children's Services	3,593.1	1,239.7	3.9	4,836.7
Departmental Support Services	2,893.5	1,064.2	192.5	4,150.2
Health Care Services	306.1	390.1	0.0	696.2
Juvenile Justice	4,359.4	0.0	0.0	4,359.4
Public Assistance	2,288.9	2,387.5	(0.0)	4,676.4
Public Health	3,088.3	2,041.1	656.9	5,786.3
Senior and Disabilities Svcs	677.5	231.1	0.0	908.6
DEPARTMENT TOTAL	**24,511.3**	**7,457.5**	**1,269.8**	**33,238.6**

Challenges

As the administrative and management area of the department, Finance and Management Services and the Commissioner's Office are in a unique position to understand overall department challenges as well as specific impacts on our operations.

Recruitment and Retention of State Staff

First and foremost, the department as well as the administrative and management units is suffering from difficulties in recruiting and retaining staff. While there is no specific increment request associated with the problem this year, it continues to cause difficulties. For example, as you can see from the table below the department as a whole for FY2005 had a 22% turnover rate and a vacancy rate of 13%. In FY2005, we hired 708 new employees. While those are averages, you can see from the table below we have wide variations in turnover with rates varying from 8% to 32%.

DHSS Employee Movement Report for FY2005							
	Total Positions	Total Employees	Vacancy Rate	Outgoing Employee Count	Incoming Employee Count	Turnover Rate	Hire Rate
State of Alaska Executive Branch	17,177	14,556	15%	3,559	3,695	24%	22%
Department of Health and Social Services	3,329	2,905	13%	650	708	22%	21%
Division							
Pioneer's Homes	569	529	7%	87	83	16%	15%
Behavioral Health	328	260	21%	46	48	18%	15%
Children's Services	482	436	10%	140	169	32%	35%
Office of the Commissioner/Boards	49	44	10%	6	12	14%	24%
Finance and Management Services	320	267	17%	86	93	32%	29%
Health Care Services	51	40	22%	3	3	8%	6%
Juvenile Justice	449	417	7%	62	70	15%	16%
Public Assistance	507	449	11%	110	111	24%	22%
Public Health	496	402	19%	101	102	25%	21%
Senior and Disability Services	78	61	22%	9	17	15%	22%

Federal Funding issues

Many federal programs are tightening down on interpretations of federal spending rules to limit increases in federal spending. The department sees this specifically in the Medicaid and Title IV-E programs where federal policy interpretations have changed to limit funding to states and future policy changes could reduce federal financial participation. The department is currently anticipating receiving $1.1 billion in federal revenue in FY2008, any changes to federal policy could impact these funding streams.

Audit requirements & Department-wide Quality Assurance program

Funding agencies, including the federal government have become increasingly pro-active in reviewing and auditing federal and state programs. One of the cornerstones of any sound management program is to assure that an adequate Quality Assurance (QA) program exists to ensure fraud and abuse can be detected as well as a comprehensive program integrity process exists throughout the department. The department has been working for the past year to establish an independent QA program to fulfill these goals. Having a QA program in place will prepare the department for managing federal reviews and requirements.

Deferred Maintenance

The department has responsibility for an aging infrastructure to support our 24 hour facilities, including Juvenile Justice, Public Health Centers, and Pioneer Homes. It is critical that deferred maintenance requirements and funding is provided so that these critical facilities can continue to have a useful life.

(Buckets collecting rainwater from leaking roof at Sitka Pioneer Home)

(Broken stairs at the Dillingham Health Center)

(Bathroom area wall at the Fairbanks Pioneers' Home)

(Broken concrete at McLaughlin Youth Center becomes a serious trip hazard)

Medicaid Management Information System (MMIS)
The Medicaid program has increasingly become integrated into most department programs and is a more critical part of the funding picture for all divisions. The current MMIS is 20 years old and needs to be replaced. Initial efforts to develop a new MMIS began four years ago and were unsuccessful; so a new Request for Proposal (RFP) was developed and RFPs are due in February 2007. This system is critical to the department being able to function successfully and getting a new system in place during 2009 is a significant challenge.

Contribution to Department's Mission

Provide quality administrative services in support of the Department's mission.

Core Services

- Promote cost containment. Maximize revenue.
- Provide divisions with necessary information to improve compliance with federal and state laws/policies to ensure our fiduciary responsibilities are met.
- Improve DHSS staff knowledge and skills and maintain high morale to continually improve performance and services for Alaskans.
- Provide efficient centralized administrative support to 9 DHSS divisions; offices in Juneau and Anchorage.

Department Level Measures

I: Result - Outcome Statement #9: The efficient and effective delivery of administrative services.

Target #1: Increase by 5% the percentage of customers that report Finance and Management Services (FMS) is meeting their needs.

Measure #1: Percentage of customer service internal survey respondents that report FMS is meeting their needs.

% of Survey Respondents rating that FMS met their needs

Year	FMS Overall %	% Change	Avg % of All Services	% Change
2003	58.7%	0.0%	70.6%	0.0%
2004	64.7%	6.0%	70.6%	0.0%
2005	64.0%	-0.7%	71.5%	0.9%

Analysis of results and challenges: An internal customer survey on Finance and Management Services (FMS) performance is conducted annually. A 2006 survey was not done.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed; however, only the overall results are shown in the above table. You can reference the specific program areas reported at the division level Result B, Target 1, Measure 1. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the percentage of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall percentage did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations

from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in the next survey.

Target #2: Reduce the average response time for complaints/inquiries to 14 days.
Measure #2: Department Inquiry/Complaint "HSS Track" log response times.

# of Inquiries/Complaints

Fiscal Year	Opened	Closed	Avg Days to Close
FY 2005	552	503	15.18
FY 2006	1590	1408	25.78
FY 2007	323	282	10.39

FY2007-represents the first quarter of FY2007.

Analysis of results and challenges: The response log "HSS Track" includes all inquiries or complaints that are received by the DHSS Commissioner's Office (i.e., public or legislative complaints, legislative questions, press inquires, etc.).

The increase in the inquiries/complaints opened in FY06 is attributed to the fact that in FY05 only a limited number of sections in the department were utilizing the log. In FY06, the Office of Children's Services was added to the HSS Track. This greatly increased the number and complexity involved to close out inquiries.

The response log "HSS Track" will be monitored by the Commissioner's Office.

Target #3: Reduce by 5% per year processing time for key indicators.
Measure #3: Track number of days it takes to process: Purchase Requisitions; Operating Grant Awards; Processing Time for Payments; Capital Grant Awards; and Legislative inquiries.

Timeliness and Accuracy

Fiscal Year 2006	# Processed	Days to Process
Purchase Requisitions	507	7.00
Operating Grant Awards	610	19.12
Processing Time for Payments	158,281	9.33
Capital Grant Awards	93	3.36
Legislative Inquiries	172	3.52

Analysis of results and challenges: This is a new indicator with new data for FY2006. The data will develop a baseline for future comparisons.

I1: Strategy - Implement results of Business Process Review.

Division Level Measures

A: Result - Facilitate the Department's Mission Through Superior (effective & efficient) Delivery of Administrative Services.

Target #1: DHSS Administration as a percentage of the department overhead should be below 2%.
Measure #1: Percentage administration personal services is to total department budget.

Percentage administration personal services is to total department budget

Year	YTD Total
2003	3.6%
2004	4.3%
2005	1.3%
2006	1.4%

Analysis of results and challenges: It is the goal of Department of Health and Social Services to keep administrative costs as low as practicable.

Department administration personnel services equal all of Department Support Services RDU. This number is compared to the total DHSS Expenditures.

Target #2: Process capital grant payments within 5 days.
Measure #2: Number of days to process a grant payment after receiving reports.

Number of days to process a grant payment after receiving reports.

Fiscal Year	YTD Total
FY 2003	5.60 days
FY 2004	4.89 days
FY 2005	3.11 days
FY 2006	3.36 days

Analysis of results and challenges: For FY06, there were 93 capital grant payments, all processing within 15 days.

A1: Strategy - Implement Business Process Reviews.

A2: Strategy - Implement Department's Administrative Training Plan Curriculum.

B: Result - Improve Customer Service

Target #1: Increase by 2% the percentage of customers that report that Finance and Management Services is meeting their needs.
Measure #1: Percentage of survey respondents to each Finance and Management Section (FMS) that report FMS is meeting their needs.

Finance and Management Service Functions - % Agree or Strongly Agree meeting service needs:					
Service	2003	2004	% Change	2005	% Change
Grants & Contracts	68.2%	64.9%	-5.1%	65.4%	0.8%
Procurement	70.6%	66.5%	-6.2%	71.3%	6.7%
Facilities Management	75.7%	76.1%	0.5%	76.5%	0.5%
Audit	74.0%	81.9%	9.6%	78.3%	-4.6%
Finance	63.1%	64.8%	2.6%	62.7%	-3.3%
Information Services	72.4%	71.4%	-1.4%	70.9%	-0.7%
Budget	66.8%	67.4%	0.9%	70.8%	4.8%
Assistant Commissioner's Office	74.3%	71.9%	-3.3%	76.7%	6.3%
Human Resources*	60.0%	57.0%	-5.3%	65.2%	12.6%
* No longer in DHSS but still tracking.					

Analysis of results and challenges: An internal customer survey on Finance and Management Services performance is conducted annually. The 2006 survey has not been completed.

Survey results show that 64.0% of survey respondents ranked overall FMS service performance to be above average (6) or higher on a scale of 1-10.

Individual core services are surveyed, however only the overall results are shown in the above table. Combined average of respondents agreeing or highly agreeing that core services are meeting their needs is 71.5% for 2005, an increase of 0.9% over 2004. This is compared to a 0% increase from FY03 to FY04.

The long-term target is to increase the % of respondents showing that FMS is meeting their needs by 5% from the base year of 2003.

Although the department saw increased results in some service areas from FY04 to FY05, the overall % did meet expectations. Finance and Management Services conducted Business Process Reviews in FY05 on all services provided and is in the process of implementing recommendations from those reviews. We anticipate that these improvement areas, i.e. finance, budget and revenue, will help increase respondent ratings in FY06.

B1: Strategy - Establish and Maintain Guaranteed Standards.

B2: Strategy - Continue Customer Service Plan.

C: Result - Improve overall management of DHSS budget processes.

Target #1: Increase percentage of federal collections by 1% a year.
Measure #1: Percentage of federal collections.

Percent of DHSS Budget that is Federal

Year	YTD Total
2002	51.4%
2003	53.6%
2004	54.5%
2005	54.8%
2006	54.5%

Analysis of results and challenges: It is important to note that because the Department of Health and Social Services has a large number of federal programs, the more federal revenue that we receive, and the less general funds that the department has to use.

Target #2: Improve Legislative understanding of the DHSS budget.
Measure #2: Respond to 80% of legislative inquiries by Budget Unit within 5 working days.

% of Responses for Legislative Requests made within 5 working days

Fiscal Year	YTD Total
FY 2002	83%
FY 2003	83%
FY 2004	78%
FY 2005	79%
FY 2006	80%

Analysis of results and challenges: It is important that policy makers working on key budget issues get their information timely in order to make decisions regarding the DHSS budget.

The Budget Section received approximately 147 requests in CY 2003, 186 in CY 2004 and 236 in FY 2005.

In previous years (2002 to 2004) the data was reported on calendar year but starting in (2005) the data is collected by fiscal year. The average processing time for FY2006 is 3.52 days and 80% were completed within 5 working days.

C1: Strategy - Increase federal collections.

C2: Strategy - Improve Legislative understanding of the budget.

D: Result - Facilitate the Department's day-to-day operations through effective and efficient delivery of services.

Target #1: Reduce the length of time and number of days to respond and close out service calls.
Measure #1: Number of days to close out service calls.

Average Number of Days to Complete Service

Fiscal Year	YTD Total
FY 2005	8.2 days
FY 2006	4.9 days

FY 2005 data represents only 3 quarters. This measure began at the start of the 2nd quarter.

Analysis of results and challenges: This measure was developed at the start of 2nd quarter in FY05. It is important to note that FY05 was the first year of integrated service delivery and not all divisions were in the system. In 2006, all divisions were in the system; the data was consistent and showed a 50% improvement in turnaround time.

There are a total of 15 categories of work/service performed that have been used to calculate the above averages. (In the 2nd quarter there were only 13 categories tracked.)

Examples of categories are, but not limited to:

Setting up Accounts; Application work; password setup; procurement of equipment; relocation of equipment; security; software; web; hardware or file maintenance, etc.

Target #2: 85% of construction projects completed on time and within budget.
Measure #2: Percentage of construction projects done on-time and within budget.

Percent of Completed Construction Projects On Time and Within Budget.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	YTD Total
FY 2006	100%	100%	56%	85%	85.25%

Analysis of results and challenges: The Department began tracking construction projects in FY 06. Since that time, 85.25% of construction projects have been completed on time and within budget.

D1: Strategy - Improve IT service call turn around time by implementing and maintaining software tracking system.

Mission

Provide a mechanism for broad-based, on-going public input to planning, policy development, and program evaluation, including capacity building, advocacy and systems change.

Introduction

The Boards and Commissions are statutorily required to advocate, plan, evaluate, advise, partner, and actively involve the citizens of Alaska with regard to alcoholism and drug abuse, Alzheimer's and other related disorders, developmental and other severe disabilities, special education, infant learning program/early intervention, mental health, suicide prevention and faith-based initiatives.

Core Services

- The Alaska Mental Health Board (AMHB) is the state planning and coordinating agency for purposes of federal and state laws relating to the mental health program. The AMHB is responsible for evaluating the mental health program and provides a forum for Alaskans with mental illness.
- The Advisory Board on Alcoholism and Drug Abuse is the state planning agency that advocates for policies, programs and services that help Alaskans achieve health and productive lives, free from the devastating effects of the abuse of alcohol and other substances.
- The Alaska Commission on Aging (ACoA) is the state planning, policy development and coordinating agency for preparing a state plan of services for older Alaskans for the allocation of federal funds under the Older Americans Act. The ACoA is responsible for evaluating service systems and programs that impact the lives of older Alaskans and advocates for programs and policies by promoting public awareness of aging issues and trends, providing information to policymakers and the public on senior issues and making recommendations to the governor and legislature for legislation that benefits older Alaskans.
- The Governor's Council on Disabilities and Special Education is charged with creating change that improves service systems for Alaskans with developmental and other severe disabilities, students receiving special education services, and infants and toddlers with disabilities.
- The Governor's Advisory Council on Faith-Based and Community Initiatives is charged with advising the governor on policies and practices to increase the contributions of faith-based and community organizations to meet the mission of the Department of Health and Social Services and other state departments. Promote service partnerships between faith-based, community and governmental entities.
- Pioneers' Home Advisory Board conducts annual inspections of the Alaska Pioneers' Homes and making recommendations for changes and improvements.
- The Suicide Prevention Council is charged with developing a state suicide prevention plan and advising the Governor and Legislature with respect to what actions can and should be taken to reduce suicide and its effects in Alaska.

Services Provided

Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse
The combined Boards learn from consumers and providers and use this information to amplify the voice of Alaskans as they: Plan for an integrated, comprehensive behavioral health system; coordinate with other Boards, agencies, and programs to most effectively use resources; educate Alaskans about behavioral health issues and availability of services; advise all branches of government on most effective treatment responses to behavioral health problems; evaluate the effectiveness of behavioral health programs and their cost effectiveness; and advocate for continued support for effective, efficient behavioral health programs.

Alaska Commission on Aging
The services of the Alaska Commission on Aging (ACoA) is to ensure the dignity and independence of all older Alaskans through planning, advocacy, education and interagency cooperation. By statute, ACoA has a variety of duties. These responsibilities include the development of a comprehensive statewide plan for senior services; making recommendations to the Governor and Legislature regarding services to enhance the quality of life for older Alaskans; collaborating with the Department of Health and Social Services, the Alaska Mental Health Trust Authority and other agencies on policy development; and promoting education and awareness of older adult issues and concerns to legislators, caregivers, seniors and the general public.

Governor's Council on Disabilities and Special Education
The Governor's Council on Disabilities and Special Education engages in advocacy, capacity building and systems change to improve the lives, status and circumstances of people with disabilities, infants and toddlers with disabilities or delays, and students in special education and their families. Specific activities include but are not limited to training; technical assistance; supporting and educating communities; interagency collaboration and coordination; coordination with related councils, committees and programs; barrier elimination, systems design and redesign; coalition development and citizen participation; informing policymakers; and demonstration of new approaches to services and supports. The Council also governs the Special Education Service Agency (SESA), with the assistance of people filling designated seats specified in state statute; and provides to the Alaska Mental Health Trust Authority information on the status and needs of beneficiaries with developmental disabilities and makes budget recommendations on their behalf.

Governor's Advisory Council on Faith-Based and Community Initiatives
The Governor's Advisory Council on Faith-Based and Community Initiatives is charged with advising the governor on policies and practices to increase the contributions of faith-based and community organizations to meet the mission of the Department of Health and Social Services and other state departments, as well as promoting service partnerships between faith-based, community and governmental entities.

Pioneer's Home Advisory Board
The Advisory Board holds meetings or teleconferences regarding inspections of the property and policies and procedures of the Alaska Pioneers' Homes for recommendations to the Governor.

Suicide Prevention Council

The Statewide Suicide Prevention Council is the state planning and coordinating agency for issues surrounding suicide and suicide prevention. The powers, duties, and responsibilities of the Council are to act in an advisory capacity to the governor and the legislature with respect to what actions can and should be taken to improve the health and wellness throughout the state by reducing suicide and its

effect on individuals, families and communities; broaden the public's awareness of suicide and the risk factors; enhance suicide prevention services and programs; develop healthy communities through comprehensive, collaborative, community-based and faith-based approaches; develop and implement a statewide suicide prevention plan; and, strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse

AS 44.29.100	Advisory Board on Alcoholism and Drug Abuse
AS 47.30.470-500	Welfare, Social Services & Institutions, Mental Health
AS 47.30.661-666	Alaska Mental Health Board
AS 47.37	Welfare, Social Services & Institutions, Uniform Alcoholism and Intoxication Treatment Act

Alaska Commission on Aging

AS 47.45.200-290	Older Alaskans, Alaska Commission on Aging
AS 47.65.100-290	Service Programs for Older Alaskans and Other Adults

Governor's Council on Special Education and Developmental Disabilities

AS 14.30.231	Education, Libraries and Museums, Advisory Panel
AS 14.30.610	Education, Libraries and Museums, Governing Board
AS 47.80.030-090	Welfare, Social Services & Institutions, Persons with Disabilities
PL 106-402	Programs for Individuals with Developmental Disabilities
PL 105-17 Part B and C	Individuals with Disabilities Education Act

Governor's Advisory Council on Faith-Based & Community Initiatives

Admin Order #221	Governor's Advisory Council on Faith-Based & Community Initiatives

Pioneers Homes Advisory Board

AS 44.29.500	Alaska Pioneers' Homes Advisory Board

Suicide Prevention Council

AS 44.29.300-390	Department of Health & Social Services, Statewide Suicide Prevention Council

Boards and Commissions	2007	2008 Proposed	07 to 08 Change
General Funds	633.3	776.5	143.2
Federal Funds	1,581.1	1,678.1	97.0
Other Funds	1,288.0	1,483.9	195.9
Total	**3,502.4**	**3,938.5**	**436.1**

Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse Component

Alaska Mental Health Trust Authority Project $19.7 MHTAAR
The Mental Health Trust Authority authorized this increase for the MHTAAR Project Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse Component bundling together the joint staffing, infrastructure and board trust partnership into one project.

Governor's Council on Special Education and Developmental Disabilities Component

Comprehensive Recruitment/Marketing Strategies $350.0 MHTAAR
This increment represents the addition of two MHTAAR projects from the Alaska Mental Health Trust Authority. The two projects are responding to the need to develop a comprehensive workforce plan, serving all Trust beneficiary areas, to articulate an agreed upon set of actions to facilitate the preparation and continuing education of qualified health workforce.

Governor's Advisory Council on Faith-Based and Community Initiatives Component

Faith Based Council Quarterly Meetings $24.0 GF
This increment is to establish the Advisory Council meetings to facilitate communication and collaboration between faith-based and community-based organizations and government. The focus of the Faith-Based and Community Initiatives is to provide support and technical assistance to faith and community organizations to increase their capacity to serve, and to form collaborative partnerships with other groups and government agencies that work to improve the lives of people around the state.

Alaska Longevity Bonus Programs	Longevity Bonus Grants
Alaska Longevity Bonus Programs	Longevity Bonus Hold Harmless
Alaska Longevity Bonus Programs	Alaska Longevity Programs Management
Alaska Pioneer Homes	Alaska Pioneer Homes Management
Alaska Pioneer Homes	Pioneer Homes
Behavioral Health	AK Fetal Alcohol Syndrome Program
Behavioral Health	Alcohol Safety Action Program (ASAP)
Behavioral Health	Behavioral Health Medicaid Services
Behavioral Health	Behavioral Health Grants
Behavioral Health	Behavioral Health Administration
Behavioral Health	Community Action Prevention & Intervention Grants
Behavioral Health	Rural Services and Suicide Prevention
Behavioral Health	Psychiatric Emergency Services
Behavioral Health	Services to the Seriously Mentally Ill
Behavioral Health	Designated Evaluation and Treatment
Behavioral Health	Services for Severely Emotionally Disturbed Youth
Behavioral Health	Alaska Psychiatric Institute
Children's Services	Children's Medicaid Services
Children's Services	Children's Services Management
Children's Services	Children's Services Training
Children's Services	Front Line Social Workers
Children's Services	Family Preservation
Children's Services	Foster Care Base Rate
Children's Services	Foster Care Augmented Rate
Children's Services	Foster Care Special Need
Children's Services	Subsidized Adoptions & Guardianship
Children's Services	Residential Child Care
Children's Services	Infant Learning Program Grants
Children's Services	Women, Infants and Children
Children's Services	Children's Trust Programs
Children's Services	Child Protection Legal Services
Adult Preventative Dental Medicaid Services	Adult Preventative Dental Medicaid Services
Health Care Services	Medicaid Services
Health Care Services	Catastrophic and Chronic Illness Assistance (AS 47.08)
Health Care Services	Medical Assistance Administration
Juvenile Justice	McLaughlin Youth Center
Juvenile Justice	Mat-Su Youth Facility
Juvenile Justice	Kenai Peninsula Youth Facility
Juvenile Justice	Fairbanks Youth Facility
Juvenile Justice	Bethel Youth Facility
Juvenile Justice	Nome Youth Facility
Juvenile Justice	Johnson Youth Center
Juvenile Justice	Ketchikan Regional Youth Facility

Juvenile Justice	Probation Services
Juvenile Justice	Delinquency Prevention
Juvenile Justice	Youth Courts
Public Assistance	Alaska Temporary Assistance Program
Public Assistance	Adult Public Assistance
Public Assistance	Child Care Benefits
Public Assistance	General Relief Assistance
Public Assistance	Tribal Assistance Programs
Public Assistance	Senior Care
Public Assistance	Permanent Fund Dividend Hold Harmless
Public Assistance	Energy Assistance Program
Public Assistance	Public Assistance Administration
Public Assistance	Public Assistance Field Services
Public Assistance	Fraud Investigation
Public Assistance	Quality Control
Public Assistance	Work Services
Public Health	Nursing
Public Health	Women, Children and Family Health
Public Health	Public Health Administrative Services
Public Health	Certification and Licensing
Public Health	Chronic Disease Prevention and Health Promotion
Public Health	Epidemiology
Public Health	Bureau of Vital Statistics
Public Health	Community Health/Emergency Medical Services
Public Health	Community Health Grants
Public Health	Emergency Medical Services Grants
Public Health	State Medical Examiner
Public Health	Public Health Laboratories
Public Health	Tobacco Prevention and Control
Senior and Disabilities Services	Senior and Disabilities Medicaid Services
Senior and Disabilities Services	Senior and Disabilities Services Administration
Senior and Disabilities Services	Protection and Community Services
Senior and Disabilities Services	Senior Community Based Grants
Senior and Disabilities Services	Senior Residential Services
Senior and Disabilities Services	Community Developmental Disabilities Grants
Departmental Support Services	Unallocated Reduction
Departmental Support Services	Commissioner's Office
Departmental Support Services	Office of Program Review
Departmental Support Services	Office of Faith Based & Community Initiatives
Departmental Support Services	Rate Review
Departmental Support Services	Assessment and Planning
Departmental Support Services	Administrative Support Services
Departmental Support Services	Hearings and Appeals
Departmental Support Services	Medicaid School Based Admin Claims
Departmental Support Services	Facilities Management
Departmental Support Services	Health Planning and Infrastructure
Departmental Support Services	Information Technology Services
Departmental Support Services	Facilities Maintenance
Departmental Support Services	Pioneers' Homes Facilities Maintenance
Departmental Support Services	HSS State Facilities Rent

Boards and Commissions	AK Mental Health & Alcohol & Drug Abuse Boards
Boards and Commissions	Commission on Aging
Boards and Commissions	Governor's Council on Disabilities and Special Education
Boards and Commissions	Governor's Advisory Council on Faith-Based & Community Initiatives
Boards and Commissions	Pioneers Homes Advisory Board
Boards and Commissions	Suicide Prevention Council
Human Services Community Matching Grant	Human Services Community Matching Grant

ABADA .....Advisory Board on Alcoholism and Drug Abuse
ABDR .....Alaska Birth Defects Registry
ABS.....Alaska Budget System
ACOA .....Alaska Commission on Aging
ACT.....Alaska Children's Trust
ADRD .....Alzheimer's Disease and Related Dementias
ADTPF.....Alcohol and other Drug Treatment and Prevention Fund
AERT .....Alaska Emergency Response Team
AFHCAN .....Alaska Federal Health Care
AJJAC.....Alaska Juvenile Justice Advisory Committee
AKAIMS……Alaska Automated Information Management System
AKPH……Alaska Pioneer Homes
AKSAP .....Alaska Senior Assistance Program
AKSAS .....Alaska State Accounting System
AMHB.....Alaska Mental Health Board
AMHTA.....Alaska Mental Health Trust Authority
APA.....Adult Public Assistance
APD.....Adults with Disabilities (Waivers)
APHIP.....Alaska Public Health Improvement Process
APHL .....Alaska Public Health Laboratories
API .....Alaska Psychiatric Institute
ARND .....Alcohol and Related Neurodevelopmental Disorder
ARBD .....Alcohol Related Birth Defects
ART.....Aggression Replacement Training
ASAP .....Alcohol Safety Action Program
ASTHO .....Association of State & Territorial Health Officials
ATAP .....Alaska Temporary Assistance Program
ATCA.....Alaska Tobacco Control Alliance
ATSDR .....Agency for Toxic Substances and Disease Registry
AVCP.....Association of Village Council Presidents
BB .....Better Beginnings
BBNA .....Bristol Ban Native Association
BCC.....Breast and Cervical Cancer
BH.....Behavioral Health
BHIP .....Behavioral Health Integration Project
BMI.....Body Mass Index
BRFSS.....Behavioral Risk Factor Surveillance System
BRS.....Behavioral Rehabilitation Services
BTKH.....Bring the Kids Home
BVS.....Bureau of Vital Statistics

CAHPS.....Consumer Assessment of Health Plans Survey
CAMA.....Chronic and Acute Medical Assistance
CAPI .....Community Action, Prevention and Intervention
CCDF .....Child Care Development Fund
CCISC.....Comprehensive, Continuous, Integrated System of Care
CCMC.....Children with Complex Medical Conditions (Waiver)
CCTHITA .....Central Council of Tlingit and Haida Indian Tribes of Alaska
CD.....Chronic Disease Prevention and Health Promotion component
CDC .....Center for Disease Control
CDDG .....Community Developmental Disabilities Grants
CDFA.....Catalogue of Federal Domestic Assistance
CDVSA.....Council on Domestic Violence and Sexual Assault
CFR.....Code of Federal Regulations
CFSR.....Federal Child and Family Services Review
CHATS .....Community Health Aide Training and Supervision
CHEMS.....Community Health & Emergency Medical Services
CHIP .....Children's Health Insurance Program
CIMHP.....Comprehensive Integrated Mental Health Plan
C&L .....Certification & Licensing
CITC .....Cook Inlet Tribal Corporation
CLIA .....Clinical Laboratory Improvement Amendments
CMHC.....Community Mental Health Center
CMHS .....Community Mental Health Services Block Grant
CMI.....Chronically Mentally Ill
CMS .....Center for Medicare and Medicaid Services
COFIT.....Outcome Fidelity and Implementation Tool
COMPASS.....Community Partnership for Access Solutions and Success
COPD.....Chronic Obstructive Pulmonary Disease
COSIG.....Co-Occurring State Inventive Grants
CPS .....Child Protective Services (Office of Children's Services)
CPS .....Child Passenger Safety (Public Health)
CQI.....Continuous Quality Improvement
CSAT .....Center for Substance Abuse Treatment
CSM.....Children's Services Management
CSN.....Children with Special Needs
CSR.....Client Status Review
CSU.....Crisis Stabilization Unit
CTC.....Crisis Treatment Center
DAI .....Detention Assessment Instrument
DBH.....Division of Behavioral Health
DD.....Developmentally Disabled

DE&ED.....Department of Education & Early Development
DET.....Designated Evaluation & Treatment
DHSS .....Department of Health and Social Services
DJJ.....Division of Juvenile Justice
DKC .....Denali KidCare (State Children's Health Insurance Program)
DOL/WD.....Department of Labor and Workforce Development
DOT .....Direct Observed Therapy
DPA.....Division of Public Assistance
DPH.....Division of Public Health
DSDS .....Division of Senior and Disabilities Services
DSH.....Disproportionate Share Hospital
DSS .....Department Support Services (aka Finance and Management Services)
DWI.....Driving While Intoxicated
EAP .....Energy Assistance Program
EBT .....Electronic Benefit Transfer
ECCS.....Early Childhood Comprehensive Systems Project
EI.....Early Intervention
EIEIO .....Early Intervention, Enhancement and Improvement Opportunity
EI/ILP.....Early Intervention/Infant Learning Program
EIS.....Eligibility Information System
EMS .....Emergency Medical Services
EPI.....Epidemiology
EPSDT .....Early & Periodic Screening, Diagnosis and Treatment
FAE .....Fetal Alcohol Effects
FARS.....Fatal Accident Reporting System
FAS .....Fetal Alcohol Syndrome
FASD .....Fetal Alcohol Spectrum Disorder
FBCI.....Faith Based and Community Initiatives
FLSW.....Front Line Social Worker
FMAP.....Federal Medical Assistance Program
FMS.....Finance and Management Services
FS .....Food Stamps
FTE .....Full Time Equivalent
GCDSE .....Governor's Council on Disabilities and Special Education
GRA .....General Relief Assistance
HAIL .....Healthy Alaskans Information Line
HAN.....Health Alert Network
HAP.....Heating Assistance Program
HCBC.....Home and Community Based Care
HCBW.....Home and Community Based Waivers
HCP.....Health Care Program

HCS.....Health Care Services
HF .....Healthy Families
HIFA .....Health Insurance Flexibility and Accountability
HIPP.....Health Insurance Premium Payment (Medicaid)
HIPPA.....Health Insurance Portability and Accountability Act
HIV .....Human Immunodeficiency Virus
HPG.....Health Purchasing Group
HRSA.....Health Resource Services Administration
HSCMG .....Human Services Community Matching Grants
IA .....Interim Assistance
I/A .....Interagency Receipts
IDEA.....Individuals with Disabilities Education Act
IDP .....Institutional Discharge Planning
IEP.....Individualized Education Plan
IFSP.....Individual Family Service Plan
IHS .....Indian Health Services
ILLECP.....Local Law Enforcement & Community
ILP.....Infant Learning Program
IMD.....Institution for Mental Disease
IOP .....Intensive Outpatient Program
IPEAMS.....Injury Prevention & Emergency Medical Services
ISA .....Individualized Service Agreements
IT.....Information Technology
ITG.....Information Technology Group
JAIBG .....Juvenile Accountability and Incentive Block Grant
JCAHO.....Joint Commission on Accreditation of Healthcare Organizations
JJDP .....Office of Juvenile Justice and Delinquency Prevention
JOMIS.....Juvenile Offender Management Information System
JPO.....Juvenile Probation Officer
JTPA .....Job Training Partnership Act
LCSW .....Licensed Certified Social Worker
LIHEAP .....Low Income Home Energy Assistance Program
LTC.....Long Term Care
MBU .....Medicaid Budget Unit
MCAC.....Medicaid Care and Advisory Committee
MCFH .....Maternal, Child & Family Health
MCH .....Maternal, Child Health (Block Grant)
MHDD .....Mental Health and Developmental Disabilities
MHSIP .....Mental Health Statistics Improvement Project
MHTAAR .....Mental Health Trust Authority Authorized Receipts
MIS .....Management Information System

MMIS.....Medicaid Management Information System
MMIS-JUCE.....MMIS – Juneau Claims and Eligibility System
MOA .....Municipality of Anchorage or Memorandum of Agreement
MOE.....Maintenance of Effort
MRDD.....Mental Retardation/Developmental Disability (Waiver)
MYC .....McLaughlin Youth Center
NPS .....National Pharmaceutical Stockpile
NRO .....Northern Region Office
NSH.....North Star Hospital
NSIF.....Nutrition Services Incentive Program
NTSS.....Nutrition, Transportation and Support Services
OA.....Older Alaskans
OAA.....Older Alaskan's Act
OCS.....Office of Children's Services
OEP .....Office of Emergency Preparedness
OOS.....Out of State
OPR.....Office of Program Review
ORCA .....Online Resource for the Children of Alaska
ORR .....Office of Rate Review
OSEP.....Office of Special Education Programs
PA .....Public Assistance
PASS.....Parents Achieving Self-Sufficiency
PASS Grant.....Personal Assistance, Supports and Services
PC.....Personal Computer
PCA.....Personal Care Attendant
PCBs .....Polychlorinated Biphenyls
PCCM .....Primary Care Case Management
PCN.....Position Control Number
PCSA.....Protection, Community Services and Administration
PDL .....Preferred Drug List
PDPs.....Prescription Drug Plans
PEC .....Proposal Evaluation Committee
PERM.....Payment Error Rate Measure
PES.....Psychiatric Emergency Services
PFDHH .....Permanent Fund Dividend Hold Harmless
PFT.....Permanent Full Time
PHAB.....Pioneers' Homes Advisory Board
PHN.....Public Health Nursing
PIC .....Private Industry Council
PIP.....Performance (or Program) Improvement Plan
POP .....Persistent Organic Pollutants

PPC .....Prevention Policy Committee
PPT.....Permanent Part-Time
PRAMS.....Pregnancy Risk Assessment Monitoring System
PRWORA .....Personal Responsibility and Work Opportunity Reconciliation Act
PSR .....Protective Service Reports
RCC.....Residential Child Care
RDT.....Residential Diagnostic Treatment
RDU .....Results Delivery Unit
RFP .....Request for Proposal
RFR.....Request for Recommendations
RHSS.....Rural Health Services System
RPMS.....Resources and Patient Management System
RPTC.....Residential Psychiatric Treatment Center
RSA.....Reimbursable Services Agreement
RSS .....Receipt Supported Services
RSSP .....Rural Services and Suicide Prevention
SAG.....Subsidized Adoption and Guardianship
SAMHSA.....Substance Abuse and Mental Health Services Administration
SAPT.....Substance Abuse Prevention and Treatment Block Grant
SCHIP .....State Children's Health Insurance Program
SCRO .....South Central Region Office
SDPR.....Statutory Designated Program Receipts
SDS .....Senior and Disabilities Services
SECC.....State Emergency Coordination Center
SEARHC.....Southeast Alaska Regional Health Consortium
SEARCH.....Student Experiences & Rotations in Community Health
SED.....Seriously Emotionally Disturbed
SERO .....Southeast Region Office
SIG/ACT.....State Incentive Grant/Alaskans Collaborating for Teens
SME .....State Medical Examiner
SMI .....Supplementary Medical Insurance
SPMP .....Skilled Professional Medical Personnel
SSBG.....Social Services Block Grant
SSI.....Supplemental Security Income
STAR Grants.....Short Term Assistance and Referral
STD.....Sexually Transmitted Disease
SVCS/SMI .....Services to the Seriously Mentally Ill
TANF .....Temporary Assistance to Needy Families
TB .....Tuberculosis
TCC.....Tanana Chiefs Conference
TCM.....Targeted Case Management

TDM.....Team Decision Making
TEFRA.....Tax Equity and Fiscal Responsibility Act of 1982
TFAP.....Tribal Family Assistance Programs
Title V.....Maternal, Child Health Block Grant
Title X.....Family Planning (Federal)
Title XIX.....Medicaid
Title XXI.....SCHIP/Denali KidCare
T&H.....Central Council of Tlingit and Haida Indian Tribes
TPL.....Third Party Liability
TWWIIA.....Ticket to Work and Work Incentives Improvement Act of 1999
USDA.....U. S. Department of Agriculture
WAS.....Women and Adolescent Services
WIA.....Workforce Investment Act
WIC.....Women, Infants and Children
WSEA.....Western States EBT Alliance
WtW.....Welfare to Work
YF.....Youth Facility
YKHC.....Yukon-Kuskokwim Regional Health Corporation
YRBS.....Youth Risk Behavior Survey